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

Mr. Charles McAllister
C/O
Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

29 April 2022

Dear Mr. McAllister,

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 the USI
Mobile: Personal Information redacted by the 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 32 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. Charles McAllister
C/O
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

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

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

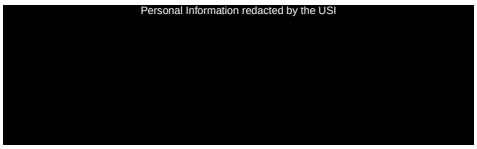
AND FURTHER TAKE NOTICE that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

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

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

SCHEDULE
[No 32 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. If you are in any doubt about the documents previously provided by the SHSCT you may wish to contact the Trust's legal advisors or, if you prefer, you may contact the Inquiry.

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 roles as 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 preliminary enquiries under Section I paragraph 15 of MHPS or the undertaking of an initial verification of the issues raised under paragraph 2.4 of the Trust Guidelines and the conduct of investigations under Section I paragraph 31 of MHPS and the Trust Guidelines.

8. The Inquiry is interested in your experience of handling of concerns regarding any staff member. Prior to your involvement in respect of the case of Mr O'Brien, specify whether you ever have had occasion to implement or apply MHPS and/or the Trust Guidelines in order to address performance concerns and outline the steps taken.

9. Outline how you understood the role of Clinical Manager was to relate to and engage with the following individuals under the MHPS Framework and the Trust Guidelines:

    I. Case Manager;
    II. Case Investigator;
    III. Chief Executive;
    IV. Medical Director;
    V. Designated Board member,
    VI. The clinician who is the subject of the investigation; and
    VII. Any other relevant person under the MHPS framework and the Trust Guidelines.

10. With regard to Section I paragraph 29 of the MHPS framework, what processes or procedures existed within the Trust to provide a clear audit route for initiating and tracking the progress of investigations, their costs and resulting actions? Who was responsible for ensuring such processes were in place and what role, if any, did you have as the Case Manager in relation to these matters?

Handling of Concerns relating to Mr O'Brien

11. In respect of concerns raised regarding Mr Aidan O'Brien:

    I. When and in what circumstances did you first become aware of concerns, or received information which could have given rise to concerns?
    II. If different, also state when you became aware that there would be an investigation into matters concerning the performance of Mr O'Brien?
    III. Outline all steps taken to address those concerns;
    IV. In respect of any attempts to resolve concerns informally in accordance with Section I Paragraph 15 of MHPS, outline the steps you took, any advice you received or discussions concerning informal resolution and any engagement you had with Mr O'Brien to attempt to informally resolve concerns; and

V. If you did not implement or apply MHPS and/or the Trust Guidelines notwithstanding the existence of performance concerns, explain why not.

Implementation and Effectiveness of MHPS

12. Having regard to your experience as Clinical Manager and, 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 can effectively discharge your role as Clinical Manager 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.

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.

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UROLOGY SERVICES INQUIRY

USI Ref: Notice 32 of 2022
Date of Notice: 29th April 2022

Witness Statement of: Charles McAllister

I, Charles McAllister, 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.**

1.1 I was appointed as a Consultant Anaesthetist and Intensivist to the Legacy Craigavon Area Hospital Trust (which became part of the Southern Health & Social Care Trust) in August 1994. I retired from the SH&SCT in April 2018. I was asked by the SH&SCT and volunteered to return to work in Intensive Care in Craigavon Hospital at the outbreak of the COVID pandemic in N. Ireland (2020) but retired again in May 2020 when no longer needed. Following retirement and ceasing all clinical work in 2018 I destroyed all paperwork, diaries and records that I could find from my working life hence I am relying on memory and documents provided to me by the Trust (and hence forwarded to the Inquiry) for this Inquiry.

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1.2 Pertaining to this Inquiry I was appointed as Associate Medical Director (AMD) for Surgery in April 2016 in addition to being AMD for ATICS (Anaesthetics, Theatre, Intensive Care and Chronic Pain, some 38 Consultants and Staff-grades). I ceased being AMD for Surgery by October 2016.

1.3 As Surgical AMD my role was to be the interface between the Director of Acute Services, their assistant (Assistant Director), the Medical Director, his assistant (Assistant Director) and the two Clinical Directors in Surgery, Lead Clinicians for the various sub-specialties, the Consultants and Staff-grades, of which there were approximately 39. This was in addition to a full clinical commitment to anaesthesia, Intensive care (ICU) and a one in five night and weekend ICU on-call including evening ward rounds at 21.00.

1.4 Aside from my clinical duties as Surgical AMD I had to attend regular meetings; monthly Morbidity and Mortality Meeting (4 hours), monthly Clinical Governance Meeting (1 Hour), monthly AMD/CD Meeting with the Medical Director (3+ hours), monthly Theatre Users Group (Chairman) Meeting (3 hours), quarterly Drugs and Therapeutics Committee Meeting (3 hours each), weekly one to one meeting with the Surgical Clinical Directors, monthly meeting with the Director of Acute Services/Assistant Director, Monthly meeting with the Medical Director (frequently cancelled) and sundry other meetings the details of which I cannot recall.

1.5 Issues that were raised with me were shared/escalated to the AD Surgery who then escalated to the Director of Acute Services, or shared/escalated directly by me to the Director of Acute Services or the Medical Director or both as seemed appropriate from who I took advice and instruction.

1.6 I have listed below the issues that were presented to me in the email sent to Ronan Carroll (AD), Esther Gishkori (Director) and the Medical Director (Dr. Richard Wright) on the 9th May 2016 at 15.41 (S21 No 32 of 2022 Attachments, 20160509 email re problems from RC). I have no memory of any meetings or discussions related to issues listed in that email other than those pertaining to Urology/Mr. O'Brien. I have

outlined the background to this, including alluding to the letter written to Mr. O'Brien by Mr. Mackle and Heather Troughton on the 23rd of March 2016 in my replies below under 4.1, 4.2, 4.3 and 5. I through to V.

1.7 As regards meetings attended by me I have included those meetings that I recall in the numbered replies referred to above, similarly for the discussions and decisions. I do not recall if minutes were taken at any of these meetings and believe that none were.

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. If you are in any doubt about the documents previously provided by the SHSCT you may wish to contact the Trust's legal advisors or, if you prefer, you may contact the Inquiry.

2.1 Documents are incorporated within this statement and appended herein.

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').

3.1 NA

Urology Services Inquiry

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?

4.1 Bearing in mind that this was quite some time ago – yes, I was aware of these guidelines and the MHPS guidelines, published in 2005. These were two of a tsunami-like wave of guidelines, policies and protocols produced by the Trust, the Department of Health and various other relevant regional and national bodies disseminated to staff via the intranet with increasing frequency between 2005 and 2016.

4.2 Shortly after assuming the role of AMD for surgery in April 2016 I was specifically made aware of issues in Urology. The issues pertaining to Mr. O'Brien predated my involvement and had been most recently addressed via a letter to him (dated the 23rd March 2016) by the previous AMD for Surgery (Mr. Mackle) and the previous Assistant Director for Surgery (Heather Trouton) with the full knowledge and support of the Director of Acute Services, Esther Gishkori, as per the Trust Guidelines 23rd September 2010, and the Medical Director (Dr Richard Wright). This was shared with me shortly after my becoming AMD for Surgery by Mr. Mackle, Heather Troughton and Head of Service for Urology (Martina Corrigan). I do not recall being told that HR were involved at this stage but would have assumed so especially as so many senior managers were involved and issues had been on-going for so long. Consequently, I did not, that I can recall, assure myself that HR were involved. On reflection this was out-with the Guidelines and a mistake on my part. Please see 11.3 below on the monitoring process and feedback I requested at the time. Please see 8.1 for another case where I was involved in implementing the Guidelines.

4.3 There was also an issue with another recently appointed Urology Consultant at that time who was reputedly uncomfortable with open urological surgery (as opposed to endoscopic surgery) and whose judgement in management plans for the more complex urological cases was a point of concern. I was informed (I believe by Martina Corrigan, HoS for Urology, Heather Trouton, outgoing AD for Surgery but it may have been by Mr

Mackle), that before I started the surgical management role, this had also been escalated to the Service Director and a management plan had been put in place that this Surgeon would be shadowed by another Consultant Urologist and a second Consultant Urologist would be on call when this Surgeon was on call. I do not know if this had been shared with the Medical Director but I assumed so. That Consultant left the Trust later that year.

The highlighted text below should read "at the end of April/beginning of May" as per email received 20/02/2023 (TRU-320005 to TRU-320006 refers). Annotated by the Urology Services Inquiry.

4.4 I set about trying to get my head around as many of the issues in Surgery as quickly as I could by talking with many relevant parties ~~over the month of April~~ 2016 on both the Craigavon Area Hospital and Daisy Hill Hospital sites. This included several surgeons, the Heads of Service for General Surgery (Amie Nelson), Head of Service for Urology and ENT Surgery (Martina Corrigan), Heather Trouton (the preceding Assistant Director for Surgery) Ronan Carroll (Assistant Director for Surgery) and Esther Gishkori (Director of Acute Services).

4.5 Since Dr. Richard Wright had been appointed to the role of Medical Director SH&SCT from the Belfast Trust in July 2015, Esther Gishkori had been appointed Director of Acute Services to the SH&SCT from the Prison Service in October 2015 and Ronan Carroll had been appointed as Assistant Director Acute Services on the 1st April 2016, I thought it wise to ensure that Esther Gishkori, (as per Trust Guidelines, 2010, paragraph 2.3), her AD Ronan Carroll and the Medical Director were aware of the issues that I had become aware of at that point. Hence, I sent the following email (9th May 2016 15:41) (S21 No 32 of 2022 Attachments, 1. 20160509 email re problems from RC):

From: McAllister, Charlie [redacted]
Sent: 09 May 2016 15:41
To: Carroll, Ronan [redacted] Gishkori, Esther [redacted] Wright, Richard [redacted]
Subject: Problems

Dear All

Since being asked to take over responsibility for Surgery as AMD I have been trying to get my head around as many of the issues as possible. To date:

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1. There is no real functioning structure for dealing with governance. Mr Reddy is the Gov laed for surgery so is supposed to attend weekly meetings with AD and HOS to review IR1s that have come in, however the AD routinely missed the meeting (Before RC) so no actions tended to come from them.

2. There were supposed to be monthly meetings with the clinical leads, AD, HoS and AMD to discuss issues but attendees poor at keeping the date so frequently cancelled.

3. FY1 rota issues. Not enough so non-compliant.

4. Paeds interface very poor and not resolved.

5. Largely each specialty left to manage themselves, reliance on HoS to escalate issues.

6. Urology. Issues of competencies, backlog, triaging referral letters, not writing outcomes in notes, taking notes home and questions being asked re inappropriate prioritisation onto NHS of patients seen privately.

7. Not enough CAH lists so very inefficient extended days (not enough beds to service these) and spare theatre capacity in DHH with underutilised nursing and anaesthetic capacity.

8. Middle grade cover is scant so unable to provide a urology rota at night thus gen surgery regs cover this. G Surg regs occasionally have to help with urology elective lists.

9. ENT – not enough theatre time so extended lists – with problems as per urology. Problem with junior doc rotas.

10. Ortho. Job plans still not agreed.

11. SOW handover – variable – some consultants don't attend – but is in job plan as far as I know.

12. NIMDAT middle grade allocation – never get our full allocation on either site. Becoming increasingly difficult to find suitable locums to fill gaps. Likely to hit the point in the next year to 18 months where running two acute middle grade rotas isn't feasible. DHH rota particularly shaky.

13. If junior doc numbers particularly low then build up a backlog in dictation and results – governance risk.

14. I am not aware that sign-off of results is secure. Governance risk.

15. Colorectal issue – dysfunctional relationship between CAH and DHH. Possibly agenda to collapse DHH in order to have two Surgical rotas on the CAH site – one colorectal and one for everything else.

16. Interface between gastroenterology and GI surgeons.

17. Breast service teetering. Radiology support precarious.

18. Significant backlog of IR1s/SAIs. Governance risk.

19. Issues around timely surgical reviews of referrals/daily consultant reviews/DNAR discussions.

20. M&M meeting dysfunctional.

21. JOB PLANS

That's what has appeared so far. Basically a very disturbing picture. Significant governance risks.

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I'd be interested in your thoughts.

Charlie

4.6 I received the following reply (9th May 2016, 15:47) from Dr Richard Wright, Medical Director (*S21 No 32 of 2022 Attachments, 20160509 email re problems from RW*);

From: Wright, Richard [redacted]
Sent: 09 May 2016 15:47
To: McAllister, Charlie [redacted]
Subject: Re: Problems

That seems a fairly accurate summing up. can't all be fixed in a day. Should we have a get together to work up an action plan? regards Richard

Sent from my iPad

4.7 And the following reply (9th May 2016 at 22:37) (S21 No 32 of 2022 Attachments, 2. 20160509 email re problems from RC) from Ronan Carroll Assistant Director Acute Services:

From: Carroll, Ronan [redacted]
Sent: 09 May 2016 22:37
To: McAllister, Charlie [redacted]
Subject: RE: Problems
Importance: High

I think it is safe to say you have a good handle on things

Ronan

Ronan Carroll

Assistant Director Acute Services

ATICs/Surgery & Elective Care

4.8 I have been unable to find a reply from Esther Gishkori, Director of Acute Services, which would have been unusual but I recall we discussed it.

4.9 So, from this email and the replies from Dr Richard Wright, Ronan Carroll and subsequent discussion with Esther Gishkori I was clear that not only were the issues generally surrounding Urology and specifically regarding Mr O'Brien known about before my appointment, but the other twenty issues I listed were also known about by the relevant people in senior management. I recall being surprised and concerned by the apparently relaxed attitude to the large number of concerns that I recounted, which I had described in correspondence as a 'very disturbing picture. Significant governance risks'.

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?**

5.1 I was aware of the Trust Guidelines for Handling Concerns about Doctors' and Dentists Performance 2010. However, when it came to medical professional issues I felt it appropriate to also inform the Medical Director, given that a medical professional was involved, in addition to the Director of Acute Services.

6. In your roles as 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.

6.I None that I can recall.
6.ii None that I can recall
6.iii None that I can recall

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7. Specifically, what if any training or guidance did you receive with regard preliminary enquiries under Section I paragraph 15 of MHPS or the undertaking of an initial verification of the issues raised under paragraph 2.4 of the Trust Guidelines and the conduct of investigations under Section I paragraph 31 of MHPS and the Trust Guidelines.

7.1 None that I can recall.

8. The Inquiry is interested in your experience of handling of concerns regarding any staff member. Prior to your involvement in respect of the case of Mr O'Brien, specify whether you ever have had occasion to implement or apply MHPS and/or the Trust Guidelines in order to address performance concerns and outline the steps taken.

8.1 I cannot recall having to implement MHPS prior to the case of Mr. O'Brien but I was parachuted into a MHPS Formal Process in progress on one occasion. Shortly after taking over the role of AMD for Surgery I was asked to take over the role of Case Manager in a case of a Consultant in Obstetrics and Gynaecology. This case had been running for some time before my involvement. [redacted] Irrelevant information redacted by the USI [redacted] Dr Richard Wright (MD) asked me to take over as Case Manager for this case which I agreed to do. I was invited to an Oversight meeting in early May 2016 Chaired by Kieran Donaghy (Acting Chief Executive) and attended by Vivienne Toal (Acting Director of HR), Esther Gishkori, Dr Phillip Murphy (AMD for Medicine) and a couple of others that I cannot recall. We were brought up to speed with the case by Kieran Donaghy supported by Vivienne Toal and informed that the PSNI were now involved and that any Trust based investigation was consequently suspended.

8.2 As I stated above this case had been on-going for some time and the subject of the MHPS process was in receipt of a rolling 4-week exclusion order. My role, as I recall, was limited to signing letters provided to me by HR (Vivienne Toal) which were sent to the Consultant every four weeks informing of the ongoing sanction of exclusion from work whilst the police investigation was taking place (as per paragraph 16, Restriction of Practice and Exclusion from Work). It was my understanding at the time

and now that my involvement in that case and my contribution was in accordance with the guidelines and that the MHPS Guidelines were being followed closely. This was to be expected as the acting Chief Executive at the time was Kieran Donaghy who was, prior to taking up the role of Chief Executive, Director of Human Resources and it was a particularly sensitive case.

8.3 This process eventually ceased when the Consultant subject to MHPS left the jurisdiction

9. Outline how you understood the role of Clinical Manager was to relate to and engage with the following individuals under the MHPS Framework and the Trust Guidelines:

I. Case Manager;
II. Case Investigator;
III. Chief Executive;
IV. Medical Director;
V. Designated Board member,
VI. The clinician who is the subject of the investigation; and
VII. Any other relevant person under the MHPS framework and the Trust Guidelines.

9.1 I did not understand then (or now) that my role as the Clinical Manager was to relate to and engage with the Case Manager, Chief Executive or the Designated Board Member. It was my understanding that it was my role as Surgical AMD to escalate any concerns raised with me or that I became aware of with the Assistant Director of Acute Services, the Director of Acute Services and the Medical Director and to take instructions from them on the appropriate/best way forward. If an Oversight Group was subsequently appointed I would have provided any information/facts/reports/evidence in my possession to the Case Investigator when asked. I would already have informed the Medical Director of concerns and provided whatever information I had.

9.2 I would have been guided/told by the Service Director and Medical Director what to do from that point on, who would, I assumed, be guided by the nominated HR Case Manager, as would I.

9.3 In regards to the clinician who is the subject of the investigation – the Clinical Director (CD) would have been the conduit between that individual and the process, informing them as appropriate of what was happening as advised unless the CD was also the Case Investigator.

9.4 I note that in MHPS 2005 paragraph 28 it states that: “The seniority of the Case Investigator will differ depending on the grade of practitioner involved in the allegation. Several Case Investigators should be appropriately trained, to enable them to carry out this role.” And in the Trust Guidelines for Handling Concerns about Doctors’ and Dentists’ Performance 2010 it states “Case Investigator. This role will usually be undertaken by the relevant Clinical Director” (Page 18). I am not aware of any CD/AMD who received training for this role but I would not necessarily expect to be so aware.

10. With regard to Section I paragraph 29 of the MHPS framework, what processes or procedures existed within the Trust to provide a clear audit route for initiating and tracking the progress of investigations, their costs and resulting actions? Who was responsible for ensuring such processes were in place and what role, if any, did you have as the Case Manager in relation to these matters?

10.1 I do not know what process or procedures existed within the Trust to provide a clear audit route for initiating and tracking the progress of investigations, their costs and resulting actions. If such processes or procedures were in place I was never made privy to this and I never saw or heard of any results to the best of my knowledge, including the case referred to in my response to question 8.

10.2 Again to the best of my knowledge MHPS does not define who should assume this responsibility and I do not know who in the SH&SCT was the responsible officer for this. I would think it would have rested with the HR Department or perhaps the Medical Director although the latter would be unlikely to have the resources for this whereas the HR Director/Department would likely have ample capacity and knowledge to assume such a role. Others would be able to provide the information on this – specifically Vivienne Toal, Director of HR or Dr Richard Wright, Medical Director.

10.3 Since I was not made aware of or contributed to any such audit process I did not have any role in relation to these matters.

Handling of Concerns relating to Mr O'Brien

11 In respect of concerns raised regarding Mr Aidan O'Brien:

I. When and in what circumstances did you first become aware of concerns, or received information which could have given rise to concerns?

II. If different, also state when you became aware that there would be an investigation into matters concerning the performance of Mr O'Brien?

III. Outline all steps taken to address those concerns;

IV. In respect of any attempts to resolve concerns informally in accordance with Section I Paragraph 15 of MHPS, outline the steps you took, any advice you received or discussions concerning informal resolution and any engagement you had with Mr O'Brien to attempt to informally resolve concerns; and

V. If you did not implement or apply MHPS and/or the Trust Guidelines notwithstanding the existence of performance concerns, explain why not.

11.1 On assuming the role of AMD for Surgery (April 2016) Mr. Mackle (previous AMD for Surgery) informed me that there had been issues with Mr. O'Brien's performance and practice that had been a long running problem (he also informed me that the relationship between the two of them had become very strained). Subsequently this was confirmed in discussions I had with Heather Trouton (AD for Surgery until March 2016) and the Head of Urology/ENT service Martina Corrigan in April 2016. I was given a copy of a letter to Mr. O'Brien, dated 23rd March 2016, signed by Heather Trouton and Mr Mackle listing the areas of Clinical Practice that were causing concerns. I cannot remember who gave me a copy of that letter – I think it was Heather Trouton but it could have been Martina Corrigan and I don't think it was Mr Mackle. I sought

clarification from Mr. Mackle on this point shortly after receiving this Section 21 and he doesn't remember either.

11.2 In that letter they listed 4 areas of concern

a). Untriaged outpatient referral letters – "There are currently 253 untriaged letters dating back to December 2014", so a 15-month backlog.

b). Current review backlog up to 29th February 2016 "Total in Review backlog = 679" dating back to 2013.

c). Patient Centre letters and recorded outcomes from Clinics – "Consultant colleagues from not only Urology but other specialties are frustrated that there is often no record of your consultations /discharges on Patient Centre or in the patients' notes." "If your patient is reviewed at another Urology Clinic a new appointment slot is required due to the lack of documentation."

d). Patient notes at home. 'This has been on ongoing issue for years and must be addressed immediately."

11.3 Following my being appraised in April 2016 of the situation by Heather Trouton and Martina Corrigan (which I believe was together and at the same time in Martina's office) of the above issues and the above refenced letter to Mr. O'Brien I asked Martina what processes were in place to monitor compliance with the letter and she informed me that she was monitoring it in concert with someone from the Out-Patients Department, the details of whom I cannot remember. I do remember asking her to keep me in the loop and informed of what was happening with regard to the four issues or if there were further issues. In August 2016 I was informed that at least some of the issues outlined had not improved. I believe it was Martina Corrigan who informed me of this but it could have been Ronan Carroll. See answer 11.6 below for more on this.

11.4 I became aware that a range of issues were being considered/investigated regarding Mr. O'Brien in an email from Simon Gibson (incorporating the letter to Mr. O'Brien from the 23rd March 2016) dated 22nd August 2016 at 15.54 to myself (S21 No 32 of 2022 Attachments, 20160914 E Confidential – AOB EG) (S21 No 32 of 2022

Urology Services Inquiry

Attachments, 4. 20160914 E Confidential - AOB EG A1), Mr Mackle, Heather Trouton and Ronan Carroll.

From: Gibson, Simon
Sent: 22 August 2016 15:54
To: Mackle, Eamon; McAllister, Charlie **Cc:** Carroll, Ronan; Trouton, Heather **Subject:** Confidential - AOB

Dear all

I have been asked by the Medical Director to consider a range of issues in relation to Mr O'Brien. As part of this, I would be grateful if each of you could confirm back to me if you have received any plans or proposals from Mr O'Brien to address the issues outlined in the attached letter.

I am asking all four of you due to the changing roles and responsibilities you have all had between 23rd March and today, as at some point you would have had responsibilities with regard to Mr O'Brien and/or the service he delivered.

I would be grateful if you could respond to this e-mail, even if you have not received any plans or proposals. Given the sensitivity of this subject, I would be grateful if you would respect the confidentiality of this e-mail. Kind regards

Simon

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

11.5 To which I replied (S21 No 32 of 2022 Attachments, 20160822 E Confidential AOB SG):

From: McAllister, Charlie
Sent: 22 August 2016 17:57
To: Gibson, Simon; Mackle, Eamon **Cc:** Carroll, Ronan; Trouton, Heather **Subject:** Re: Confidential - AOB

Gibson, Simon Personal Information redacted by the USI
22 August 2016 18:02
McAllister, Charlie
RE: Confidential - AOB

Dear Simon
As you know I came into this mid stream. I have received no communication from Mr O'Brien on this

topic.
Charlie
Sent from my BlackBerry 10 smartphone.

And Simon Gibson replied (S21 No 32 of 2022 Attachments, 4. 20160822 E Confidential AOB SG);

From:

Gibson, Simon	Personal Information redacted by the USI
22 August 2016 18:02	
McAllister, Charlie	
RE: Confidential - AOB	

Ta
Thought not, just covering off all the angles! Kind regards

Simon

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

11.6 Prior to the email from Simon Gibson above and my reply I had learned during the week beginning the 15th August 2016 that it had been appreciated, by I believe Martina Corrigan, that there was an ongoing issue with triage of referrals by Mr O'Brien and rather than improving the situation had actually got worse. I am fairly certain that it was the HoS Martina Corrigan who told me this and that this information had been escalated to Esther Gishkori and the Medical Director however it might have been Esther who told me, I do not recall. Armed with this information ~~and the subsequent rumor that Formal procedures under MHPS were being considered/discussed (again I cannot recall who informed me of this)~~ I discussed the situation with Mr. Colin Weir, CD for Urology, at our regular Thursday meeting on the 18th August 2016. We discussed what steps could be taken to sort this chronic problem out once and for all. Among the things we discussed I suggested that removal from theatre until the backlog was cleared would be the most effective incentive for Mr. O'Brien to address the triage backlog and any other issues. Mr. Weir appeared concerned at this suggestion and said that Mr.

The highlighted text above should be deleted as per email received 20/02/2023 (TRU-320005 to TRU-320006 refers) as Mr Weir was not aware of the rumour until approximately September 2016. Annotated by the Urology Services Inquiry.

O'Brien would 'go mad'. I asked him to think about it over the weekend and come up with a solid plan that would sort this problem out once and for all and consider speaking with Mr. O'Brien the following week.

11.7 However following Simon Gibson's email of the 22nd August 2016 I emailed Mr. Weir 23rd August 2016 at 11.11) (S21 No 32 of 2022 Attachments, 20160830 E confidential AOB CW):

From: McAllister, Charlie
Sent: Tuesday, 23 August 2016 11:11 **To:** Weir, Colin
Subject: FW: Confidential - AOB

Strictly in confidence.

Hi Mr Weir

Please see below. This has come to light subsequent to our discussions on this subject last Thursday. It appears that the boat is missed. I know that you are on leave this week and I'm off for the following two so wont get a chance to meet/discuss.

Please hold off on attempting to address this issue until the dust settles on the process below.
Thanks
Charlie

From: Gibson, Simon
Sent: 22 August 2016 15:54
To: Mackle, Eamon; McAllister, Charlie **Cc:** Carroll, Ronan; Trouton, Heather **Subject:** Confidential - AOB

Dear all

I have been asked by the Medical Director to consider a range of issues in relation to Mr O'Brien. As part of this, I would be grateful if each of you could confirm back to me if you have received any plans or proposals from Mr O'Brien to address the issues outlined in the attached letter.

I am asking all four of you due to the changing roles and responsibilities you have all had between 23rd March and today, as at some point you would have had responsibilities with regard to Mr O'Brien and/or the service he delivered.

I would be grateful if you could respond to this e-mail, even if you have not received any plans or proposals. Given the sensitivity of this subject, I would be grateful if you would respect the confidentiality of this e-mail. Kind regards

Simon

Urology Services Inquiry

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

11.8 A week later Personal Information redacted by USI Mr. Weir replied (30th August 09.13) (*S21 No 32 of 2022 Attachments, 5. 20160830 E confidential AOB CW*):

From: Weir, Colin
Sent: Tuesday, 30 August 2016 09:13 **To:** McAllister, Charlie
Subject: Re: Confidential - AOB

OK got it

Colin Weir
From Blackberry

11.9 And I replied (30th August 09.02) (S21 No 32 of 2022 Attachments, 5. 20160830 E confidential AOB CW);

From: Sent: To: Subject:

McAllister, Charlie Personal Information redacted by the USI
30 August 2016 09:02
Weir, Colin
Re: Confidential - AOB

Thanks. V disappointing. This is not the direction of travel I wanted for many reasons.

C

Sent from my BlackBerry 10 smartphone.

11.10 At the time I sent this email I was already away Personal Information redacted by the USI for two weeks of annual leave (hence the time that this email displays is 09.02 which antedates the email sent by Mr Weir by 11 minutes – it was a smartphone and I assume it reset it's clock to the geographical location – one hour ahead).

Urology Services Inquiry

11.11 Following my return from annual leave on the Monday the 12th September I had one of our regular monthly meetings with Esther Gishkori and Ronan Carroll. Esther Gishkori informed us that an Oversight Committee had been established and that Mr. O'Brien was going to be subject to a Formal procedure under MHPS. I informed Esther that Mr. Weir and I had discussed the problem three weeks before hand and thought that given a chance and support that we could crack the problem once and for all. She was taken with this and asked for a clear plan of action that she could share with Dr Richard Wright and Vivienne Toal. There followed a series of emails (S21 No 32 of 2022 Attachments, 3. 20160914 E Confidential – AOB EG)(S21 No 32 of 2022 Attachments, 4.20160914 E Confidential - AOB EG A1) -

From:	Gishkori, Esther [redacted]
Sent:	14 September 2016 13:17
To:	McAllister, Charlie
Subject: Attachments:	FW: Confidential - AOB Confidential letter to AOB - updated March 2016 final.docx

Thanks Charlie.
At least you have a starting point.
I am clear that I wish you and Colin to take this forward and explore the options and potential solutions before anyone else gets involved.
We owe this to a well respected and competent colleague.
I can confirm that you will have communication in relation to this before the end of the week.
Best
Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust

Office [redacted] **Mobile** [redacted]

[redacted]

From: McAllister, Charlie
Sent: 14 September 2016 12:25 **To:** Gishkori, Esther
Subject: FW: Confidential - AOB

Hi Esther
Further to our meeting today here is the only communication that I have received on this subject.
Regards
Charlie

Urology Services Inquiry

From: Gibson, Simon
Sent: 22 August 2016 15:54
To: Mackle, Eamon; McAllister, Charlie **Cc:** Carroll, Ronan; Trouton, Heather **Subject:** Confidential - AOB

Dear all

I have been asked by the Medical Director to consider a range of issues in relation to Mr O'Brien. As part of this, I would be grateful if each of you could confirm back to me if you have received any plans or proposals from Mr O'Brien to address the issues outlined in the attached letter.

I am asking all four of you due to the changing roles and responsibilities you have all had between 23rd March and today, as at some point you would have had responsibilities with regard to Mr O'Brien and/or the service he delivered.

I would be grateful if you could respond to this e-mail, even if you have not received any plans or proposals. Given the sensitivity of this subject, I would be grateful if you would respect the confidentiality of this e-mail. Kind regards

Simon

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

11.12 I subsequently learned that Mr. Gibson had had a telephone conversation with NCAS (the National Clinical Assessment Service, which was subsequently rebranded as Practitioner Performance Advice, PPA) on the 7th September 2016 essentially listing the issues raised in Mr Mackle and Heather Trouton's letter to Mr O'Brien of the 23rd March 2016. NCAS in the form of Dr Colin Fitzpatrick replied by letter dated the 13th September 2016. Interestingly despite not having sight or knowledge of this NCAS letter or contents our plan closely mirrored the advice given by NCAS, including considering the removal from theatre. I also note that Formal procedure was not recommended. I don't know what happened after the 22nd September 2016 or the success or otherwise of any action because by October 2016 I was no longer AMD for Surgery.

11.13 By the time I came on the scene, in April 2016, informal steps had already been taken a week or two previously by Mr. Mackle and Heather Trouton as evidenced in their letter of the 23rd March 2016. I do not know what advice they had received or what discussions they had had other than I was made aware that there had been discussions

with Mr. O'Brien (on more than one occasion), that the Director of Acute services, Esther Ghiskori was involved as was the Medical Director, Dr. Richard Wright. Consequently, since an informal approach had already been initiated by others very recently, I did not when presented with this information specifically engage with Mr. O' Brien. Those involved in the discussions around the sending of that letter and the signatories would be better placed than me to answer this question perhaps.

11.14 As I have answered above – an informal approach had already been initiated just prior to my assuming the role of AMD for Surgery with involvement of the Director of Acute Services and the Medical Director.

11.15 Subsequent to further information becoming available in August 2016 at the behest of the Director of Services, Esther Gishkori I forwarded the outline of an informal process agreed between the Clinical Director, Mr Weir and myself for consideration in September 2016. Specifically – in the email below (*S21 No 32 of 2022 Attachments, 20160921 E meeting with Mr O'Brien)* there was a plan proposed to the Director of Acute Services where Mr Weir and I agreed that we would both meet with Mr O'Brien in an official Informal Process (as per MHPS and Trust Guidelines) and that we, together, would provide regular follow up.

From: McAllister, Charlie
Sent: 21 September 2016 11:55
To: Gishkori, Esther; Weir, Colin; Carroll, Ronan Subject: RE: meeting re Mr O'Brien.

Hi Colin

Thank you very much for this. Apart from the fact that you spelt my name wrong (!) this is absolutely excellent and I agree completely. It would be important to do this in a positive/constructive/supportive role and that Mr O'Brien would be aware of this. I think that this approach will give the best chance to achieve this. And for improving the current situation.

Since I can't improve on this I am forwarding in toto. Thanks

Charlie

Urology Services Inquiry

From: Weir, Colin
Sent: 16 September 2016 14:41 To: McAllister, Charlie
Subject: Action Plan

Charlie
These are my initial thoughts. Anything to add? Change?

Dear Dr McCallister

Further to discussions I propose that I as CD and you as AMD implement the following action plan in relation to outstanding issues in respect of Mr O'Brien

1. That I (initially) have a series of face to face meetings with Mr O'Brien and aim to have resolution or plan for resolution in next 3 months. That is by mid December. I propose the first meeting would involve you me and Mr O'Brien
2. To implement a clear plan to clear triage backlog.
3. Make arrangements to validate the review backlog and adapt clinic new to review ratios to reduce this
4. All correspondence to GPs and copies for patient centre /ECR to be done at time of consultation
5. All patient notes to be return from home without exception
6. These meetings will report back regularly to Dr McCallister as AMD and he will be involved in some further meeting to assist me and provide support when needed
7. Throughout the process we want to encourage full engagement and have Mr O'Brien understand that if we achieve these aims through these processes that will satisfy the Trust and no further actions would be taken
8. That monitoring would continue to ensure there is no drift with an understanding that if this happened further investigations would take place.

Colin Weir FRCSEd, FRCSEng, FFSTEd
Consultant Surgeon | Honorary Lecturer in Surgery | AMD Education and Training |Clinical Director SEC Southern Health and Social Care Trust

11.16 However shortly after this I ceased to be AMD and consequently never had a meeting with Mr O'Brien and I do not know what process was pursued subsequently or it's success or otherwise. I had a handover meeting with the two Clinical Directors for Surgery – Mr Colin Weir and Mr Mark Haynes with Ronan Carroll present, the date of which I cannot remember. I was subsequently succeeded as AMD for Surgery by Mr Mark Haynes I believe.

12.Having regard to your experience as Clinical Manager and, 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?

12.1 The MHPS and Trust Guidelines were reasonably effective or at least would have been be if implemented in full in a timely manner.

12.2 The Trust/HR department and MD by and large, in my opinion, underused the informal approach at an early stage to generate behavioral/performance change in a positive/constructive/supportive way in concert with the Clinician with the understanding that if this was unsuccessful then it could/would to a formal approach. (An understanding by clinicians of the content, meaning and consequences of MHPS and Trust Guidelines would I feel be conducive to a positive outcome. This would necessitate more than sending out the policies via the Intranet to clinicians). As a consequence, issues seemed to be left to progress and fester until there was a crisis or cliff edge. At that time there was a culture of serial crisis management of issues as they came to a head rather than pro-actively dealing with them at an earlier stage.

12.3 MHPS on page 6, point 6 states “In the vast majority of cases when action other than immediate exclusion can ensure patient safety the clinician should always initially be dealt with using an informal approach. Only where a resolution cannot be reached should a formal investigation be instigated. This will often depend on an individual’s agreement to the solutions offered. It is imperative that action is carried out without undue delay”

12.4 And on page 25, section 3, “Wherever possible such issues [Matters which fall under the performance procedures] should be dealt with informally, seeking advice from the NCAS where appropriate. The vast majority of cases should be adequately dealt with through a plan of action agreed between the practitioner and employer.”

12.5 I think that although the guidance states “the vast majority of cases” should (not could) be dealt with informally, MHPS is very light on guidance/procedures and follow up/assurance/completing the circle- (about two pages) and very heavy on the Formal Approach (about 40 pages).

12.6 I would use the analogy of Critical Incident Reporting v IR1’s (reports of actual patient/client harm/death). There are in my experience many more critical incidents (where an event could have caused patient harm) – ‘vast majority’, than there are IR1’s (where there was actual harm/death). A robust approach to Critical Incident reporting and action can lead to a significant reduction in actual patient harm events. Similarly, a robust and early use of the Informal Approach at an early stage with informed Clinical Managers and Clinicians, serially for multiple issues if necessary, and an equally robust

follow-up and assurance process coordinated by one designated individual for that Clinician could prevent the progression of issues until a crisis leading to a Formal Approach. This would also reduce the danger of the non-MD Clinical Manager being accused of bullying or harassment, or being perceived as behaving in such a way, as it would move the process out-with the non-MD Clinical Manager. It also would remove any potential reluctance of a non-MD Clinical Manager risking a consequent breakdown in working relationships with a fellow colleague that they are going to have to work with for many years, probably including after that Clinical Manager is no longer a Clinical Manager. This presumably is why in MHPS under the Informal Process flow chart on page 43 of MHPS the first box under Clinical Manger states "(usually the MD)", although I cannot find this actually written or referenced in the narrative part of the document. Obviously, this would require a MD to be proactive when informed of a performance issue.

12.7 Specifically, with regards to the case of Mr. O'Brien I became aware in April 2016 that there had been longstanding issues around triaging of referrals, in the letter written to Mr. O'Brien on the 23rd March 2016 by Mr. Mackle and Heather Trouton four issues were referenced;

1. Untriaged outpatient referral letters dating back to December 2014.
2. Current review backlog dating back to 2013
3. Patient Centre letters and recorded outcomes from Clinics
4. Patient notes at home which was an 'ongoing issue for 'years'.

12.8 I was aware that there had been meetings/discussions with Mr O'Brien by Heather Trouton (AD Surgery), Martina Corrigan (Head of Service, Surgery) and Mr Mackle but I was not made aware of what reply, if any, Mr. O'Brien gave to this or with whom else this step had been shared with other than the Medical Director, Dr. Richard Wright, the Director of Acute Services, Esther Ghiskori, and the Head of Service, Martina Corrigan. I asked Martina what process were in place to monitor compliance with the letter and she informed me that she was monitoring it, in concert with someone from the Out-Patients Department, the details of which I cannot remember.

12.9 Clearly issues around Mr. O'Brien's performance were longstanding and despite Mr Mackle's best endeavors remained unresolved. These issues were also well known

to the Head of Service, Martina Corrigan, the Assistant Director with responsibility for Surgery Heather Trouton (subsequently Ronan Carol from April 2016) and the serial Directors of Acute Services – Joy Youart, Dr Gillian Rankin, Debbie Burns and Esther Ghiskori. This of course was part of the problem – the roster of Directors of Acute Services over a short period of time who were in crisis management mode for much of that time.

12.10 Perhaps, in the interest of providing as full a response to the Section 21 Schedule as possible I could outline why in my email of the 30th August 2016 to Mr Weir I though it - “V disappointing. This is not the direction of travel I wanted for many reasons” when a different direction was taken than the approach proposed by Esther, Mr. Weir and myself.

12.11 I had no knowledge of the medical management issues that led subsequently to Mr. O’Brien being referred to the GMC. I understand that this followed on from a look-back exercise conducted in 2020 some 4 years after my involvement. In 2016 Mr. O’Brien was generally considered to be extremely hard working, if not the hardest working Surgeon in the Trust, was regarded as technically excellent in Theatre with the most demanding of major urological surgery, and just as importantly excellent in direct pre-op and post-op care.

12.12 Personally, although I have anaesthetised for Mr. O’Brien I more frequently have looked after his patients in the Intensive Care Unit. What I saw was as good as any surgeon and better than most. He saw his patients in ICU twice a day during the week and at least once a day at the weekend whenever he had a patient there. He was always available for consultation/advice/action on any patient who was admitted to ICU with or who developed urological issues whether they were his patient or not. I never heard any colleague criticise or complain about his clinical work and anaesthetists seem to enjoy working with him. He was one of the very few Consultants I would regularly see in the hospital at night (ICU consultants do an evening ward round between 21.00 and 22.00) and he was frequently in at weekends. Whenever a patient of his did not have what he thought was an optimal outcome he would present this himself (and not a trainee as most Consultants did) at the monthly Morbidity and Mortality meeting in painstaking or even excruciating detail.

12.13 This work ethic and his characteristics of being tenacious, painstaking and narrowly focused is what enabled him to single handedly set up the Urology Service in the Legacy Craigavon Hospital (now part of the SH&SCT) in 1992, despite opposition from the Regional Centre in Belfast, and work as a solo practitioner until 1998

12.14 It was also these characteristics that had me convinced that an aggressive, formal approach with MHPS would lead to heels being dug in on both sides and a prolonged and tortuous process.

12.15 In 2016 I felt there was an opportunity to help Mr. O'Brien address his undoubted short-comings which had been ongoing for years, as evidenced in the letter of the 23rd March 2016. There was a new Clinical Director (Mr. Weir who he got on well with and as far as I know liked and respected) and a new AMD (me). There was an opportunity to focus on helping him address his issues in a 'positive/constructive/supportive role' by individuals where there was a mutual respect, but with the sword of Damocles hanging over his head of being barred from Theatre if he did not comply. I did not see how suspension from all clinical duties or a dogfight was going to help the triage, outpatient, cancer care and Theatre waiting lists and that was our most pressing concern. It would also have a very negative effect on his Surgical and Nursing Colleagues who respected him. Certainly Mr. Weir, Ronan Carroll and Esther Gishkori were up for it. Please see series of emails in PDF 20160922 E Meeting re Mr O'Brien 15th September – 22nd September 2016 *(S21 No 32 of 2022 Attachments, 6. 20160921 E Meeting re Mr O'Brien)*. I do not know what happened after the 22nd September as I ceased to be AMD soon after.

13. Consider and outline the extent to which you feel you can effectively discharge your role as Clinical Manager 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.

13.1 I ceased to be a Clinical Manager in October 2016 and retired from the SH&SCT in April 2018. Hence, I am not aware of the extant systems in the Trust and do not have a role to utilise them. I would hazard that those systems have changed significantly since 2016, more especially since November 2020.

13.2 However, in my response to question 12 I have offered a view on what the situation was in 2016 and the application of MHPS and the systems in the Trust at that time.

Statement of Truth

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

Signed: _____Charles McAllister 3009291

Date: _____9th June 2022_____

S21 32 of 2022

Witness statement of: Charles McAllister

Table of Attachments

Attachment	Document Name
1	20160509 email re problems from RC
2	20160509 email re problems from RW
3	20160914 E Confidential – AOB EG
4	20160914 E Confidential – AOB EG A1
5	20160822 E Confidential AOB SG
6	20160830 E confidential AOB CW
7	20160921 – E meeting Mr O'Brien

Stinson, Emma M

From: Carroll, Ronan [redacted]
Sent: 09 May 2016 22:37
To: McAllister, Charlie
Subject: RE: Problems

Importance: High

I think it is safe to say you have a good handle on things
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]

From: McAllister, Charlie
Sent: 09 May 2016 15:41
To: Carroll, Ronan; Gishkori, Esther; Wright, Richard
Subject: Problems

Dear All

Since being asked to take over responsibility for Surgery as AMD I have been trying to get my head around as many of the issues as possible. To date:

1. There is no real functioning structure for dealing with governance. Mr Reddy is the Gov laed for surgery so is supposed to attend weekly meetings with AD and HOS to review IR1s that have come in, however the AD routinely missed the meeting (Before RC) so no actions tended to come from them.
2. There were supposed to be monthly meetings with the clinical leads, AD, HoS and AMD to discuss issues but attendees poor at keeping the date so frequently cancelled.
3. FY1 rota issues. Not enough so non-compliant.
4. Paeds interface very poor and not resolved.
5. Largely each specialty left to manage themselves, reliance on HoS to escalate issues.
6. Urology. Issues of competencies, backlog, triaging referral letters, not writing outcomes in notes, taking notes home and questions being asked re inappropriate prioritisation onto NHS of patients seen privately.
7. Not enough CAH lists so very inefficient extended days (not enough beds to service these) and spare theatre capacity in DHH with underutilised nursing and anaesthetic capacity.
8. Middle grade cover is scant so unable to provide a urology rota at night thus gen surgery regs cover this. G Surg regs occasionally have to help with urology elective lists.
9. ENT – not enough theatre time so extended lists – with problems as per urology. Problem with junior doc rotas.
10. Ortho. Job plans still not agreed.
11. SOW handover – variable – some consultants don't attend – but is in job plan as far as I know.
12. NIMDAT middle grade allocation – never get our full allocation on either site. Becoming increasingly difficult to find suitable locums to fill gaps. Likely to hit the point in the next year to 18 months where running two acute middle grade rotas isn't feasible. DHH rota particularly shaky.
13. If junior doc numbers particularly low then build up a backlog in dictation and results – governance risk.
14. I am not aware that sign-off of results is secure. Governance risk.
15. Colorectal issue – dysfunctional relationship between CAH and DHH. Possibly agenda to collapse DHH in order to have two Surgical rotas on the CAH site – one colorectal and one for everything else.
16. Interface between gastroenterology and GI surgeons.
17. Breast service teetering. Radiology support precarious.
18. Significant backlog of IR1s/SAIs. Governance risk.

19. Issues around timely surgical reviews of referrals/daily consultant reviews/DNAR discussions.
20. M&M meeting dysfunctional.
21. JOB PLANS

That's what has appeared so far. Basically a very disturbing picture. Significant governance risks.

I'd be interested in your thoughts.

Charlie

Stinson, Emma M

From: Wright, Richard [redacted]
Sent: 09 May 2016 15:47
To: McAllister, Charlie
Subject: Re: Problems

That seems a fairly accurate summing up. can't all be fixed in a day. Should we have a get together to work up an action plan? regards Richard

Sent from my iPad

On 9 May 2016, at 15:41, McAllister, Charlie [redacted] wrote:

> Dear All
>
> Since being asked to take over responsibility for Surgery as AMD I have been trying to get my head around as many of the issues as possible. To date:
>
> 1. There is no real functioning structure for dealing with governance. Mr Reddy is the Gov laed for surgery so is supposed to attend weekly meetings with AD and HOS to review IR1s that have come in, however the AD routinely missed the meeting (Before RC) so no actions tended to come from them.
> 2. There were supposed to be monthly meetings with the clinical leads, AD, HoS and AMD to discuss issues but attendees poor at keeping the date so frequently cancelled.
> 3. FY1 rota issues. Not enough so non-compliant.
> 4. Paeds interface very poor and not resolved.
> 5. Largely each specialty left to manage themselves, reliance on HoS to escalate issues.
> 6. Urology. Issues of competencies, backlog, triaging referral letters, not writing outcomes in notes, taking notes home and questions being asked re inappropriate prioritisation onto NHS of patients seen privately.
> 7. Not enough CAH lists so very inefficient extended days (not enough beds to service these) and spare theatre capacity in DHH with underutilised nursing and anaesthetic capacity.
> 8. Middle grade cover is scant so unable to provide a urology rota at night thus gen surgery regs cover this. G Surg regs occasionally have to help with urology elective lists.
> 9. ENT – not enough theatre time so extended lists – with problems as per urology. Problem with junior doc rotas.
> 10. Ortho. Job plans still not agreed.
> 11. SOW handover – variable – some consultants don't attend – but is in job plan as far as I know.
> 12. NIMDAT middle grade allocation – never get our full allocation on either site. Becoming increasingly difficult to find suitable locums to fill gaps. Likely to hit the point in the next year to 18 months where running two acute middle grade rotas isn't feasible. DHH rota particularly shaky.
> 13. If junior doc numbers particularly low then build up a backlog in dictation and results – governance risk.
> 14. I am not aware that sign-off of results is secure. Governance risk.
> 15. Colorectal issue – dysfunctional relationship between CAH and DHH. Possibly agenda to collapse DHH in order to have two Surgical rotas on the CAH site – one colorectal and one for everything else.
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That's what has appeared so far. Basically a very disturbing picture. Significant governance risks.

I'd be interested in your thoughts.

Charlie

Stinson, Emma M

From: Gishkori, Esther [redacted]
Sent: 14 September 2016 13:17
To: McAllister, Charlie
Subject: FW: Confidential - AOB
Attachments: Confidential letter to AOB - updated March 2016 final.docx

Thanks Charlie.
At least you have a starting point.
I am clear that I wish you and Colin to take this forward and explore the options and potential solutions before anyone else gets involved.
We owe this to a well respected and competent colleague.
I can confirm that you will have communication in relation to this before the end of the week.
Best
Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office [redacted] **Mobile** [redacted]
[redacted]

From: McAllister, Charlie
Sent: 14 September 2016 12:25
To: Gishkori, Esther
Subject: FW: Confidential - AOB

Hi Esther

Further to our meeting today here is the only communication that I have received on this subject.

Regards

Charlie

From: Gibson, Simon
Sent: 22 August 2016 15:54
To: Mackle, Eamon; McAllister, Charlie
Cc: Carroll, Ronan; Trouton, Heather
Subject: Confidential - AOB

Dear all

I have been asked by the Medical Director to consider a range of issues in relation to Mr O'Brien. As part of this, I would be grateful if each of you could confirm back to me if you have received any plans or proposals from Mr O'Brien to address the issues outlined in the attached letter.

I am asking all four of you due to the changing roles and responsibilities you have all had between 23rd March and today, as at some point you would have had responsibilities with regard to Mr O'Brien and/or the service he delivered.

I would be grateful if you could respond to this e-mail, even if you have not received any plans or proposals.

Given the sensitivity of this subject, I would be grateful if you would respect the confidentiality of this e-mail.

Kind regards

Simon

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

Southern Health and Social Care Trust

23 March 2016

Mr Aidan O'Brien,
Consultant Urologist
Craigavon Area Hospital

Dear Aidan,

We are fully aware and appreciate all the hard work, dedication and time spent during the course of your week as a Consultant Urologist. However, there are a number of areas of your clinical practice causing governance and patient safety concerns that we feel we need to address with you.

1. Untriaged outpatient referral letters

There are currently 253 untriaged letters dating back to December 2014. Lack of triage means we do not know whether the patients are red-flag, urgent or routine. Failure to return the referrals to the Booking Centre means that the patients are only allocated on a chronological basis with no regard to urgency.

2. Current Review Backlog up to 29 February 2016

Total in Review backlog = 679

2013	41
2014	293
2015	276
2016	69

We need assurances that there are no patients contained within this backlog that are Cancer Surveillance patients. We are aware that you have a separate oncology waiting list of 286 patients; the longest of whom was to have been seen in September 2013. Without a validation of the backlog we have no assurance that there are not clinically urgent patients on the list. Therefore we need a plan on how these patients will be validated and proposals to address this backlog.

3. Patient Centre letters and recorded outcomes from Clinics

Consultant colleagues from not only Urology but also other specialties are frustrated that there is often no record of your consultations/discharges on Patient Centre or in the patients' notes. Validation of waiting lists has also highlighted this issue. If your

Surgical And Elective Division, Acute Directorate, Craigavon Area Hospital, 68 Lurgan Road, Portadown, Craigavon, Co Armagh BT63 5QQ Telephone: Personal Information redacted by the USI

patient is reviewed at another Urology Clinic a new appointment slot is required due to the lack of documentation.
This lack of documentation combined with no record of clinic outcomes means further investigations/follow-up may not be organised by admin staff.

4. Patient Notes at home

This has been an ongoing issue for years and needs addressed urgently. We request that all SHSCT charts that are in your home or in your car be brought to the hospital without further delay.

You will appreciate that we must address these governance issues and therefore would request that you respond with a commitment and immediate plan to address the above as soon as possible.

Yours sincerely,

Eamon Mackle	**Heather Trouton**
Associate Medical Director	**Assistant Director**

Surgical And Elective Division, Acute Directorate, Craigavon Area Hospital, 68 Lurgan Road, Portadown, Craigavon, Co Armagh BT63 5QQ Telephone: Personal Information redacted by the USI

Stinson, Emma M

From: Gibson, Simon [redacted]
Sent: 22 August 2016 18:02
To: McAllister, Charlie
Subject: RE: Confidential - AOB

Ta

Thought not, just covering off all the angles!

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
[redacted]
Mobile: [redacted]
DHH: [redacted] Ext [redacted]

From: McAllister, Charlie
Sent: 22 August 2016 17:57
To: Gibson, Simon; Mackle, Eamon
Cc: Carroll, Ronan; Trouton, Heather
Subject: Re: Confidential - AOB

Dear Simon

As you know I came into this mid stream. I have received no communication from Mr O'Brien on this topic.

Charlie

Sent from my BlackBerry 10 smartphone.

From: Gibson, Simon
Sent: Monday, 22 August 2016 15:54
To: Mackle, Eamon; McAllister, Charlie
Cc: Carroll, Ronan; Trouton, Heather
Subject: Confidential - AOB

Dear all

I have been asked by the Medical Director to consider a range of issues in relation to Mr O'Brien. As part of this, I would be grateful if each of you could confirm back to me if you have received any plans or proposals from Mr O'Brien to address the issues outlined in the attached letter.

I am asking all four of you due to the changing roles and responsibilities you have all had between 23rd March and today, as at some point you would have had responsibilities with regard to Mr O'Brien and/or the service he delivered.

I would be grateful if you could respond to this e-mail, even if you have not received any plans or proposals.

Given the sensitivity of this subject, I would be grateful if you would respect the confidentiality of this e-mail.

Kind regards

Simon

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

Stinson, Emma M

From: McAllister, Charlie [redacted]
Sent: 30 August 2016 09:02
To: Weir, Colin
Subject: Re: Confidential - AOB

Thanks. V disappointing. This is not the direction of travel I wanted for many reasons.

C

Sent from my BlackBerry 10 smartphone.

From: Weir, Colin
Sent: Tuesday, 30 August 2016 09:13
To: McAllister, Charlie
Subject: Re: Confidential - AOB

OK got it

Colin Weir
From Blackberry

From: McAllister, Charlie
Sent: Tuesday, 23 August 2016 11:11
To: Weir, Colin
Subject: FW: Confidential - AOB

Strictly in confidence.

Hi Mr Weir

Please see below. This has come to light subsequent to our discussions on this subject last Thursday. It appears that the boat is missed. I know that you are on leave this week and I'm off for the following two so wont get a chance to meet/discuss.

Please hold off on attempting to address this issue until the dust settles on the process below.

Thanks

Charlie

From: Gibson, Simon
Sent: 22 August 2016 15:54
To: Mackle, Eamon; McAllister, Charlie
Cc: Carroll, Ronan; Trouton, Heather
Subject: Confidential - AOB

Dear all

I have been asked by the Medical Director to consider a range of issues in relation to Mr O'Brien. As part of this, I would be grateful if each of you could confirm back to me if you have received any plans or proposals from Mr O'Brien to address the issues outlined in the attached letter.

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Simon

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Corrigan, Martina

From: Carroll, Ronan [redacted]
Sent: 22 September 2016 15:41
To: McAllister, Charlie; Gishkori, Esther; Weir, Colin
Subject: RE: meeting re Mr O'Brien.

Importance: High

Charlie/Colin
So can I ask and offer some suggestions/solutions as to how we may monitor progress against the action listed below. The clock is ticking now toward December
Come back to me if you wish me to action anything/all

1. That I (initially) have a series of face to face meetings with Mr O'Brien and aim to have resolution or plan for resolution in next 3 months. That is by mid December. I propose the first meeting would involve you me and Mr O'Brien – At the first meeting obviously after the context of the meeting being explained the proposed plan/actions need to be shared with AOB and agreed
2. To implement a clear plan to clear triage backlog. – is this the outpatient referral letters, including RF's? How are you planning to monitor that this is cleared? I would propose with regard to the RF's that I would ask the cancer team to monitor the triage turnaround, with regard to outpatients I would ask Anita to put a process in place to monitor
3. Make arrangements to validate the review backlog and adapt clinic new to review ratios to reduce this – RBL validation – are we offering additional Pas for this to be done? If not, then something in his job plan will have to stop for this clinical validation to happen. Then when this task has been completed the remaining on the RBL can only be dealt by as your suggestion the template being adjusted, this has a lead in time of 6 weeks due to partial booking process. When this is implemented we will monitor the progress of AOBs RBL (I can have this run at anytime)
4. All correspondence to GPs and copies for patient centre /ECR to be done at time of consultation – I will speak to Anita to ensure AOBs secretary receives digital dictation following any consultation
5. All patient notes to be return from home without exception NA
6. These meetings will report back regularly to Dr McCallister as AMD and he will be involved in some further meeting to assist me and provide support when needed absolutely
7. Throughout the process we want to encourage full engagement and have Mr O'Brien understand that if we achieve these aims through these processes that will satisfy the Trust and no further actions would be taken
8. That monitoring would continue to ensure there is no drift with an understanding that if this happened further investigations would take place.

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]

From: McAllister, Charlie
Sent: 21 September 2016 11:55
To: Gishkori, Esther; Weir, Colin; Carroll, Ronan
Subject: RE: meeting re Mr O'Brien.

Hi Colin

Thank you very much for this. Apart from the fact that you spelt my name wrong (!) this is absolutely excellent and I agree completely. It would be important to do this in a positive/constructive/supportive role and that Mr O'Brien would be aware of this. I think that this approach will give the best chance to achieve this. And for improving the current situation.

Since I can't improve on this I am forwarding in toto.

Thanks

Charlie
From: Weir, Colin
Sent: 16 September 2016 14:41
To: McAllister, Charlie
Subject: Action Plan

Charlie
These are my initial thoughts. Anything to add? Change?

Dear Dr McCallister

Further to discussions I propose that I as CD and you as AMD implement the following action plan in relation to outstanding issues in respect of Mr O'Brien

1. That I (initially) have a series of face to face meetings with Mr O'Brien and aim to have resolution or plan for resolution in next 3 months. That is by mid December. I propose the first meeting would involve you me and Mr O'Brien
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Colin Weir FRCSEd, FRCSEng, FFSTEd
Consultant Surgeon | Honorary Lecturer in Surgery | AMD Education and Training |Clinical Director SEC
Southern Health and Social Care Trust

Secretary Jennifer Personal Information redacted by USI

From: Gishkori, Esther
Sent: 15 September 2016 14:59
To: Weir, Colin; McAllister, Charlie; Carroll, Ronan
Subject: FW: meeting re Mr O'Brien.

FYI below.
……and my response will be?

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office Personal Information redacted by the USI **Mobile** Personal Information redacted by USI

Personal Information redacted by the USI

From: Wright, Richard
Sent: 15 September 2016 14:52
To: Gishkori, Esther
Cc: Toal, Vivienne
Subject: Re: meeting re Mr O'Brien.

Hi Esther. As director of the service naturally we have to listen to your opinion. Before I would consider conceding to any delay in moving forward with what was our agreed position after the oversight meeting I would need to see what plans are in place to deal with the issues and understand how progress would be monitored over the three month period.
Perhaps when we have seen these we could meet again to consider. regards Richard

Sent from my iPad

On 15 Sep 2016, at 14:40, Gishkori, Esther Personal Information redacted by the USI wrote:

> Dear Richard and Vivienne,
> Following our oversight committee on Tuesday 13th September I had a meeting with Charlie McAllister and Ronan Carroll, my AMD and AD for surgery.
> I mentioned the case that was brought to the oversight meeting in relation to Mr O'Brien and the plan of action.
>
> Actually, Charlie and Colin Weir already have plans to deal with the urology backlog in general and Mr O'Brien's performance was of course, part of that.
> Now that they both work locally with him, they have plenty of ideas to try out and since they are both relatively new into post, I would like try their strategy first.
>
> I am therefore respectfully requesting that the local team be given 3 more calendar months to resolve the issues raised in relation to Mr O'Brien's performance.
>
> I appreciate you highlighting the fact that this long running issue has not yet been resolved. However, given the trust and respect that Mr O'Brien has won over the years, not to mention his life-long commitment to the urology service which he built up singlehandedly, I would like to give my new team the chance to resolve this in context and for good. This I feel would be the best outcome all round.
>
> Happy to discuss any time and I will of course brief the oversight committee of any progress we make.
>
> Many thanks
> Best
> Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust

 **Office** Personal Information redacted by the USI **Mobile** Personal Information redacted by USI
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Corrigan, Martina

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Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
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