Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
T: 02890 251005 | E: info@usi.org.uk | W: www.urologyservicesinquiry.org.uk

Eamon Mackle
C/O
Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

29 April 2022

Dear Sir,

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 provision of evidence in the form of a written statement

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.

You will be aware that the Inquiry has commenced its investigations into the matters set out in its Terms of Reference. The Inquiry is continuing with the process of gathering all of the relevant documentation from relevant departments, organisations and individuals. In addition, the Inquiry has also now begun the process of requiring individuals who have been, or may have been, involved in the range of matters which come within the Inquiry's Terms of Reference to provide written evidence to the Inquiry panel.

The Urology Services Inquiry is now issuing to you a Statutory Notice (known as a Section 21 Notice) pursuant to its powers to compel the provision of evidence in the form of a written statement in relation to the matters falling within its Terms of Reference.

The Inquiry is aware that you have held posts relevant to the Inquiry's Terms of Reference. The Inquiry understands that you will have access to all of the relevant information required to provide the witness statement required now or at any stage

throughout the duration of this Inquiry. Should you consider that not to be the case, please advise us of that as soon as possible.

The Schedule to the enclosed Section 21 Notice provides full details as to the matters which should be covered in the written evidence which is required from you. 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.

You will note that certain questions raise issues regarding documentation. As you are aware the Trust has already responded to our earlier Section 21 Notice requesting documentation from the Trust as an organisation. However if you in your personal capacity hold any additional documentation which you consider is of relevance to our work and is not within the custody or power of the Trust and has not been provided to us to date, then we would ask that this is also provided with this response.

If it would assist you, I am happy to meet with you and/or the Trust's 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 particular, you are asked to provide your evidence in the form of the template witness statement which is also enclosed with this correspondence. 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 you must make 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.

Finally, I would be grateful if you could acknowledge receipt of this correspondence and the enclosed Notice by email to Personal Information redacted by the USI.

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 USI
Mobile: Personal Information redacted by USI

Issued by the Urology Services Inquiry on 29 April 2022. Annotated by the Urology Services Inquiry.

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

Chair's Notice

[No 34 of 2022]

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:

Mr. Eamon Mackle
C/O
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

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.

WITNESS STATEMENT 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)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by **noon on 10th June 2022.**

APPLICATION TO VARY OR REVOKE THE NOTICE

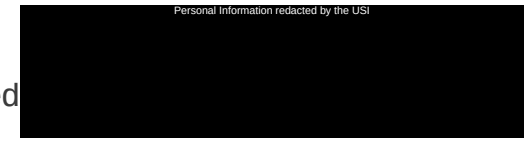
AND FURTHER TAKE NOTICE that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

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 **noon on 3rd June 2022**.

Issued by the Urology Services Inquiry on 29 April 2022. Annotated by the Urology Services Inquiry.

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 29th April 2022

Signed 

Christine Smith QC

Chair of Urology Services Inquiry

Urology Services Inquiry

SCHEDULE
[No 34 of 2022]

General

1. Having regard to the Terms of Reference of the Urology Services Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of sub-paragraph (e) of those Terms of Reference concerning, inter alia, 'Maintaining High Professional Standards in the Modern HPSS' ('MHPS Framework') and the Trust's investigation. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, 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 using the form provided.

2. Provide any and all documents within your custody or under your control relating to paragraph (e) of the Terms of Reference except where those documents have been previously provided to the Inquiry by the SHSCT. Provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below.

3. Unless you have specifically addressed the issues in your reply to Question 1 above, answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person. When answering the questions set out below you will need to equip yourself with a copy of *Maintaining High Professional Standards in the Modern HPSS' framework ('MHPS')* and the '*Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance' ('Trust Guidelines').*

Policies and Procedures for Handling Concerns

4. Were you aware of the '*Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance'* published 23 September 2010? If so, when you were aware of concerns, did you implement those Guidelines? If so, set out in full how you did so on every occasion and with whom you engaged. If not, why not?

5. If you were not aware of the '*Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance'* what was your understanding of the reporting of concerns relating to other doctors practices? How, if at all, did this understanding inform your response to concerns you were aware of regarding urology services?

6. In your role as a clinical manager what, if any, training or guidance did you receive with regard to:

I. The MHPS framework;
II. The Trust Guidelines; and
III. The handling of performance concerns generally.

7. Specifically, what if any training or guidance did you receive with regard to the conduct of "*preliminary enquiries*" under Section I para 15 of MHPS or the undertaking of an *"initial verification of the issues raised"* under paragraph 2.4 of the Trust Guidelines.

Handling of Concerns relating to Mr O'Brien

8. In respect of concerns which you are aware of regarding the practice of Mr Aidan O'Brien prior to 23 March 2016, explain why you did not implement or apply the MHPS Framework and/or the Trust Guidelines notwithstanding the existence of performance concerns. Outline the full extent of any advice or discussions you had with any other individual on decision making concerning the implementation or application of the MHPS Framework and/or the Trust Guidelines.

9. With regard to the meeting held with Mr Aidan O'Brien on 23 March 2016 and the associated letter which was handed to him, and while noting your response to a previous notice under Section 21, further detail is required which is to be provided by addressing the following matters;

    I. Outline when you first become aware of concerns, or received information which could have given rise to concerns, relating to;
        i. Untriaged outpatient referral letters
        ii. Current Review Backlog up to 29 February 2016
        iii. Patient Centre letters and recorded outcomes from Clinics
        iv. Patient Notes at home

    II. Outline fully the circumstances which led to these four concerns being discussed with Mr O'Brien and included in the correspondence dated 23 March 2016.

    III. What, if any action, did you take to verify the nature or extent of these concerns prior to March 2016 and who did you discuss these concerns with?

    IV. Do you consider that this meeting and the associated letter were steps taken under or pursuant to the MHPS framework and/or the Trust Guidelines? If so, at what stage of those respective processes did those steps represent?

    V. If you consider that this meeting and the associated letter did not constitute steps taken under or pursuant to the MHPS framework and/or Trust Guidelines, explain why you are of that view, and specify the procedure you and your colleague(s) were operating under when those steps were taken.

    VI. What action did you take as Mr O'Brien's clinical manager to assess the substance or accuracy of the concerns, whether to verify or refute them?

    VII. How did Mr O'Brien respond to being informed of the concerns and presented with the letter?

    VIII. What action was Mr O'Brien to take in respect of the matters referred to at the meeting and letter, and was a time-frame for compliance specified for him?

    IX. What, if any, support or assistance was offered to Mr O'Brien to ensure that he was enabled to comply with the stipulated actions?

    X. Following the issuing of the letter, was an action plan to deal with the concerns ever received from Mr O'Brien and if not, were further requests made for its production requested?

XI. Following the meeting held with Mr O'Brien, what arrangements were put in place to ensure that the concerns were being monitored and addressed? Whether or not arrangements were put in place, who was responsible for monitoring the issues which gave rise to concern?

XII. Were the concerns raised, registered or escalated with the Chief Executive as required by Section I paragraph 8 of MHPS and paragraph 2.2 of the Trust Guidelines? If not, why not?

XIII. Outline how the concerns were raised, registered or escalated to the Service Director and the Medical Director?

XIV. Outline how the correspondence and the outcome from the meeting were raised, registered or escalated to the Service Director and the Medical Director?

10. When, and in what circumstances, did you first became aware of concerns, or receive any information which could have given rise to a concern that Mr O'Brien may have been affording advantageous scheduling to private patients.

11. On your retirement from your role of Associate Medical Director for Surgery in April 2016, who replaced you in that role? What handover did your provide that individual generally and specifically with regard to issues of concern raised with Mr Aiden O'Brien in March 2016? Disclose copies of any documentation which may have formed part of a handover generally or specifically with regard to Mr Aiden O'Brien, or confirm that no such documentation exists.

Implementation and Effectiveness of MHPS

12. Having regard to your experience as a clinical manager in relation to the investigation into the performance of Mr Aidan O'Brien, what impression have you formed of the implementation and effectiveness of MHPS and the Trust Guidelines both generally, and specifically as regard the case of Mr O'Brien?

13. Consider and outline the extent to which you feel you could effectively discharge your role under MHPS and the Trust Guidelines in the extant systems within the Trust and what, if anything, could be done to strengthen or enhance that role.

14. Having had the opportunity to reflect, outline whether in your view the MHPS process could have been better used in order to address the problems which were found to have existed in connection with the practice of Mr O'Brien.

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.

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: S21 No.34 of 2022
Date of Notice: 29 April 2022

Witness Statement of: Edward (Eamon) John Mackle

I, Edward (Eamon) John Mackle, will say as follows:-

[1] Having regard to the Terms of Reference of the Urology Services Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of sub-paragraph (e) of those Terms of Reference concerning, inter alia, 'Maintaining High Professional Standards in the Modern HPSS' ('MHPS Framework') and the Trust's investigation. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, 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 using the form provided.

1. In this witness statement I have attempted to provide as detailed an answer as I can to each of the specific questions at numbers 4 to 14. I consider that, together, my answers to those questions provide a comprehensive and broadly chronological account of my involvement in the matters relevant to sub-paragraph (e) of the Inquiry's Terms of Reference. However, in light of the request made in Question 1, from paragraph 2 to 19 below I offer a narrative overview of my involvement in the relevant issues (referring, where appropriate, to my answers to other questions in this statement). This is not intended to replace, but rather to complement, the more detailed responses given at Questions 4 to 14.

2. As indicated in my earlier Witness Statement (S.21 Notice No.4 of 2022), I was appointed Associate Medical Director for Surgery and Elective Care in the Southern Trust in 2008. One of my responsibilities was for the Urology Service. While I was aware that policies and procedures existed within the Trust for when one had concerns regarding a doctor's practice, I would have had to ask for advice to identify the policies and/or procedures to be followed.

3. While reflecting on this S.21 Notice, I recalled that in, I believe, approximately 2008, I was asked by the Western Trust to assist in a review of one of their consultants. I attended a training session on the MHPS framework that the Western Trust ran for their staff. I cannot be sure if it was a half day or a full day course. Afterwards, however, my assistance was not required. Following this I do not recall any further updates or training on the Framework or its implementation. In particular, I do not recall the Trust organising any training.

4. On review of the minutes of the AMD meeting held on 17 September 2010 I note that a draft of the document "Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance" was tabled. I was on leave at that time and I do not recall reading the draft nor a final non-draft copy. I cannot recall the Trust organising any training in respect of its implementation.

5. In approximately March 2009 (and as outlined in my statement in response to No.4 of 2022), the issue of IV fluids and IV antibiotics arose in respect of urology. Paddy Loughran, Medical Director, oversaw the investigation of the practice and obtained independent advice. He introduced a protocol involving a multidisciplinary team that was to be followed in respect of the management of these patients. On 9 September 2010, Gillian Rankin, Acute Services Director, and I met with Aidan O'Brien and informed him of the process to be followed. We required to meet with him again on 9 June 2011 to reinforce the process and I emailed him on 15 June 2011, following a further breach, informing him that the protocol was not-negotiable.

6. On 1 September 2010, Dr Diane Corrigan, Consultant in Public Health Medicine, wrote to Paddy Loughran regarding the high number of benign cystectomies being

performed in the Trust. On Paddy Loughran's instructions I obtained an independent review of the practice by Marcus Drake, Consultant Urologist in Bristol. While Marcus Drake had been unable to obtain all the requested information, Dr Loughran concluded that there were no gross errors and assured Diane Corrigan that no further elective cystectomies would be performed in the trust.

7. Failure to complete timely triage was a problem which occurred at several intervals. As Lead Clinician for Out-patients, in approximately 1996 I was asked to speak to Aidan O'Brien regarding untriaged letters. I also informed my Clinical Director, Osmond Mulligan, and the Chief Executive, John Templeton. I believe I was also asked to speak to Mr O'Brien on two occasions in the period 2007 to 2009.

8. In April 2010 we became aware of a significant number of untriaged referrals and, following instruction from Gillian Rankin, I informed Aidan O'Brien that planned study leave would be cancelled if he didn't complete his triage; by the following day it was completed. On 6 April 2011 Gillian Rankin, Heather Trouton (Assistant Director) and I met with Aidan O'Brien to discuss delay in triaging.

9. Robin Brown, Clinical Director, spoke to Aidan O'Brien regarding triage in July 2013. Heather Trouton in November 2013 requested Michael Young (Lead Clinician) and Robin Brown to help sort the issue of triage.

10. In February 2014 Debbie Burns (Acute Director) wrote to say that Aidan O'Brien would only be triaging named referrals (i.e., referrals specifically sent to him). Then at some stage in 2014 Debbie Burns instructed the Booking Centre to initially record all referrals as per the GP grading pending a completed triage in order to reduce any potential risk to patient safety by a delay in placing them on the waiting list.

11. Gillian Rankin and Debbie Burns were both aware of the issues regarding triage and I also made Paddy Loughran and John Simpson (Medical Director) aware during my one-on-one meetings. I admit, however, that I did not raise it as a serious governance issue. I cannot recall if I spoke to Richard Wright (Medical Director) about the matter prior to December 2015.

12. I admit that, in the context of these persistent and recurring triage issues, I do not recall considering the MHPS Framework at any point. It also appears, as far as I can tell, that none of the Acute Directors or Medical Directors considered the MHPS Framework either. On reflection, I now believe that the persistent failure by Aidan O'Brien to complete timely triage should have triggered an investigation into his practice under the MHPS Framework.

13. On 15 June 2011 it was discovered that Aidan O'Brien had disposed of portions of the medical records of two patients in the bin. This led to HR being informed and an investigation was performed utilising the Trust Disciplinary Procedures and he was issued with an informal warning.

14. In 2011 I became aware that, following an SAI into a 'never event', it was apparent that Aidan O'Brien did not routinely review test results until the patient was reviewed. On 26 August 2011 I raised it with Gillian Rankin as a governance issue. My recollection is that Gillian Rankin, following a survey of other consultants' practice, issued an instruction to all consultants that it was their responsibility to review the results of investigations on their patients when they became available.

15. Diane Corrigan also noted the issue on reviewing the SAI and she wrote to John Simpson, Gillian Rankin and Debbie Burns (at that stage Assistant Director Clinical & Social Care Governance) regarding the issue on 14 November 2011, and John Simpson then wrote to Gillian Rankin on 9 December 2011 looking for an update.

16. In September 2013 the issue of charts being at Aidan O'Brien's home was raised by Helen Forde (Head of Health Records) with Heather Trouton and Anita Carroll (Assistant Director Support Services) and, through them, to Debbie Burns (Acute Director). On 3 September 2013 Debbie Burns instructed Robin Brown to speak to him. A further DATIX was raised on 21 September 2013 so Martina Corrigan (Head of Urology Service) wrote to Robin Brown who replied saying that he would speak to him.

17. I don't recall the issue of charts at home being raised again with me as a concern until the end of 2015. Heather Trouton made me aware of the Aidan O'Brien issues detailed in the letter of 23 March 2016, namely:

(i) A significant number of untriaged letters - It was only when an investigation was performed by Martina Corrigan that we became aware of the figure 253.

(ii) Review backlog - Unlike his colleagues, there was no agreement on validation of the review backlog. The issue of a review backlog was not unique to Aidan O'Brien or Urology but what was needed was agreement on how the backlog could be validated and to also ensure that there were no clinically urgent patients sitting on the list.

(iii) The Trust became aware at the end of 2015 that letters were not being dictated after clinics and also that patient outcomes were not being recorded.

(iv) Aidan O'Brien was attending South West Acute Hospital for outpatient clinics. The Trust delivered the charts to SWAH but the consultants had to transport the charts back to the hospital. It became apparent that there was a significant number of charts in either Aidan O'Brien's house or car.

18. Heather Trouton and I both felt that serious governance concerns had been discovered. I do not recall considering the Trust Guidelines or the MHPS Framework at that time. However, we both agreed that we needed advice from Richard Wright as to the management of the issues. In, I believe, January 2016 Richard Wright met us on the Admin Floor of Craigavon Area Hospital and recommended an exercise be undertaken to confirm the facts and then to present a summary to Aidan O'Brien for action. I do not recall Richard Wright discussing utilising either the MHPS or the Trust Framework at that stage.

19. Whatever else one may say about Aidan O'Brien, no one can say that he wasn't hard working and committed to his patients. He was certainly not the first to arrive in the morning but he was among the last, if not *the* last, to leave in the evening. He was held in high regard by the majority of the staff in the hospital including porters, other ancillary staff, nurses, doctors and his Clinical Director. It was against this background that we judged him and his flaws. As a result, on reflection, I believe that

there was a collective failure at all levels within the Trust to recognise that Aidan O'Brien's repeated administrative failings could lead to serious harm.

20. I think training of all consultants in respect of the Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance and/or the MHPS Framework should have taken place. Furthermore, as with other items of Trust Mandatory training, there should be regular updates, particularly for the Lead Clinicians, Clinical Directors and Associate Medical Directors as I have come to realise that, if training is not followed by utilising the information obtained, then it can quickly be forgotten.

[2] Provide any and all documents within your custody or under your control relating to paragraph (e) of the Terms of Reference except where those documents have been previously provided to the Inquiry by the SHSCT. Provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below.

[3] Unless you have specifically addressed the issues in your reply to Question 1 above, answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person. When answering the questions set out below you will need to equip yourself with a copy of *Maintaining High Professional Standards in the Modern HPSS' framework ('MHPS')* and the '*Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance' ('Trust Guidelines').*

<u>Policies and Procedures for Handling Concerns</u>

[4] Were you aware of the '*Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance'* published 23 September 2010? If so, when you were

aware of concerns, did you implement those Guidelines? If so, set out in full how you did so on every occasion and with whom you engaged. If not, why not?

21. I was aware that there were policies and procedures in respect of concerns about a doctor's performance. On recently reviewing my emails I realise that a draft of the 2010 document "Trust Guidelines for Handling Concerns about Doctors' and Dentist's Performance" was tabled and discussed at the AMD meeting on 17 September 2010. *Document located in S21 No 34 of 2022 Attachments, 20100917 AMD Meeting Notes.* I was not present at the meeting as I was on leave from 11 September until 26 September. I do not recall reading the draft nor a final non-draft version. Once I was made aware, at the end of 2015, of the significant concerns regarding the failure of Aidan O'Brien to dictate clinic letters and of the lack of recording of clinic outcomes by, I believe, Heather Trouton, action was taken. While the Guidance was not followed (because, I believe, that at that time I did not recall that there was Guidance) the issues were escalated to the Medical Director for advice on how to manage the situation and the Acute Director was also made aware of the issues. As mentioned above, I did not follow the Trust's Guidelines because I believe that I did not recall the document and as a result I sought advice from the Medical Director.

[5] If you were not aware of the '*Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance*' what was your understanding of the reporting of concerns relating to other doctors practices? How, if at all, did this understanding inform your response to concerns you were aware of regarding urology services?

22. My understanding was that significant concerns regarding a doctor's practice needed to be escalated to the Medical Director and the Director of Acute Services. Hence when we became aware of the failure to record patient consultations and outcomes as well as ongoing issues regarding triage and notes at home both Heather Trouton and I felt that advice was required from the Medical Director.

Urology Services Inquiry

[6] In your role as a clinical manager what, if any, training or guidance did you receive with regard to:

The MHPS framework;

The Trust Guidelines; and

The handling of performance concerns generally.

23. I do not recall the Trust delivering any training or guidance regarding the (i) MHPS framework, (ii) The Trust Guidelines or (iii) the handling of concerns generally. However, on reflection regarding this question, I recall that in, I believe, approximately 2008 I was asked by the Western Trust to assist in a review of one of their consultants. I therefore attended a training session on the MHPS framework that the Western Trust ran for their staff. I cannot be sure if it was a half day or full day course. Ultimately, however, my assistance was not required by the Western Trust. Following this I do not recall any further updates or training on the Framework or its implementation by any other body.

[7] Specifically, what if any training or guidance did you receive with regard to the conduct of "*preliminary enquiries*" under Section I para 15 of MHPS or the undertaking of an *"initial verification of the issues raised"* under paragraph 2.4 of the Trust Guidelines.

24. As detailed in my response to question 6 above, I do not recall the Trust delivering any training or guidance regarding the conduct of "preliminary enquiries" under Section 1, para 15 of MHPS or the undertaking of an "initial verification of the issues raised" under paragraph 2.4 of the Trust Guidelines. However, as also indicated above, I believe I attended a course run by the Western Trust regarding the MHPS Framework in approximately 2008. I believe the course did cover the overall conduct of enquiries but I cannot recall any details.

<u>Handling of Concerns relating to Mr O'Brien</u>

[8] In respect of concerns which you are aware of regarding the practice of Mr Aidan O'Brien prior to 23 March 2016, explain why you did not implement or apply the MHPS Framework and/or the Trust Guidelines notwithstanding the existence of performance concerns. Outline the full extent of any advice or discussions you had with any other individual on decision making concerning the implementation or application of the MHPS Framework and/or the Trust Guidelines.

25. As detailed in my responses to Questions 54 to 57 of my first Section 21 Notice (No.4 of 2022) there were several issues over the years. I will attempt to summarise these and the actions taken below.

(I) IV Fluids and IV Antibiotics

(a) In approximately March 2009 we became aware of the issue of IV fluids and IV antibiotics. Paddy Loughran was informed of the practice, and he sought independent advice, following which he set up a multidisciplinary team to oversee the conversion of these patients from IV to oral administration. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20100902 Email Urology Services*.

(b) On 9 September 2010 Gillian Rankin and I met with Aidan O'Brien to inform him of the process he had to follow. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20100910-email urgent.*

(c) On 9 June 2011 Gillian Rankin, Heather Trouton and myself once more met with Aidan O'Brien to reinforce the process. *20110627-email urology meetings (this can be found in WIT 11854 – WIT 11861).* When I was made aware of a further breach of the protocol, one week later, I wrote to Aidan O'Brien again, copying Gillian Rankin, Heather Trouton and Helen Walker (Human Resources), informing him the protocol was not-negotiable. This can be located at *Relevant to PIT/ Evidence Added or Renamed 2019 2001 202022/ Evidence no 77/ No77-Eamon Mackle/ 20110615-email antibiotics and urology patients.pdf*

(II) Benign Cystectomies

(d) Paddy Loughran was made aware on 1 September 2010 by Diane Corrigan, Consultant in Public Health Medicine, of the high number of benign cystectomies being performed in the Trust. Document located in *Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20100901 – email urology.*

(e) An independent review of the practice was undertaken and, while Marcus Drake (Consultant Urologist in Bristol) had been unable to obtain all the requested information, Dr Loughran concluded that there were no gross errors and assured Diane Corrigan that no further elective cystectomies would be performed in the trust. Document located in *Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle*, *20110503-email NI SouthenTrust review of cystectomy cases.* Document located in *Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20110728, Email Urology Review.*

(f) On 6 August 2011 I became aware that Aidan O'Brien had performed a cystectomy on 6 July 2011. Document located in *S21 No 34 of 2022, 20110806 E re Cystectomy.* I wrote to Martina Corrigan asking her to check that I was correct. Following this, Gillian Rankin drafted a letter on 7 September 2011 informing the urologists that if any elective cystectomy was proposed then it had to be performed by the Belfast Service. Document located in *Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20110907-email - for comment correspondence to urologists.*

(III) Delayed Triage

(g) Delay in triage was an issue which occurred at several intervals.

(h) In approximately 1996, as Lead Clinician for Out-patients, I spoke to Aidan O'Brien about untriaged letters and I also informed my Clinical Director, Osmond Mulligan, and the General Manager, John Templeton. I believe I was asked to speak to Aidan O'Brien on two subsequent occasions in the period 2007 to 2009 but I can't remember who asked me to do so.

(i) In April 2010 we became aware of a significant number of untriaged referrals and, following instruction from Gillian Rankin, I informed Aidan O'Brien that planned study

leave would be cancelled if he didn't complete his triage; by the following day it was completed.

(j) On 6 April 2011 Gillian Rankin, Heather Trouton and I met with Aidan O'Brien to discuss delay in triaging. I do not have a minute of this meeting.

(k) As stated in paragraph 215 of my response to me first Section 21 Notice (No.4 of 2022), Heather Trouton shared an email with me which showed that Robin Brown spoke to Aidan O'Brien in July 2013 and December 2013 regarding triage. *20131204 E re Missing Triage. (this can be found in WIT 11954 – WIT 11962).*

In 2014 Debbie Burns wrote to me to say that Aidan O'Brien would only be triaging named referrals (referrals specifically sent to him). Document located in *Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 2010221 Email Yesterday.*

(l) At some stage in, I believe, 2014, Debbie Burns instructed the Booking Centre to initially record all referrals as per the GP grading pending a completed triage in order to reduce any potential risk to patient safety by a delay in placing them on the waiting list.

(m) During my one-on-one meetings with Paddy Loughran and John Simpson I discussed any issues which had occurred within the surgical specialties following our previous meeting and this included Aidan O'Brien and his tardiness at triage. I cannot recall if I discussed it with Richard Wright prior to December 2015.

(IV) Patient Records in a Bin

(n) On 15 June 2011 it was discovered that Aidan O'Brien had disposed of portions of the medical records of two patients in a bin. This led to HR being informed and an investigation was performed utilising the Trust Disciplinary Procedures and he was issued with an informal warning. Document located in *Relevant to HR/reference no 63/20110600 Ref 63 Disciplinary Report Mr AOBrien.*

(V) Reviewing Test Results

(o) In 2011 it was noted, following an SAI into a 'never event' (involving a retained swab) that Aidan O'Brien had a policy of not reviewing results until the patient was reviewed. When I became aware of this practice I raised it with Gillian Rankin on 26 August 2011 as a Governance concern. *Document located in Relevant to PIT,*

Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20110826 E re Results and Reports of Investigations.

(p) My recollection is that Gillian Rankin issued an instruction to all consultants that it was their responsibility to review the results of investigations on their patients when they became available.

(q) I note that, on 14 November 2011, Diane Corrigan wrote to John Simpson, Gillian Rankin and Debbie Burns regarding the issue. John Simpson then wrote to Gillian Rankin on 9 December 2011 asking for an update, I have not seen a copy of the reply. *Document located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20111209 SAI DB K.*

(VI) Patient Records at Home

(r) In 2013 the Head of Health Records, Helen Forde raised the issue of charts at Aidan O'Brien's home with Heather Trouton and Anita Carroll and, through them, Debbie Burns. *20130905 E re Charts to Consultants Home (this can be found in WIT 11963 – WIT 11965).*

(s) Debbie Burns on 3 September instructed Robin Brown to speak to Aidan O'Brien and, following a further DATIX, Martina Corrigan wrote to Robin Brown on 21 September 2013. I understand Robin had emailed Aidan O'Brien and said he would go and talk to him. *20130922 E re Datix Incident Report*. (*this can be found in WIT 11966 – WIT 11967*). I don't recall the issue of charts at home being raised with me again as a concern until the end of 2015.

(VII) Issues Raised in 2015

(t) When Heather Trouton made me aware of the issues that were ultimately detailed in the 23 March 2016 letter to Aidan O'Brien, I did not recall the Trust Guidelines. Rather, we agreed that advice should be obtained from the Medical Director. I then spoke to Richard Wright and appraised him of our initial concerns. A meeting was then held in the Administration Floor of the hospital in, I believe, January 2016, at which Heather Trouton and I together informed Richard Wright of our concerns regarding Aidan O'Brien. Richard Wright advised us to obtain as accurate figures as possible regarding the extent of the concerns and then present them to Aidan

O'Brien in a written form for his response. The Director of Acute Services was also made aware of the concerns and agreed with the advised plan of action.

Use/Non-use of MHPS and or Trust Guidelines

26. I address the use or non-use of the MHPS and Trust Guidelines in respect of each of the above issues below.

(I) IV Fluids and IV Antibiotics

(a) This issue was discussed with the Medical Director, who then took control of the process to be followed. Paddy Loughran engaged an independent opinion and then set up a multidisciplinary team and introduced a protocol which was required to be followed. In light of the Medical Director's direct involvement and instructions regarding management, I do not recall any consideration being given regarding applying the MHPS Framework.

(II) Benign Cystectomies

(b) Paddy Loughran was made aware of the issue by Diane Corrigan. He then advised Dr Rankin and myself of the process to be followed. I was instructed to seek assistance from Mark Fordham (Clinical advisor to the NI Urology Review) regarding a suitable expert to review a selection of the cases. When the results of Marcus Drake's review were obtained, Dr Loughran determined that there were no gross errors or faults.

(III) Delayed Triage

(c) As acknowledged above, I accept that, in the context of the persistent and recurring issues regarding triage, I do not recall ever considering the MHPS Framework. As far as I can tell, none of the Acute Directors or Medical Directors considered the MHPS Framework either. As also acknowledged above, I now believe, on reflection, that the repeated failure by Aidan O'Brien to complete timely triage should have triggered an investigation under the MHPS Framework.

(IV) Patient Records in a Bin

(d) When HR was informed of this matter they utilised the Trust's Disciplinary Procedures and Aidan O'Brien was issued with an informal warning.

(V) Reviewing Test Results

(e) I raised this with Gillian Rankin as a Governance issue and she issued an instruction to all consultants that it was their responsibility to review the results of investigations on their. John Simpson was aware of the issue. It was considered that the matter had been resolved.

(VI) Patient Records at Home

(f) The issue of notes at home was reported by Helen Forde to Heather Trouton and Anita Carroll and on through to Debbie Burns in September 2013. Debbie instructed Robin to speak to Aidan O'Brien. I don't recall any concerns regarding charts at home being further raised with me as an issue until December 2015. I did not therefore consider any further action necessary.

(VII) Issues Raised in 2015

(g) When I was made aware of the issues, Heather Trouton and I did not consider any particular set of Guidelines or Framework to follow; rather we approached the Medical Director for his advice on how to manage the issues and carried out his instructions.

[9] With regard to the meeting held with Mr Aidan O'Brien on 23 March 2016 and the associated letter which was handed to him, and while noting your response to a previous notice under Section 21, further detail is required which is to be provided by addressing the following matters;

I. **Outline when you first become aware of concerns, or received information which could have given rise to concerns, relating to;**
   - **i. Untriaged outpatient referral letters**
   - **ii. Current Review Backlog up to 29 February 2016**
   - **iii. Patient Centre letters and recorded outcomes from Clinics**
   - **iv. Patient Notes at home**

27.

(i) As indicated above and in my previous statement (No.4 of 2022) I was aware of periodic issues with Aidan O'Brien's triaging of referral letters at various points between 1996 and 2013. However, I believe that it was in December 2015 that I was informed by Heather Trouton that there was a significant number of untriaged letters. It was then only following an investigation by Martina Corrigan that I became aware of the figure of 253.

(ii) I believe it was January 2016 that I became aware of the concerns regarding the review backlog. The problem of a review backlog was widespread in all surgical specialities but the issue, as I understand it, was that the Trust had been unable to agree a process of validation of these patients with Aidan O'Brien to ensure that there were no red flag patients in the backlog.

(iii) I believe I first became aware of the issue regarding failure to dictate clinic letters and the non-recording of patient outcomes in December 2015.

(iv) It was known that Aidan O'Brien would have notes at home and, in this respect, he was not the only consultant who at times would have had charts in their house or private facility. In 2013 it was raised as a significant issue with Debbie Burns and she instructed Robin Brown to speak to Aidan O'Brien. I was copied into the correspondence by Debbie Burns. I do not recall it being raised with me as a significant issue until December 2015 or early 2016., *20130922 E re Datix Incident Report* (*this can be found in WIT 11966 – 11967)*.

II. **Outline fully the circumstances which led to these four concerns being discussed with Mr O'Brien and included in the correspondence dated 23 March 2016.**

28. My recollection is that in December 2015 Heather Trouton made me aware of the issues regarding a failure to record outcomes from Clinics and a failure to dictate clinic letters. My recollection is that the Trust became aware of the problem when other consultants who were validating waiting lists found that in many cases that there was no dictation following attendance at his out-patient clinics and there was no record on PAS of patient outcome. Heather Trouton also made me aware that delay in triage appeared to be a problem once more. Heather Trouton also made me aware that there appeared to be a significant number of hospital records that were in Aidan O'Brien's possession. I cannot recall when I was told about the issue regarding validation of the review backlog but I have a belief it was after we had met with Richard Wright. In light of the multiple issues, Heather Trouton and myself felt that we needed advice on management of the issues. We discussed the issues with Richard Wright and, on his advice, Martina Corrigan was tasked with trying to identify the extent of the problem. He advised us that, once we had verified the issues and their extent, it should be put in writing and given to Aidan O'Brien. Once Martina Corrigan had identified the extent of the problem, Heather Trouton drafted a letter to Aidan O'Brien, which I co-signed, summarising the issues.

III. **What, if any action, did you take to verify the nature or extent of these concerns prior to March 2016 and who did you discuss these concerns with?**

29. As stated above, once I was made aware by Heather Trouton of the concerns, we discussed the issues with Richard Wright. Martina Corrigan then undertook an exercise to identify the extent of the problem and reported back to Heather Trouton and myself. Esther Gishkori (Director of Acute Services) was made aware of the issues and of Richard Wright's advice by Heather Trouton and myself. Heather Trouton drafted the letter to Aidan O'Brien which I co-signed and I then met with Aidan O'Brien in the presence of Martina Corrigan. I informed him of the contents of the letter and presented him with a copy.

IV. **Do you consider that this meeting and the associated letter were steps taken under or pursuant to the MHPS framework and/or the Trust Guidelines? If so, at what stage of those respective processes did those steps represent?**

30. As stated above, I had not considered or recalled the MHPS framework or Trust Guidelines at the time. Rather, I had sought advice from the Medical Director and was following his instructions. I cannot say whether he (or any of the other persons involved) considered the letter and meeting to constitute part of the process under either the MHPS Framework or the Guidelines.

V. **If you consider that this meeting and the associated letter did not constitute steps taken under or pursuant to the MHPS framework and/or Trust Guidelines, explain why you are of that view, and specify the procedure you and your colleague(s) were operating under when those steps were taken.**

31. As stated above, I had not considered or recalled the MHPS framework or Trust Guidelines. Rather, I had sought advice from the Medical Director and was following his instructions.

VI. **What action did you take as Mr O'Brien's clinical manager to assess the substance or accuracy of the concerns, whether to verify or refute them?**

32. Before considering approaching Aidan O'Brien in respect of the issues, Heather Trouton and I requested Martina Corrigan to try to identify the extent of the problem regarding triage and to confirm the issue regarding Patient Centre letters and Clinic outcomes. My recollection is that the issue regarding validation of the review backlog was also identified and tabulated during this period.

VII. **How did Mr O'Brien respond to being informed of the concerns and presented with the letter?**

33. My recollection is that, when Aidan O'Brien attended the meeting, I thanked him for coming and explained I had a letter to discuss with him. Upon informing him of the issues, I asked him to respond with a commitment to address the issues and to produce a plan to address all the issues. Aidan O'Brien took the letter and my recollection is that all he then said was that he would have to consider the points in the letter. I believe I also asked him to let us know if he needed any help.

VIII. **What action was Mr O'Brien to take in respect of the matters referred to at the meeting and letter, and was a time-frame for compliance specified for him?**

34. Aidan O'Brien was requested to bring back to the hospital all the charts in his house and or car. He was requested to respond with a commitment to address the other issues and to respond to the Trust with a plan as to how to implement the plan. No specific time frame for response and compliance was specified.

IX. **What, if any, support or assistance was offered to Mr O'Brien to ensure that he was enabled to comply with the stipulated actions?**

35. I do not recall any specific support or assistance being offered to Aidan O'Brien nor do I recall him requesting any from the Trust. As stated in (VII) above, however, I believe I did ask him to let us know if he required any help. As I stepped down in April 2016 I am unaware if he ever requested any help or assistance.

X. **Following the issuing of the letter, was an action plan to deal with the concerns ever received from Mr O'Brien and if not, were further requests made for its production requested?**

36. I stepped down as Associate Medical Director the following month and I am not aware as to when and if any action plan was produced by Aidan O'Brien.

XI. **Following the meeting held with Mr O'Brien, what arrangements were put in place to ensure that the concerns were being monitored and addressed? Whether or not arrangements were put in place, who was responsible for monitoring the issues which gave rise to concern?**

37. As indicated in the previous answer, I stepped down as AMD the following month and the Assistant Director, Heather Trouton, who had initially made me aware of the concerns, changed roles in April 2016 (and was replaced by Ronan Carroll). Martina Corrigan meanwhile continued in her role as Head of Service. I therefore assumed that monitoring would be carried out by Martina Corrigan and Ronan Carroll.

XII. **Were the concerns raised, registered or escalated with the Chief Executive as required by Section I paragraph 8 of MHPS and paragraph 2.2 of the Trust Guidelines? If not, why not?**

38. As stated above, I had not considered or recalled the MHPS Framework or Trust Guidelines. Rather, I sought advice from the Medical Director and was following his instructions. The Acute Director was also made aware of the concerns but I do not know whether either the Medical Director or the Acute Director made the Chief Executive aware.

XIII. **Outline how the concerns were raised, registered or escalated to the Service Director and the Medical Director?**

39. When I was made aware by Heather Trouton of the issues we agreed that we should seek advice from the Medical Director. I informed Richard Wright of our concerns and he then organized to meet us in the Administration Floor of Craigavon Area Hospital in, I believe, January 2016, at which stage he advised the course of action for us to follow. Esther Gishkori was also informed of the issues by Heather Trouton and myself and of Richard Wright's advice.

XIV. **Outline how the correspondence and the outcome from the meeting were raised, registered or escalated to the Service Director and the Medical Director?**

40. Esther Gishkori was appraised of the correspondence and of the discussion with Aidan O'Brien. I cannot recall if I discussed it with Richard Wright before I stepped down as AMD.

[10] When, and in what circumstances, did you first became aware of concerns, or receive any information which could have given rise to a concern that Mr O'Brien may have been affording advantageous scheduling to private patients.

41. I cannot recall being presented with any evidence that Aidan O'Brien was prioritising patients for scheduling on the basis of them having seen him privately. I believe the issue was raised as a possibility with Heather Trouton on a few occasions but that, when challenged by Heather Trouton or Martina Corrigan, Aidan O'Brien had sound clinical reasons for his prioritisation. I cannot recall when I was informed of this and, for the avoidance of doubt, I had no direct or first-hand involvement in the matter.

[11] On your retirement from your role of Associate Medical Director for Surgery in April 2016, who replaced you in that role? What handover did your provide that individual generally and specifically with regard to issues of concern raised with Mr Aiden O'Brien in March 2016? Disclose copies of any documentation which may have formed part of a handover generally or specifically with regard to Mr Aiden O'Brien, or confirm that no such documentation exists.

42. I was replaced by Dr Charles McAllister. I have, when gathering information to aid with this response, sought information from Charles McAllister. He was able to confirm he had a copy of the 23 March 2016 letter but I can't recall if I gave it to him nor can he recall if it was given to him by me or by someone else. I recall that I carried out a verbal handover of any pressing issues in the Department and included the issues regarding Aidan O'Brien. I informed Dr McAllister that we had become aware of several issues namely: (a) failure to triage and that there was to the best of our knowledge 253 referral letters untriaged; (b) that there appeared to be a problem with recording of consultations/discharges; and (c) that there appeared to be a significant number of charts that were in his possession. I don't recall if I informed Dr McAllister about the issue of validation of the review backlog. I believe that I informed Dr McAllister when I had been made aware by Heather Trouton, and that I had had discussions with the Medical Director, Dr Richard Wright, and appraised him of our concerns. I advised him how, on the advice of Dr Wright and following confirmation by Martina Corrigan as to the extent of the problem, Heather Trouton drafted the 23 March 2016 letter which I co-signed and had given to Aidan O'Brien. I informed him that Aidan O'Brien was to address the issues and to revert with a plan of action. I also informed him that the Director of Acute Services, Esther Gishkori, was aware of the problem and was in agreement with the advice from Richard Wright and with the letter.

Implementation and Effectiveness of MHPS

[12] Having regard to your experience as a clinical manager in relation to the investigation into the performance of Mr Aidan O'Brien, what impression

have you formed of the implementation and effectiveness of MHPS and the Trust Guidelines both generally, and specifically as regard the case of Mr O'Brien?

43. When I sought advice I do not recall specific utilisation of either process being discussed. I understand that the informal approach under MHPS involves preliminary enquiries to verify or refute the accuracy of the complaint and, in essence, this is what we were instructed to do by the Medical Director. The data was checked by Martina Corrigan, a letter summarising the issues was drawn up, and then Aidan O'Brien was presented with a copy. He said he would consider the points and was to respond. As such the process was effective in alerting more senior managers, verifying the extent of the concerns and bringing them to Aidan O'Brien so that he had to provide a plan for resolution.

[13] Consider and outline the extent to which you feel you could effectively discharge your role under MHPS and the Trust Guidelines in the extant systems within the Trust and what, if anything, could be done to strengthen or enhance that role.

44. I do not recall the Trust delivering any training or guidance regarding the MHPS framework, the Trust Guidelines or the handling of concerns generally. I believe that I received training from the Western Trust in approximately 2008 but that training was never reinforced by putting it into practice. I believe that Lead Clinicians, Clinical Directors and Associate Medical Directors should all have received training in the above processes and that there should have been regular refresher training. Furthermore, if the steps being followed in March 2016 were part of the informal approach identified in section 1, paras 6 and 15-17 of the MHPS, then all those involved should have been made aware of this.

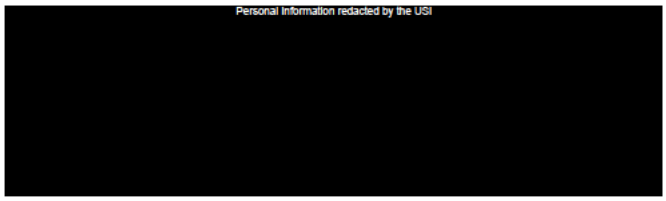
[14] Having had the opportunity to reflect, outline whether in your view the MHPS process could have been better used in order to address the problems which were found to have existed in connection with the practice of Mr O'Brien.

Urology Services Inquiry

45. As acknowledged at the beginning of this statement, whatever else one may say about Aidan O'Brien, no one can say that he wasn't hard working and committed to his patients. He was certainly not the first to arrive in the morning but he was among the last, if not *the* last, to leave in the evening. He was held in high regard by the majority of the staff in the hospital including porters, other ancillary staff, nurses, doctors and his Clinical Director. It was against this background that we judged him and his flaws. On reflection, I consider that there was a failure within the Trust to appreciate that the intermittent / recurring issues regarding Aidan O'Brien could lead to patient harm and serious governance issues. The Acute Directors and the Medial Directors were appraised at my one-on-one meetings of the issues if they were not already aware. I admit and accept that there was a collective failure to appreciate the risks of the issues, in particular, regarding the repeated failure to complete timely triage, and thus to implement the MHPS process prior to 2016.

Statement of Truth

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

Signed: 

Date: __07/06/2022_____

S21 34 of 2022

Witness statement of: Edward (Eamon) John Mackle

Table of Attachments

Attachment	Document Name
1	*20100917 AMD Meeting Notes*
2	*20110806 E re Cystectomy*

Subject: AMD Meeting - Friday 19th November
From: White, Laura <Personal information redacted by USI>
To: Aljarad, Bassam Dr - Children & Young Peoples Services <[redacted]>, Beckett Peter Dr - Older People and Primary Care <[redacted]>, Hall +15 More
Cc: Cunningham, Teresa <[redacted]>, Brennan, Anne <[redacted]>, Beattie Pauline <[redacted]>, Cornett +17 More
Sent: 11/16/2010, 2:26:09 PM

Message

Agenda - 19nov2010.doc

ITEM 2.1 - AMD Meeting 130810.doc

ITEM 2.2 - AMD Meeting 170910.doc

AMD Meeting held on on 17th September 2010

Present: Roberta Wilson, Dr C McAllister, Dr P Beckett, Anne Brennan, Dr B Aljarad, Dr S Hall, Dr P Murphy, Dr P Loughran

ITEM	NOTE	ACTION
1	**APOLOGIES** Dr J Simpson, Dr M Hogan. **WELCOME** Dr McAllister was welcomed to the meeting.	
	Audrey McCausland – Coding Presentation Audrey McCausland, Coding Manager reported to the group that there are 14 coders across hospital sites and 106,000 episodes. Audrey outlined work of coding offices. She outlined the process for collecting coding 95% completed in 31 days. ICD codes are available online. OPC not available online. Group discussed timing of coding and challenges this brings. Dr Loughran suggested that Dr John Harty should meet with Audrey/Coders to discuss Filemaker system. Group discussed the potential use of the Check list after death to support coding. be revised to assist coding.	***Dr Harty to meet with Coding staff re filemaker***

		Checklist After Death to be revised
	Medical Recruitment Issues – Karyn Patterson & Lynn Magee joined the meeting. Karyn Patterson outlined the current process for the recruitment and selection of medical staff. Group discussed dates for refresher training. The Group requested that a Programme for people who have had no training should be provided.	***Refresher dates to be circulated*** ***Dates for new training to be circulated***
2	**MINUTES OF LAST MEETING** Agreed	
3	**MATTERS ARISING** On Agenda	
4	**DRAFT GUIDANCE ON HANDLING CONCERNS** Dr Loughran outlined background to this guidance document. Group raised issues, Anne Brennan to redraft.	***Anne Brennan to redraft guidance.***
5	**PROFESSIONAL DEVELOPMENT AND STUDY LEAVE POLICY** AMDs discussed papers and expressed dissatisfaction with £600 budget. They outlined budgets in other Trusts. ➢ ·Belfast Trust – 2 overseas/2 local ➢ ·Western approve on request	***Dr Loughran to bring back comments to SMT***
6	**ROLE OF ASSOCIATE SPECIALIST** Group discussed papers and made changes. A Brennan to circulate.	***Anne Brennan to recirculate***
7	**JOB PLANNING UPDATE** Dr Loughran outlined progress to date on job planning SPAs. Group discussed concerns about how to standardise SPAs. Group discussed concerns about undertaking job planning in the period Jan – March 2010. Group discussed concept of uniformity of SPAs. Group discussed a way forward for deciding roles that trust is willing to pay for.	***Group agreed to review SPAs***

8	**APPRAISAL UPDATE** A Brennan to circulate	***Anne Brennan to circulate appraisal update***
9	**ANY OTHER BUSINESS** **9.1 Confidence in Care Guidance** A Brennan discussed and circulated the document to AMDs - comments to be forwarded to A Brennan **9.2 Hyponatremia** Dr Aljarad stressed the importance of Hyponatremia. **9.3 BBE and Hand Hygiene** Dr Loughran reiterated the importance of BBE among Medical staff **9.4 On-Call Microbiology Cover** Dr Loughran advised that there as a new protocol in distribution. Nurse led first on-call for Infection Control. **9.5 Governance Review** Dr Hall questioned when AMDs would see the new governance structures. Dr Loughran to share draft document.	***Comments from AMDs to Confidence in Care Documents*** ***Dr Loughran to share draft guidance***
12	**DATE OF NEXT MEETING** Friday 19th November 2010	

Stinson, Emma M

From: Corrigan, Martina
Sent: 19 May 2022 20:52
To: Stinson, Emma M
Subject: FW: Cystectomy

Hi Emma

As requested

Many thanks

Martina

-----Original Message-----
From: Mackle, Eamon <Personal Information redacted by USI>
Sent: 06 August 2011 10:52
To: Corrigan, Martina <Personal Information redacted by USI>
Subject: Re: Cystectomy

It said urostomy but included cystectomy.

----- Original Message -----
From: Corrigan, Martina
To: Mackle, Eamon
Sent: Sat Aug 06 10:41:41 2011
Subject: RE: Cystectomy

Oh this is the patient who had made a complaint about delay in treatment with Aidan and Dr Rankin met her with along with her Personal Information redacted by USI and I had been linking with Aidan and Anne McVey about her and it took a few weeks to organise!!

This patient had a joint operation with one of the gynae consultants but I was not aware that that she was to have a cystectomy.

I will look up all the information on her complaint - for some reason won't let me into my archive files at home but will let you know on Monday.

martina

-----Original Message-----
From: Mackle, Eamon
Sent: 06 August 2011 10:36
To: Corrigan, Martina
Subject: Re: Cystectomy

Personal Information redacted by USI, Patient 71

----- Original Message -----
From: Corrigan, Martina
To: Mackle, Eamon
Sent: Sat Aug 06 10:34:59 2011
Subject: RE: Cystectomy

Eamon

As far as I was aware he should not be - I am unsure whether he was ever told this and if it was just the benign ones that he could not do???

I have as you know been keeping an eye on theatre lists and Shirley normally lets me know which she had not done so. The date that this was done on was actually the week that I was in London with Anita but I would have still expected Shirley to let me know as I was still accessing emails and taking calls this week.

If you have patient name I will see if I can find out more on this?

Thanks

Martina

Martina Corrigan
Head of ENT and Urology
Craigavon Area Hospital

Tel: [redacted]
Mobile: [redacted]
Email: [redacted]

-----Original Message-----
From: Mackle, Eamon
Sent: 06 August 2011 09:36
To: Corrigan, Martina
Subject: Cystectomy

Martina

Are we still doing cystectomies? Aiden did one on 6/7/11

Eamon