WIT-55601

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Received from Mr Mark Haynes on 20/09/22. Annotated by the Urology Services Inquiry.

Corrigan, Martina

From: Haynes, Mark <Personal Information redacted by the USI>
Sent: 10 March 2019 09:19
To: Carroll, Ronan
Subject: RE: Patient 110 Complaint
Attachments: Patient 110 complaint (2.64 KB)

Or to this from Friday.

Confidential but I have a meeting with Maria on Monday regarding these issues. Do we have a list of complaints / coroners / litigation that has been held up by his non-responding?

Mark

From: Carroll, Ronan
Sent: 10 March 2019 09:16
To: Haynes, Mark; Corrigan, Martina; McNaboe, Ted
Subject: RE: Patient 110 Complaint

no

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

From: Haynes, Mark
Sent: 08 March 2019 06:51
To: Corrigan, Martina; Carroll, Ronan; McNaboe, Ted
Subject: RE: Patient 110 Complaint

Has Aidan responded to the last enquiry (from Ronan) regarding what time he needs to do this?

Mark

From: Corrigan, Martina
Sent: 07 March 2019 18:01
To: Carroll, Ronan; McNaboe, Ted; Haynes, Mark
Cc: Corrigan, Martina
Subject: RE: Patient 110 Complaint

Dear Mark and Ted,

I know that we had talked about this at one of our meetings, but we really need help at resolving this complaint as it now outstanding since 2017.

Problem is that Aidan advises that we can't meet the family until he has done an in-depth timeline on the patient and then when asked says he has not the time, and we cannot move without this information.

Regards

Martina

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Martina Corrigan
Head of ENT, Urology, Ophthalmology & Outpatients
Craigavon Area Hospital

Telephone:
EXT Personal Information (Internal)
Personal Information redacted by the USI (External)
Personal Information redacted by the USI (Mobile)

From: Carroll, Ronan [Personal Information redacted by the USI]
Sent: 17 January 2019 14:19
To: McNaboe, Ted; Haynes, Mark
Cc: Corrigan, Martina
Subject: FW: Patient 110 Complaint
Importance: High

Ted/mark
Need a resolution to this outstanding issue
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by the USI
Ext Personal Informatio

From: Cardwell, David
Sent: 17 January 2019 14:17
To: Carroll, Ronan; Corrigan, Martina
Cc: Gurbanova, Esmira
Subject: Patient 110 Complaint
Importance: High

Dear Ronan and Martina, I would appreciate your assistance in moving this complaint forward.

At this time we are waiting on Mr O'Brien reviewing the notes again before we arrange the meeting with the family.

This complaint has been ongoing now for over 4 years and we need to make all necessary efforts to expedite its closure as soon as possible.

If we are unable to meet the family I believe it would be better to write to them and explain the reason why rather than keeping them lingering. If the matter progresses to the Ombudsman I can image any report produced would not make good reading.

Thanking you in anticipation of your response.

Kind Regards

David Cardwell

HSC Southern Health and Social Care Trust

Senior Governance Officer | Acute Services Clinical and Social Care Governance Team |
The Maples | Craigavon Area Hospital | 68 Lurgan Road | Portadown BT63 5QQ |
Tel: Personal Information redacted by the USI | Email: Personal Information redacted by the USI

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Corrigan, Martina

From: Carroll, Ronan <Personal Information redacted by the USI>
Sent: 14 March 2019 10:11
To: Haynes, Mark
Subject: FW: Patient 110 Complaint

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

From: Hainey, Lynne
Sent: 13 March 2019 19:16
To: Carroll, Ronan
Subject: RE: Patient 110 Complaint

Hi Ronan
Only one case where information is outstanding from Mr O'Brien (Patient 108). Mr O'Brien has been asked to provide an involvement report and this has been outstanding since May 2017. The Case Manager continues to follow up on this with last phone call being to his secretary in Feb 19.
Regards

Lynne

Lynne Hainey
Litigation Manager
Litigation Department,
1st Floor, Bernish House (old Nurse's Home)
Daisy Hill Hospital
Newry

Tel No: Personal Information redacted by the USI

Personal Information redacted by the USI

Please consider the environment before printing this email

From: Carroll, Ronan
Sent: 10 March 2019 09:24
To: Hainey, Lynne

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Cc: Haynes, Mark
Subject: FW: Patient 110 Complaint
Importance: High

Lynn
I know we have communicated with regard to cases awaiting AOB input/reports, are you still waiting. If so can you detail who what the cases are
Tks
Ronan

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

From: Carroll, Ronan
Sent: 10 March 2019 09:16
To: Haynes, Mark; Corrigan, Martina; McNaboe, Ted
Subject: RE: Patient 110 Complaint

no

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

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Head of ENT, Urology, Ophthalmology & Outpatients
Craigavon Area Hospital

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Ted/mark
Need a resolution to this outstanding issue
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by the USI
Ext Personal Informatio

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Kind Regards

David Cardwell

HSC Southern Health and Social Care Trust

Senior Governance Officer | Acute Services Clinical and Social Care Governance Team |
The Maples | Craigavon Area Hospital | 68 Lurgan Road | Portadown BT63 5QQ |
Tel: Personal Information redacted by the USI | Email: Personal Information redacted by the USI

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Corrigan, Martina

From: Haynes, Mark <Personal Information redacted by the USI>
Sent: 31 August 2016 09:34
To: Corrigan, Martina
Subject: Fw: Patient 93 HCN Personal Information redacted by the USI
Attachments: aob 050516.pdf

Importance: High

Ignore the hcn but the story here is raised PSA referred by GP on 4th may. GP referral as routine. Not returned from triage so on wl as routine. If had been triaged would have been RF upgrade (PSA 34 and 30 on repeat). Saw Mr Weir for leg pain and CT showed metastatic disease from prostate primary. Referred to us and seen yesterday. As a result of no triage delay in treatment of 3.5 months. Wouldn't change outcome.
SAI?

Sent from my BlackBerry 10 smartphone.

From: Coleman, Alana <Personal Information redacted by the USI>
Sent: Wednesday, 31 August 2016 08:34
To: Haynes, Mark
Subject: FW: Patient 93 HCN Personal Information redacted by the USI

From: Coleman, Alana
Sent: 31 August 2016 08:34
To: Haynes, Mark
Subject: RE: Patient 93 HCN Personal Information redacted by the USI
Importance: High

Ah I found Patient 93 !!

This referral went for triage to Mr O'Brien on the 05/05/2016 – and was not returned.
We have been advised that if we get no response after chasing missing triage that we are to follow instruction per referral – the GP originally referred Patient 93 as Routine.
I have attached what was sent for triage – Patient 93 s referral is pg25-31.

Thanks
Alana

From: Coleman, Alana
Sent: 31 August 2016 08:14
To: Haynes, Mark
Subject: RE: Patient 93 HCN Personal Information redacted by the USI

Morning Mr Haynes,

The HCN is for a Personal Information redacted by the USI – referral we got yesterday from SWAH?

If it is definitely Patient 93 your querying do you have a date of birth?

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Thanks
Alana

From: Haynes, Mark
Sent: 31 August 2016 07:08
To: Coleman, Alana
Subject: Patient 93 HCN Personal Information redacted by the USI

Morning Alana

Could you find out what happened at triage to the referral from 4th May 2016 on this man and let me know please?

Mark

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Urology Outcome Sheet

(for face to face appointments and advice)

Consultant's name: MR O'BRIEN

Date: 05.05.16

Patient Name	H & C or Hospital Number	DOB	Source of Referral	New or Review	Action: Add to op w/l list, add to inpt w/l, discharge etc	Type of Contact: Face to Face/Telephone/Email
[redacted]						

Personal Information redacted by the USI

Patient Name	H & C or Hospital Number	DOB	Source of Referral	New or Review	Action: Add to op w/l list, add to inpt w/l, discharge etc	Type of Contact: Face to Face/Telephone/Email
Personal Information redacted by the USI						
Patient 93	Personal Information redacted by the USI					
Personal Information redacted by the USI						

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust
Quality Care – for you with you

LURGAN HOSPITAL
SLOAN STREET
LURGAN
BT66 8NX

Secretary: Mrs Valerie Jackson
Tel: Personal Information redacted by the USI Fax: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

OLDER PEOPLE & PRIMARY CARE

REFERRAL LETTER

MR YOUNG
CONSULTANT UROLOGIST
CAH

SOUTERN TRUST BOOKING CENTRE
RECEIVED
05 MAY 2016
CAH

Dear DR MR YOUNG

Re: Patient Name: Personal Information redacted by the USI
D.O.B.:
Address:
Hospital No:

Thank you for assessing this Personal Information redacted by the USI old gentleman with Personal information redacted by USI mild cognitive impairment, small AAA, gallstones, hiatus hernia and atrial fibrillation on Dabigatran who presents with macroscopic haematuria.

Personal Information redacted by the USI has been attending our Personal Information redacted by the USI clinic for two years. On several occasions he has had macroscopic haematuria and an ultrasound scan in May 2014 revealed one or two right sided kidney stones but no other abnormality in the urinary tract. He now has one month of macroscopic haematuria but no other urinary symptoms.

I have referred this gentleman for repeat ultrasound scan and sent urine for organisms and culture. I would appreciate your evaluation, query other pathology.

Medications include Bisoprolol 1.25mg once daily, Citalopram 10mg once daily, Dabigatran 100mg once daily, Omeprazole 20mg once daily and Zopiclone 3.75mg once daily.

Personal Information redacted by the USI remains independent of ADL's in spite of his mild cognitive impairment and Personal Information redacted by the USI

Yours sincerely

Personal Information redacted by the USI

DR KARIN HOUSTON, SPECIALITY DOCTOR TO
DR P MC CAFFREY, CONSULTANT GERIATRICIAN

Date Dictated:7/4/16 | Date Typed: 11/04/16 lh

Dept Rec
Upstairs
Urgent
Routine
Other
Virtual

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN
BT63 5QQ
TEL: Personal Information redacted by the USI
Secretary: Michelle Graham

REFERRAL LETTER

20/04/16

SOUTHERN TRUST BOOKING CENTRE
RECEIVED
05 MAY 2016
CAH

CONSULTANT UROLOGIST
CRAIGAVON AREA HOSPITAL

Dear Colleague

Re: Patient Name: Personal Information redacted by the USI
D.O.B.:
Address:
Hospital No:

We would be grateful if you would see this gentleman. He was recently in hospital with minor stroke. He has had ongoing symptoms of frequency and nocturia. He would be grateful for assessment. PSA was normal.

Yours sincerely

Personal information redacted by USI

DR GRAINNE TALLON
ASSOCIATE SPECIALIST TO
DR P MCCAFFREY
CONSULTANT GERIATRICIAN/STROKE PHYSICIAN

Date Dictated:	Date Typed: 20/04/16 mg

Ref Cat?
Urgent
Urgent
Routine
Other
Virtual

Personal Information redacted by the USI

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

HSC Southern Health and Social Care Trust

Craigavon Area Hospital, Lurgan Road, Portadown, Craigavon, County Armagh, BT63 5QQ
Tel: Personal Information redacted by the USI

Ward Tel:

Personal Information redacted by the USI

RECEIVED 04 MAY 2016 CAH

GP Copy

Date: 28/04/2016 18:58
Discharge Id Personal information redacted by USI
Version: 41

Dear Dr Personal Information redacted by the USI

DISCHARGE NOTIFICATION

The patient was admitted under the care of **DR A MCCLELLAND** (specialty: **CARDIOLOGY MEDICINE(C)**) into **1 NORTH CCU/CARDIOLOGY** Ward at **CRAIGAVON AREA HOSPITAL** on Personal Information redacted by the USI and discharged on Personal Information redacted by the USI.

Forenames: Personal Information redacted by the USI
Surname:
D.O.B:
Hospital No:
NHS No:
Gender: Male
Ward: 1 NORTH CCU/CARDIOLOGY

Address: Personal Information redacted by the USI

Initial Diagnosis
Heart failure

Method of Admission Emergency

Principle Discharge Diagnosis
Obstructing ureteric calculi

Additional Information for GP

Changes to Medications - Start/Stop
Start bisoprolol, tamsulosin and furosemide

Clinical Information/Comments

Personal Information redacted by the USI was admitted with new onset confusion, SoB, reduced ET and

Personal information redacted by USI

28/04/2016

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

lethargy. New diagnosis of dilated cardiomyopathy. BG chronic back pain. O/e dehydrated. Reduced eGFR noted on bloods. CT abdomen showed large obstructing ureteric calculi and AAA 5cm. He underwent emergency ureteroscopy with laser lithotripsy and stenting. He was admitted to ICU post for some inotropic support. He was successfully weaned from this and discharged to ward. He has been well post-procedure and will require urology follow up re definitive management of stones once fully recovered. He will also undergo Cardiac MRI and angiogram as OP. He is currently medically fit for discharge. He will require monitoring of his U&E and LFTs - could you please repeat on Personal information redacted by USI Many thanks for ongoing care,

Did the patient receive a blood transfusion?

No

Allergies:

Patient Has No Known Allergies

Details of Allergies:

Known Reactions to Allergies:

Additional Information:

Infection Status:

Follow Up Details

Arrangements for Follow Up:	Please cc Mr Glackin secretary re urology f/u. OP CMRI and angiogram.
Further Detailed Discharge Letter to Follow:	No
Awaiting Further Results:	No
Awaited Results:	
Patient Aware of Diagnosis:	Yes

Other Management Information For GP

Please monitor U&E and LFT Personal Information redacted by the USI

disp check completed by NMcA 28/4/16 @16.24
- perindopril and metformin on hold whilst in hosp but to recommence and be reviewed

Discharge Prescription: (POD = Patient's Own Drugs, PODH = Patient's Own Drugs at Home)

Drug	Dose	Frequency	Days	Route	GP Continue?

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

[redacted]

Authorised Forms

Form	Authorised By
Adult Clinical Details (Emergency-CMPM)	JORDAN MCVEY

Irrelevant redacted by the USI

28/04/2016

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Prescribing Clinician: JORDAN MCVEY **Bleep No:** Personal Information redacted by the USI

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

HCN [redacted] Surname [redacted] Forename [redacted] [redacted]

AE Number [redacted]

GP [redacted] [redacted]

GP TEL. [redacted]

Diagnosis

1. Urinary Retention

2. piles

3.

Investigations and Results Bloods

SOUTHERN TRUST BOOKING CENTRE RECEIVED 04 MAY 2016 CAH

ED Discharge Plan

Patient to attend GP

u. catheter → catheter care pathway

TTO

Referred to Specialty

Time

GP to monitor BP in 2 week

Admission Agreed By:

DTA Time

Grade of Doctor

Patient to make appt with GP

Prescription (Medicines on discharge)

Medicine	Dose	Route	Frequency	Duration	Signature	Supply required	Supply Checked by	Given	Quantity
#1 Inst. Hagel	as needed	pr	prn	5/7	[redacted]				
Anusol supp	as per box	pr	prn	7/7					

FINAL PLACEMENT

Admit to ward — GP — other hospital OPD

CDU — ED Review — Did not wait/refuses Rx

TNF to OH — Fracture Clinic — Died in ED

Home [redacted]

[redacted]

Breach Time 21:38

Exam Finish Time

Departure Time 4 ho

P	BP	RESP	TEMP	SPO2	GCS	CR	BM
69	206/161	21	36.4	98	15		

Transport booked — Time booked — Ref if NIAS

IV Cannula removed — Advice leaflet given — UNOCINI complete

CBYL given — GP letter given — Patient property returned

Breach Time 21:38

Time left department 22:32

Signature Nurse [redacted]

Rechecked 195/96

CRAIGAVON HOSPITAL
EMERGENCY DEPARTMENT

Lurgan Road, Craigavon, BT6 35QQ

Tel: [redacted] Fax: [redacted]

[redacted]

FBC ☑ Coag ☐ Amylase ☑

U&E ☑ D dimer ☐ Other:

CRP ☑ Troponin ☐ Time: 1840

LFT's ☑ VBG ☐ Sign:

Cardiac ☐ Toxscreen ☐

AE Number [redacted]

HCN [redacted]

Surname [redacted]

Forename [redacted]

Dob [redacted]

Sex M MS M

Occ. [redacted]

Casenote [redacted]

Mobile/Other

Priority Code 3

G [redacted]

Arrival Date/Time [redacted] 17:38

Arrival Mode PR Incident Type NT

Source of Referral Other

Accompanied By

Patient at risk of leaving Yes/No

Prev Episodes 03 / 01

Triage Date/Time [redacted]

Breach Time 21:38

Nurse: EJ

ELISSHA JONES

Tetanus Status:

Booster Given Yes/No

Adult Safeguarding Concerns Yes/No

Child Protection Concerns Yes/No

Special Needs

Presenting Complaint NIL OUTPUT OF URINE

Presentation URINARY PROBLEMS

Discriminator RETENTION OF URINE

Triage Text HAD HERNIA OPERATION UNDER DR HEWITT ON 28/4, NOW C/O URINARY RETENTION.

Medication

Allergies NKDA

Signature [redacted]

Pulse	B/P	RR	PFR	Temp	SaO2	GCS	CRT	BM	PERL	AVPU
75	194/99	17		36.7	99					A

Visual Acuity — Right Eye — Left Eye — Urine — Pregnancy Test — Weight

ECG required yes/no (< 10 minutes cardiac)

History

MRSA

CDIFF

Patient Location MAJORS 1

Pain Score

Time 18:06

Category 3 Infection

Commenced on NEWS/CNS/PEWS chart Yes No Signature

Nursing Assessment

MENTAL STATE	Yes	No	WASHING AND DRESSING	Yes	No	SOCIAL HISTORY	Yes	No
Alert and Orientated			Independent			Lives Alone		
Confused			Help Required			Lives With		
Agitated			Full Assistance Required			Relatives Present		
Aggressive			Pressure Areas Checked			Aware		
Drowsy			Commode required			Contacted by		
Trolley Sides in Situ			Pad Changed					
MOBILITY			FEEDING AND DIET			Relative Contact Number		
Independent			Dietary Requirements					
Walk with Help			Dentures top			Patient updated at regular intervals		
Walk with Aids			bottom			Yes		No

Version - 10.0.1

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

HCN [redacted] Surname [redacted] Forename [redacted] Dob [redacted]
AE Number [redacted]

Assessment Seen By [redacted] Time 20.38

History and Examination

Pc Urinary Retention

H/o Inguinal Hernia Repair 28/6

Unable to PU 1/7

Catheterised. At the GP's ?
Abdo soft, [illegible] enlarged bladder

14FG Cath insertion

22/6 20 ↓ 550 ml urine drained → pt is comfortable
Request med. [illegible] pils (painful)

Rx < Catheter care pathway
TTO – [illegible] (prn)
└ [illegible] (prn) [illegible]

PTFE AquaFlate
PTFE Coated Latex
Short/Medium-Term
(up to 4 weeks use)
Standard, 2-way Foley
SIZE Ch. 14 (4.7mm) / 10ml
REF P310114
LOT 15HE35
2020-07

Indication ____
Residual Volume (ml) ____
Colour of Urine ____
Easy Insertion? Y N If No, why? ____
Name ____
Signed ____
Date ____

"Case discussed with ED consultant" yes ☐ ____

HCN [redacted] Surname [redacted] Forename [redacted] Dob [redacted]
AE Number [redacted]

Prescription (Medicines in Department) — Administration

Medicine	Dose	Route	Time to be given	Signature	Given by	Time

Nursing/care delivered in ED

Bloods
Ⓦ | abn
any time
FBC → Hb | WCC 24.69 ← (urinary retention) CLL
CRP 1.64 | lymph 52
LFT → 6.1, 23.3 [illegible]
U+E

Signatue of Nurse ____

Admission checklist (please tick if completed)

Time Bed manager informed ____ Ward Ready at ____

Copy ED Flimsy	☐	MEWS/CNS	☐	IV Cannula Form	☐
Fluid Balance	☐	Relevant performa	☐	C diff completed	☐
Copy of NIAS notes stroke PTs	☐	Own Drugs	☐	Relatives aware admission	☐

Patient handover given to admitting nurse ____ (please record their name) Time ____

Patient has previous history of C Diff	yes ☐	no ☐
Patient has vomiting and /or diarrhoea	yes ☐	no ☐
Patient had contact with anyone with vomiting and /or diarrhoea in last 5 days	yes ☐	no ☐

If yes to any of above refer to agreed guidance.

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

SOUTHERN TRUST BOOKING CENTRE RECEIVED 04 MAY 2016 CAH

For Trust use only:
HCN: Personal Information redacted by the USI
Date Sent: 04-May-2016

Referral Date: 04-May-2016
Surname: Personal Information redacted by the USI

Personal Information redacted by the USI

Practice address
Personal Information redacted by the USI

Practice code: Personal Information redacted by the USI

Contact number(s)
Telephone: Personal Information redacted by the USI
Fax:

Red Flag
Upgrade
Urgent
Routine
Practice Email:

Referral to:	Craigavon Area Hospital	**Referral Type:**	Out Patient
Specialty:	UROLOGY		
Urgency:	**ROUTINE**		
Urgency Reason:	no priority reason given		
Electronic Attachment Present?:	No		
HCP Name:			
Designation:			

Other
Virtual

Practice Code:	Personal Information redacted by the USI	**Registered GP:**	Personal Information redacted by the USI
Registered GP Cypher:	Personal Information redacted by the		
Referring GP:	Personal Information redacted by the USI	**Referring GP Cypher:**	

HCN Number	Personal Information redacted by the USI	**Title:**	Miss
Surname:	Personal Information redacted by the USI	**Forenames:**	Personal Information redacted by the USI
Previous Surname:		**Known as:**	
DOB:	Personal Information redacted by the USI	**Gender:**	Female
Registered Contact Details:	Personal Information redacted by the USI		
Tel No:	Personal Information redacted by the USI	**Mobile:**	Personal Information redacted by the USI
Patient Email:			
Preferred Contact Details if different from above:			

Special Needs or Requirements

Reason for Referral/ History of Presenting Complaint
Description: recurrent UTI's

Personal information redacted by USI

04/05/2016

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

WIT-55620

Comment: I would be grateful if this Personal Information old girl could be seen in your clinic. She presents with recurrent UTI's and also has a history of UTI in childhood. For investigation of this she had a renal ultrasound scan this showed minimal hydronephrosis measuring 9 mm in AP transverse diameter which persists post micturition. Her BP 120/68 and her renal function is normal. I would be grateful if she could be followed up in your clinic. Thank you.

RELEVANT PAST MEDICAL HISTORY

Pre-existing conditions (High & medium priority - all)

Description	Date of onset	Date recorded
Personal Information redacted by the USI		

ALLERGIES & RISKS

Lifestyle risks

SMOKING STATUS

Description	Comment	Date Recorded
Never smoked tobacco		15-Feb-2013

ALCOHOL INTAKE

BMI

25

SOCIAL HISTORY

OTHER PATIENT DATA

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

WIT-55621

Signature of referring doctor (or other professional)

Date

Irrelevant information redacted by the USI

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

RECEIVED
04 MAY 2016

For Trust use only:
HCN: Personal Information redacted by the USI
Date Sent: 04-May-2016

Referral Date: 04-May-2016
Surname: Personal Information redacted by the

Personal Information redacted by the USI

Practice address
Personal Information redacted by the USI

Practice code: Personal Information redacted by the USI

Contact number(s)
Telephone: Personal Information redacted by the USI
Fax:

Red Flag	TRUS
Upgrade Red Flag	Flex. C/U
Urgent	Practice Email:
Routine	Out Patient
Other	
Virtual	

Referral to: Craigavon Area Hospital
Specialty: UROLOGY
Urgency: **ROUTINE**
Urgency Reason: no priority reason given
Electronic Attachment Present?: No
HCP Name:
Designation:

Referral Type:

Practice Code: Personal Information redacted by the USI
Registered GP: Personal Information redacted by the USI
Registered GP Cypher: Personal Information redacted by the
Referring GP: Personal Information redacted by the USI
Referring GP Cypher: Personal Information

HCN Number Personal Information redacted by the USI
Title: Mr
Surname: Personal Information redacted by the USI
Forenames: Personal Information redacted by the USI
Previous Surname: -
Known as: -
DOB: Personal Information redacted by the USI
Gender: Male
Registered Contact Details: Personal Information redacted by the USI
Tel No: -
Mobile: Personal Information redacted by the USI
Patient Email: -
Preferred Contact Details if different from above:

Special Needs or Requirements

Reason for Referral/ History of Presenting Complaint
Description: lower urinary tract symptoms

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

WIT-55623

Comment: Please may I have your opinion on this Personal Information redacted by old man with lower urinary tract symptoms.

This man complains of a two year history of nocturia x 2 and daily urinary frequency. He denies any haematuria, dysuria, hesitancy or terminal dribbling.

Personal Information redacted by the USI

On examination BMI 34, BP 136/8, abdomen soft non-tender with no masses. PR reveals central skin tag and smooth prostate.

Urinalysis nad.

I referred him for an ultrasound of abdomen and urinary tract.

Please find normal report on ECR.

He has been commenced on combodart but I would appreciate your assessment.

Yours sincerely,

Dr Personal Information redacted by

RELEVANT PAST MEDICAL HISTORY

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded	Duration
Personal Information redacted by the USI				
				-
				-
				-
				-
				-

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

WIT-55624

[redacted]

ALLERGIES & RISKS

Lifestyle risks

SMOKING STATUS

Description	Comment	Date Recorded
Ex smoker	ex-	06-Oct-2015

ALCOHOL INTAKE

Description	Comment	Date Recorded
Alcohol consumption, 0 units/week		13-Nov-2015

BMI

33.91

SOCIAL HISTORY

OTHER PATIENT DATA

Signature of referring doctor (or other professional)

Date

[redacted]

04/05/2016

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

WIT-55625

For Trust use only:

HCN: [redacted]

Date Sent: 04-May-2016

04 MAY 2016 CAH

Referral Date: 04-May-2016

Surname: [redacted]

[redacted]

Practice address

[redacted]

Practice code: [redacted]

Contact number(s)

Telephone: [redacted]

Fax:

Red Flag | TRUS

Upgrade Req Flag | Flex. C/U

Urgent | Flow Type

Routine | Clinician

Other

Virtual

Practice Email:

Referral to: Craigavon Area Hospital

Specialty: UROLOGY

Urgency: **URGENT**

Urgency Reason: no priority reason given

Electronic Attachment Present?: No

HCP Name:

Designation:

Referral Type: Out Patient

Practice Code: [redacted]

Referring GP: [redacted]

Registered GP: [redacted]

Referring GP Cypher:

Registered GP Cypher: [redacted]

HCN Number [redacted]

Surname: [redacted]

Previous Surname:

DOB: [redacted]

Registered Contact Details: [redacted]

Tel No: -

Patient Email: -

Preferred Contact Details if different from above:

Title: Mr

Forenames: [redacted]

Known as:

Gender: Male

Mobile: [redacted]

Special Needs or Requirements

Reason for Referral/ History of Presenting Complaint

Description: haematuria

Comment: many thanks for review of this [redacted] who has recent onset haematuria, brigh red, attended A+E, given

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

WIT-55626

trimethoprim for ?UTI, culture negative, inflamm markers negative. denies any back/loin pain, no previous symptoms of same. abdo soft, non tender, renal function normal. persisting on but settling, not to same extent. still PU ok. many thanks for review/assessment ?calculi ?cause

RELEVANT PAST MEDICAL HISTORY

Past procedures (High and medium priority - all)

Description	Comment	Date recorded
[redacted]		

ALLERGIES & RISKS

Lifestyle risks

SMOKING STATUS

Description	Comment	Date Recorded
Current smoker		29-Apr-2016

ALCOHOL INTAKE

BMI

19

SOCIAL HISTORY

OTHER PATIENT DATA

Signature of referring doctor (or other professional)

Date

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

SOUTHERN TRUST BOOKING CENTRE
RECEIVED
04 MAY 2016
CAH

For Trust use only:
HCN: [redacted]
Date Sent: 04-May-2016

Referral Date: 04-May-2016
Surname: [redacted]

[redacted]

Practice address

[redacted]

Practice code: [redacted]

Contact number(s)
Telephone: [redacted]
Fax:

Red Flag | TRUS
Urgent
Routine
Other
Virtual

Practice Email:

Referral to:	Craigavon Area Hospital	**Referral Type:**	Out Patient
Specialty:	UROLOGY		
Urgency:	**ROUTINE**		
Urgency Reason:	no priority reason given		
Electronic Attachment Present?:	No		
HCP Name:			
Designation:			

Practice Code: [redacted] **Registered GP:** [redacted] **Registered GP Cypher:** [redacted]
Referring GP: [redacted] **Referring GP Cypher:**

HCN Number	[redacted]	**Title:**	Mr
Surname:	[redacted]	**Forenames:**	[redacted]
Previous Surname:		**Known as:**	-
DOB:	[redacted]	**Gender:**	Male
Registered Contact Details:	[redacted]		
Tel No:	-	**Mobile:**	[redacted]
Patient Email:	-		
Preferred Contact Details if different from above:			

Special Needs or Requirements

Reason for Referral/ History of Presenting Complaint
Description: ED and poor stream

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Comment: I would be grateful if this Personal Information redacted by old man could be seen in your clinic. He describes 2 x problems.

The first problem is difficulty in achieving erections over the past 6 months. He states that his morning erections are now not as strong as they used to be and he is unable to achieve a full erection before intercourse.

His second problem is poor urinary stream for approximately 10 years. He describes the stream as stop and start. He has no back pain and no weight loss.

On examination his prostate felt normal size and was smooth. Anal tone was normal. He had no spinal tenderness and his legs were neurologically intact.

He is a smoker of 20 cigarettes per day and I have told him this could be contributing to his erectile dysfunction and he is trying to stop smoking. BP is 120/80. Blood tests are unremarkable including hormone profile, PSA and HBA1c and cholesterol. He would be grateful if his symptoms could be further investigated.

Thank you.

RELEVANT PAST MEDICAL HISTORY

Past procedures (High and medium priority - all)

Description	Date recorded
Personal Information redacted by the USI	

ALLERGIES & RISKS

Lifestyle risks

SMOKING STATUS

Description	Comment	Date Recorded
Heavy smoker - 20-39 cigs/day		01-Feb-2016

ALCOHOL INTAKE

BMI

SOCIAL HISTORY

OTHER PATIENT DATA

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

WIT-55629

Signature of referring doctor (or other professional)

Date

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

WIT-55630

SOUTHERN TRUST BOOKING CENTRE
RECEIVED
04 MAY 2016
CAH

For Trust use only:
HCN: [redacted]
Date Sent: 04-May-2016

Referral Date: 03-May-2016

Surname: [redacted]

[redacted]

Practice address

[redacted]

Practice code: [redacted]

Contact number(s)
Telephone: [redacted]
Fax:

Red Flag	TRUS
Upgrade Red Flag	Flex. C/U
Urgent	Practice Email: Flow Rate
Routine	Out Patient Ultrasound
Other	
Virtual	

Referral to: Craigavon Area Hospital
Specialty: UROLOGY
Urgency: **URGENT**
Urgency Reason: no priority reason given
Electronic Attachment Present?: No
HCP Name:
Designation:

Referral Type:

Practice Code: [redacted]
Registered GP: [redacted]
Registered GP Cypher: [redacted]
Referring GP: [redacted]
Referring GP Cypher: [redacted]

HCN Number	[redacted]	**Title:**	MR
Surname:	[redacted]	**Forenames:**	[redacted]
Previous Surname:	-	**Known as:**	-
DOB:	[redacted]	**Gender:**	Male
Registered Contact Details:	[redacted]		
Tel No:	[redacted]	**Mobile:**	-
Patient Email:	[redacted]		
Preferred Contact Details if different from above:			

Special Needs or Requirements

Reason for Referral/ History of Presenting Complaint
Description: Raised PSA - Urinary retention - Prostatic symtoms
Comment: Dear Team

[redacted]

04/05/2016

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

WIT-55631

I would be grateful if you would see Personal Information redacted by the USI who has had a four year history of LUTS. Two weeks ago he went into acute urinary retention and was seen in Craigavon where he was catheterised. Unfortunately the catheter caused quite an acute inflammation and allergic response. We have removed the catheter today on the 3rd May and are hoping for successful removal. He had of course developed a urinary tract infection in the interim. The most specific reason for referring him at this stage is because of elevated PSA which was checked in the hospital and gave a value of 24. I would be grateful if you would look at him from the point of view of intervention to prevent further episodes of acute urinary retention and to consider management of the PSA which we will of course arrange to recheck over the next few weeks.

Yours sincerely

RELEVANT PAST MEDICAL HISTORY

Pre-existing conditions (High & medium priority - all)

Description	Comment	Modifier	Date of onset	Date recorded
Personal Information redacted by the USI				

Irrelevant information redacted by the USI

04/05/2016

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Personal Information redacted by the USI

ALLERGIES & RISKS

Lifestyle risks

SMOKING STATUS

Description	Comment	Date Recorded
Cigarette smoker	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 3.	11-Oct-2013

ALCOHOL INTAKE

Description	Comment	Date Recorded
Alcohol consumption	Drinking status on eventdate: Current drinker, Units of alcohol drank per week: 1. NOTES: alcohol occasionally only.	28-Oct-2013

BMI

24.8

SOCIAL HISTORY

OTHER PATIENT DATA

Signature of referring doctor (or other professional) **Date**

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

SOUTHERN TRUST BOOKING CENTRE RECEIVED 04 MAY 2016 CAH

For Trust use only:
HCN: Personal Information redacted by the USI
Date Sent: 04-May-2016

Referral Date: 03-May-2016

Surname: Patient 93

Personal Information redacted by the USI

Practice address

Personal Information redacted by the USI

Practice code: Personal Information redacted by the USI

Contact number(s)
Telephone: Personal Information redacted by the USI
Fax:

Practice Email:

Red Flag	TRUS
Upgrade Red Flag	Flex. C/U
Urgent	Flow Rate
Routine	Ultrasound
Other	
Virtual	

Referral to: Craigavon Area Hospital
Specialty: UROLOGY
Urgency: **ROUTINE**
Urgency Reason: no priority reason given
Electronic Attachment Present?: No
HCP Name:
Designation:

Referral Type: Out Patient

Practice Code: Personal Information redacted by the USI
Registered GP: Personal Information redacted by the USI
Registered GP Cypher: Personal Information redacted by the USI
Referring GP: Personal Information redacted by the USI
Referring GP Cypher: Personal Information redacted by the USI

HCN Number	Personal Information redacted by the USI	**Title:**	MR
Surname:	Patient 93	**Forenames:**	Patient 93
Previous Surname:	-	**Known as:**	-
DOB:	Personal Information redacted by the USI	**Gender:**	Male
Registered Contact Details:	Personal Information redacted by the USI		
Tel No:	Personal Information	**Mobile:**	
Patient Email:	-		
Preferred Contact Details if different from above:			

Special Needs or Requirements

Reason for Referral/ History of Presenting Complaint

Description: High PSA

Comment: 10/03/2016 Dysuria pain ++ when PU
no prostatism symtoms

Irrelevant information redacted by the USI

04/05/2016

WIT-55634

Good stream
no intercourse
no nocturia
PR - suspicious feeling esp left lobe seems knobbly
20/04/2016 Prostate specific antigen = 30.47 ng/mL High Original Result: "TOTAL PSA(T)" 30.47 ng/ml (0 - 6.5) Dr Personal Information redacted by the USI
11/03/2016 Prostate specific antigen = 34.8 ng/mL High Original Result: "TOTAL PSA(T)" 34.80 ng/ml (0 - 6.5) Dr Personal Information redacted by the USI

RELEVANT PAST MEDICAL HISTORY

Pre-existing conditions (High & medium priority - all)

Description	Comment	Modifier	Date of onset	Date recorded
Personal Information redacted by the USI				

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Personal Information redacted by the USI

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Personal Information redacted by the USI

Irrelevant information redacted by the USI

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Personal Information redacted by the USI

Irrelevant information redacted by the USI

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

WIT-55638

Personal Information redacted by the USI

[redacted]

ALLERGIES & RISKS

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Lifestyle risks

SMOKING STATUS

Description	Comment	Date Recorded
Ex smoker	Smoking status on date of event: Ex-smoker.	26-Jun-2013

ALCOHOL INTAKE

Description	Comment	Date Recorded
Alcohol consumption	Drinking status on eventdate: Current drinker, Units of alcohol drank per week: 24.	13-May-2004

BMI

28.6

SOCIAL HISTORY

OTHER PATIENT DATA

Signature of referring doctor (or other professional) **Date**

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

WIT-55640

SOUTH ... BOOKING CENTRE RECEIVED 04 MAY 2016 CAH

For Trust use only:

HCN: [redacted]

Date Sent: 04-May-2016

Referral Date: 04-May-2016

Surname: [redacted]

[redacted]

Practice address

[redacted]

Practice code: [redacted]

Contact number(s)

Telephone: [redacted]

Fax:

Red Flag	TRUS
Upgrade Red Flag	Flex. C/U
Urgent	Flow Rate
Routine	Ultrasound
Other	Out Patient
Virtual	

Practice Email:

Referral to:	Daisy Hill Hospital
Specialty:	UROLOGY
Urgency:	**URGENT**
Urgency Reason:	no priority reason given
Electronic Attachment Present?:	No
HCP Name:	
Designation:	

Referral Type:

Practice Code:	[redacted]	**Registered GP:**	[redacted]	**Registered GP Cypher:**	[redacted]
Referring GP:	[redacted]	**Referring GP Cypher:**	[redacted]		

HCN Number	[redacted]	**Title:**	Mr
Surname:	[redacted]	**Forenames:**	[redacted]
Previous Surname:	-	**Known as:**	-
DOB:	[redacted]	**Gender:**	Male
Registered Contact Details:	[redacted]		
Tel No:	[redacted]	**Mobile:**	-
Patient Email:	-		
Preferred Contact Details if different from above:			

Special Needs or Requirements

Reason for Referral/ History of Presenting Complaint

Description: [redacted] old man had originally attended with frank haematuria, adn been referred

Comment: US scan had been requested which shows a residual of 440ml

Irrelevant information redacted by the USI

04/05/2016

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Prostatic size 34 ml
Most recent psa 0.36ng/ml.
u&e in February 2016 had been normal, will ask hime to have it repeated.
MAny thanks Dr Personal Information

RELEVANT PAST MEDICAL HISTORY

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Personal Information redacted by the USI			

Past procedures (High and medium priority - all)

Description	Date recorded
Personal Information redacted by the USI	

MEDICATION

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Code	Formulation	Dosage	Frequency	Date started	Duration
Personal Information redacted by the USI						

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

mg DAILY 2009

Recent medication (Any medication issued within last 168 days not shown above)

Drug name	Code	Formulation	Dosage	Frequency	Date started	Duration
Personal Information redacted by the USI						

ALLERGIES & RISKS

Lifestyle risks

SMOKING STATUS

Description	Comment	Date Recorded
Ex smoker		21-Jul-2015

ALCOHOL INTAKE

Irrelevant information redacted by the USI

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

WIT-55643

Description	Comment	Date Recorded
Alcohol consumption		23-Jul-2015
BMI		
28.7		
SOCIAL HISTORY		
OTHER PATIENT DATA		

Signature of referring doctor (or other professional)

Date

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Personal Information redacted by the USI

SOUTHERN TRUST BOOKING CENTRE
RECEIVED
04 MAY 2016

Referral to: Craigavon Area Hospital

Speciality: Erectile Dysfunction Clinic

Date of Referral: 29 April 2016

Urgency: Routine Referral
RED FLAG REFERRAL: ☐

Preferred Consultant:
Referring GP: Personal Information redacted by the USI

Registered GP: Personal Information redacted by the USI

Health & Care Number: Personal Information redacted by the USI

Patient Name: Personal Information redacted by the USI

Address: Personal Information redacted by the USI

Date of Birth: Personal Information redacted by the USI
Previous Surname:
Telephone Number: Personal Information redacted by the USI

Hospital Number: Personal Information redacted by the

Reason for Referral: Erectile dysfunction

Please see this patient who complains of ED since MI in 2013. His beta blocker was changed from bisoprolol to nebivolol as this was initially queried as a factor. He was given Cialis which helped but on review of guidance in BNF in "absence of information" manufacturers advised this is contraindicated with hx of IHD. He is not on a nitrate.
I would appreciate your **assess**ment. Many thanks.

Lifestyle (Most Recent)
Height: 1.85 m
Weight: 87.00 kg
BMI: 25.40
Blood Pressure: 100/60

Past Medical History (Priority 1's)
Personal Information redacted by the USI

Allergy/Intolerance Personal Information redacted by the USI

Signature of Referrer Personal Information redacted by the USI 29 April 2016

Red Flag	TRUS
Urgent	Flow Rate
Routine	Ultrasou
Other	
Virtual	

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

WIT-55645

HCN [redacted] Surname [redacted] Forename [redacted] Dob [redacted]
AE Number [redacted]
GP [redacted]
GP TEL [redacted]

CRAIGAVON HOSPITAL EMERGENCY DEPARTMENT

Lurgan Road, Craigavon, BT6 36QQ
Tel: [redacted] Fax: [redacted]

Diagnosis
1. Renal stone
2.
3.

Investigations and Results
CT KUB – R/L stone

SOUTHERN TRUST BOOKING CENTRE RECEIVED 04 MAY 2016 CAH

Patient to attend re:

ED Discharge Plan
Stone clinic – return if unwell

Referred to Specialty Time

Admission Agreed By: DTA Time

Grade of Doctor Patient to make appt with GP

Prescription (Medicines on discharge)

Medicine	Dose	Route	Frequency	Duration	Signature	Supply required	Supply Checked by	Given by	Quantity
CODEINE	30-60mg	PO	6°	3 days	Owing				
DICLOFENAC	100mg	PR PRN	od	1 dose	Owing				

FINAL PLACEMENT

Admit to ward	GP	other hospital OPD	Sign [redacted]
CDU	ED Review	Did not wait/refuses Rx	Grade JHO
TNF to OH	Fracture Clinic	Died in ED	Breach Time 15:15
Home	CBYL	Psych. Assess CTMA	Exam Finish Time 1645
OPD ✓	Physio	Absconded	Departure Time

Discharge OBS

P	BP	RESP	TEMP	SPO2	GCS	CR	BM
62	110/65	18	36.3	97.			

Transport booked	Time booked	Ref if NIAS
IV Cannula removed	Advice leaflet given	UNOCINI complete
CBYL given	GP letter given	Patient property returned

Breach Time 15:15

Time left department 1650 Signature Nurse [redacted]

Page 4

AE Number [redacted] HCN [redacted] Priority Code 3
Surname [redacted] [redacted] [redacted]
Forename
Dob [redacted]
Sex M MS D
Occ [redacted] Tel [redacted]
Casenote [redacted] Mobile/Other [redacted]

Arrival Date/Time 03/05/2016 11:15 Prev Episodes 09 / 01 Adult Safeguarding Concerns Yes/No
Arrival Mode A9 Incident Type NT Triage Date/Time 03/05/2016 11:19 Child Protection Concerns Yes/No
Source of Referral Brought By Ambulance Breach Time 15:15 Special Needs
Accompanied By Nurse: KEH
KEYLEIGH HARNEY
Patient at risk of leaving Yes/No Tetanus Status:
Booster Given Yes/No

Presenting Complaint ?RENAL COLIC
Presentation ABDOMINAL PAIN IN ADULTS
Discriminator MOD PAIN
Triage Text ?RENAL COLIC– HX OF SAME STATES IS SIMILAR PAIN MORPHINE GIVEN WITH GOOD EFFECT BY NIAS
Medication

Allergies PENICILLEN

Pulse	B/P	RR	PFR
67	133/69	20	

Visual Acuity Right Eye Left Eye

ECG required yes/no (< 10 minutes cardiac) History MRSA CDIFF

Commenced on NEWS/CNS/PEWS ch

Nursing Assessment

MENTAL STATE Yes No WASH
Alert and Orientated Indep
Confused Help
Agitated Full A
Aggressive Press
Drowsy Com
Trolley Sides in Situ Pad
MOBILITY FEEDING
Independent Dietary Requirements
Walk with Help Dentures top bottom Patient updated at regular intervals Yes No
Walk with Aids

On cmystoscopy list for r/v in Oct '14. List currently running at May '13. Expedite?

(Due r/v Oct '14)

Page 1 Version – 10.91

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

HCN [redacted] Surname [redacted] Forename [redacted] Dol [redacted]
AE Number [redacted]

History and Examination

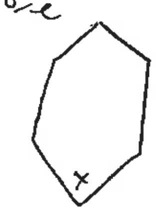
Assessment	Seen By [redacted]	Time

58 ♂
Renal stone History
Today / severe left renal flank pain
4/10 severity → relieved by morphine ... 2/10
to cont. Recent treatment x stone pain
Oct 2017 - ... left 6x4mm ... calyceal stone not destroyed
Offers
O/E

PMH
1, Yh
Renal stones
IBS

DHx
Pen allergy

BS, stable
O/E



soft
BS ✓
tender mildly

Chest
→ BS clear

MSU [illegible]
CRT <2sec
[illegible]

D/w urology
Re CT KUB

analgesia ✓
Bloods ✓
Urine ✓

CT noted ~3K stone. [illegible]
D/w ... Urology Reg
for clinic
Accord [illegible] /1420

"Case discussed with ED consultant" yes ☐ ______

HCN [redacted] Surname [redacted] Forename [redacted] Dob [redacted]
AE Number [redacted]

Prescription (Medicines in Department) / Administration

Medicine	Dose	Route	Time to be given	Signature	Given by	Time
DICLOFENAC	100mg	PR	STAT	[illegible]	[redacted]	1140

Nursing/care delivered in ED

HB 144 ... CRP 4 ... eGFR >0 x 60
plt 243 ... Creat 1?a
WCC 10.3

Pt to a/w CT KUB as per Urology. No need for Adm.
Pt told by Dr he can go for lunch. [redacted]

1655 / D/c home
with script
NEWS=0 [redacted]

Signatue of Nurse ______

Admission checklist (please tick if completed)

Time Bed manager informed ______ Ward Ready at ______

Copy ED Flimsy	☐	MEWS/CNS	☐	IV Cannula Form	☐
Fluid Balance	☐	Relevant performa	☐	C diff completed	☐
Copy of NIAS notes stroke PTs	☐	Own Drugs	☐	Relatives aware admission	☐

Patient handover given to admitting nurse ______ (please record their name) Time ____

Patient has previous history of C Diff	yes ☐	no ☐
Patient has vomiting and /or diarrhoea	yes ☐	no ☐
Patient had contact with anyone with vomiting and /or diarrhoea in last 5 days	yes ☐	no ☐

If yes to any of above refer to agreed guidance.

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

Quality Care - for you, with you

INVESTIGATION REPORT
Under the Maintaining High Professional Standards Framework

Mr Aidan O'Brien, Consultant Urologist

Case Investigator
Dr Neta Chada, Consultant Psychiatrist / Associate Medical Director
Assisted by
Mrs Siobhan Hynds, Head of Employee Relations

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

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REPORT OF FORMAL INVESTIGATION

1. Introduction

Mr Aidan O'Brien is employed by the Southern Health and Social Care Trust as a Consultant Urologist based in Craigavon Area Hospital. He was appointed to this role on 6 July 1992 and currently undertakes 12 Programmed Activities.

Mr O'Brien is one of 5 Consultant Urologists within the Trust and the team work a 'Consultant of the Week On-call' model with the consultant of the week responsible for triage of all referrals during their period on-call.

2. Context / Background

The Urology service in Craigavon Area Hospital has developed from a complement of 3 Consultants in or around 2012/13 to the current model with 5 Consultants and manages approximately 8,000 referrals per year. Each Consultant on-call manages 150 to 160 referrals during their on-call week. This model was adopted in 2014 and it was anticipated that the consultant of the week model, along with one-stop clinics for patients would allow more time to focus on cancer targets and inpatient emergency care.

Referrals to the service are received via a number of routes. The vast majority of referrals are received via an electronic CCG referral from a GP. Small numbers of other referrals are received via letter, from Trust Consultants or via the Emergency Department. All referrals are required to go through the Trust's Referral and Booking Centre for logging and then forwarded to the Consultant on-call for triage.

Currently there is an agreed triage system in place with 3 categories of patient urgency outcomes – routine, urgent and red-flag. (A red-flag referral is one where there is a suspicion / concern of cancer with a patient.) The referral will usually be sent to the Urology service with a GP categorisation on the referral determined by the GP. Triage is then completed by the Urologist, as the specialist medical practitioner, to determine if the GP categorisation is correct or if it requires to be changed. Once the referral is triaged, patients are added to the Urology waiting lists in chronological order according to their prioritisation.

All specialties including Urology are required to work to the nationally agreed 62 day pathway for all cancer patients

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3. The initial concern

A Serious Adverse Incident (SAI) investigation was commenced within the Trust in April 2017 in respect of a patient Patient 10, a patient of the Urology service. A referral had been received by the Trust in 2015 however the patient was not seen until February 2016. The patient was seen by Mr Mark Haynes, Consultant Urologist.

Mr Haynes reviewed the patient and the referral and was concerned about the delay for the patient. As a result Mr Haynes completed a Datix form to alert the Trust to the issue of concern.

Mr Anthony Glackin, Consultant Urologist chaired the SAI investigation which commenced in Autumn 2016. Through the SAI it was identified that the referral for patient Patient 10 had not been triaged. An initial look back exercise was undertaken and a number of other patients were identified as not having been triaged. Further assessment of the issue identified a significant number of patients who had not been triaged.

The issues of concern relating to patient Patient 10 were wider than the referral delay. There were issues of concerns in respect of the radiology reporting on diagnostic images however from a urology perspective, it was felt that the symptoms recorded by the patient's GP on the initial referral should have resulted in the referral being upgraded to a 'red-flag' referral and prioritised as such

4. Timeline of the Investigation

The dates below outline the key dates in respect of the background to the concerns and the management of the concerns under the Maintaining High Professional Standards (MHPS) Framework:

March 2016

On 23 March 2016, Mr Eamon Mackle, Associate Medical Director (Mr O'Brien's clinical manager) and Mrs Heather Trouton, Assistant Director (Mr O'Brien's operational manager) met with Mr O'Brien to outline their concerns in respect of his clinical practice. In particular, they highlighted governance and patient safety concerns which they wished to address with him.

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Mr O'Brien was provided with a letter detailing their concerns and asking him to respond with an immediate plan to address the concerns. **(Appendix 1)**

Four broad concerns were identified:

- Untriaged outpatient referral letters

It was identified at that time that there were 253 untriaged referrals dating back to December 2014.

- Current Review Backlog up to 29 February 2016

It was identified at that time that there were 679 patient's on Mr O'Brien's review backlog dating back to 2013, with a separate oncology waiting list of 286 patients.

- Patient Centre letters and recorded outcomes from clinics

The letter noted reports of frustrated Consultant colleagues concerned that there was often no record of consultations / discharges made by Mr O'Brien on Patient Centre or on patient notes.

- Patient's hospital charts at Mr O'Brien's home

The letter indicated the issue of concern dated back many years. No numbers were identified within the letter.

April to October 2016

During the period April to October 2016, considerations were on-going about how best to manage the concerns raised with Mr O'Brien in the letter of 23 March 2016. It was determined that formal action would not be considered as it was anticipated that the concerns could be resolved informally. Mr O'Brien advised the review team he did not reply to the letter but did respond to the concerns raised in the letter by making changes to his practice.

November 2016

Mr O'Brien was off work on sick leave from 16 November 2016 following surgery and was due to return to work on 2 January 2017.

An on-going Serious Adverse Incident (SAI) investigation within the Trust identified a Urology patient who may have a poor clinical outcome because the GP referral was not triaged by Mr O'Brien. The SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason.

December 2016

The concerns arising from the SAI were notified to the Trust's Medical Director, Dr Richard Wright in late December 2016. As a result of the concerns raised with Mr O'Brien on 23 March 2016 and the serious concern arising from the SAI investigation by late December

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2016, the Trust's Medical Director determined that it was necessary to take formal action to address the concerns.

Information initially collated from the on-going SAI of Mr O'Brien's administrative practices identified the following:

- from June 2015, 318 GP referrals had not been triaged in line with the agreed / known process for such referrals. Further tracking and review was required to ascertain the status of all referrals.
- there was a backlog of 60+ undictated clinics dating back over 18 months amounting to approximately 600 patients, who may not have had their clinic outcomes dictated. It was unclear what the clinical management plan was for these patients, and if the plan had been actioned
- some of the patients seen by Mr O'Brien may have had their clinical notes taken back to his home, and are therefore not available within the hospital. The clinical management plan for these patients was unclear, and may be delayed.

As a result of these concerns, work was undertaken to scope the full extent of the issues and to put a management plan in place to review the status of each patient. The management plan put in place was to provide the necessary assurances in respect of the safety of patients involved.

28 December 2016

Advice was sought from the National Clinical Assessment Service on 28 December 2016 and it was indicated that a formal process under the Maintaining High Professional Standards Framework was warranted.

30 December 2016

Mr O'Brien was requested to attend a meeting on 30 December 2016 with Dr Richard Wright, Medical Director and Ms Lynne Hainey, HR Manager during which he was advised of a decision by the Trust to place him on a 4 week immediate exclusion in line with the Maintaining High Professional Standards (MHPS) Framework to allow for further preliminary enquiries to be undertaken. Mr O'Brien was accompanied by his wife, Mrs Personal Information redacted by the USI. **(Appendix 2)**

A letter was issued to Mr O'Brien in follow up to the meeting detailing the decision of immediate exclusion and a request for the return of all case notes and dictation from his home. The letter also advised Mr O'Brien that Dr Ahmed Khan had been appointed as Case Manager for the case and Mr Colin Weir was identified as the Case Investigator. **(Appendix 3)**

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A note of the 30 December 2016 meeting was shared with Mr O'Brien. **(Appendix 4)**

03 January 2017

Mr O'Brien met with Mrs Martina Corrigan, Head of Service for Urology to return all case notes which he had at home and all undictated outcomes from clinics in line with the request made to him by Dr Wright on 30 December 2017.

20 January 2017

During the period of the 4 week immediate exclusion period notified to Mr O'Brien on 30 December 2016, Mr Colin Weir wrote to Mr O'Brien to request a meeting with him on 24 January 2017 to discuss the concerns identified and to provide an opportunity for Mr O'Brien to state his case and propose alternatives to formal exclusion. **(Appendix 5)**

23 January 2017

On 23 January 2017, Mr Weir wrote to Mr O'Brien seeking information from him in respect of 13 sets of case-notes that were traced out on PAS to Mr O'Brien but could not be located in his office and which had not been returned to the Trust with the other case-notes on 3 January 2017.

24 January 2017

The meeting between Mr Weir and Mr O'Brien took place on 24 January 2017 with Mrs Siobhan Hynds, Head of Employee Relations present. Mr O'Brien was accompanied to the meeting by his Personal Information redacted by the USI.

A note of the meeting was shared with Mr O'Brien. **(Appendix 6)**

26 January 2017

In line with the MHPS Framework, prior to the end of the 4 week immediate exclusion period, a case conference meeting was held within the Trust to review Mr O'Brien's immediate exclusion and to determine if, from the initial preliminary enquiries, Mr O'Brien had a case to answer in respect of the concerns identified.

A preliminary report was provided for the purposes of this meeting. **(Appendix 7)**

At the case conference meeting, it was determined by the Case Manager, Dr A Khan that Mr O'Brien had a case to answer in respect of the 4 concerns previously notified to him and that a formal investigation would be undertaken into the concerns.

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The matter of his immediate exclusion was also considered and a decision taken to lift the immediate exclusion with effect from 27 January 2017 as exclusion was not deemed to be required. Instead, Mr O'Brien's return to work would be managed in line with a clear management plan for supervision and monitoring of key aspects of his work.

These decisions were communicated to Mr O'Brien verbally by telephone following the case conference meeting on 26 January 2017.

6 February 2017

A letter was sent to Mr O'Brien on 6 February 2017 confirming the decisions from the case conference meeting on 26 January 2017 and notifying him of a meeting on 9 February 2017 to discuss the detail of the management plan and monitoring arrangements to be put in place on his return to work. **(Appendix 8)**

9 February 2017

Mr O'Brien attended a meeting with the Case Manager, Dr Ahmed Khan on 9 February to discuss the management arrangements that were to be put in place on his return to work following the immediate exclusion period. Mrs Siobhan Hynds and Mr Personal Information Personal information redacted by USI were in attendance at the meeting. The action plan was accepted and agreed with Mr O'Brien at the meeting. **(Appendix 9)**

20 February 2017

Between 27 January 2017 when the immediate exclusion was lifted and 17 February 2017, Mr O'Brien was unable to return to work due to ill health. He returned to work on 20 February 2017 in line with action plan agreed at the meeting on 9 February 2017.

January and February 2017

During January and February 2017, Mr O'Brien made a number of representations to Dr Richard Wright, Medical Director and Mr John Wilkinson, Non-Executive Director in respect of process and timescale. In considering the representations made, it was decided that Mr Colin Weir should step down as Case Investigator prior to the commencement of the formal investigation. Dr Neta Chada, Associate Medical Director and Consultant Psychiatrist was appointed as Case Investigator.

16 March 2017

The terms of reference for the formal investigation were shared with Mr O'Brien along with an initial witness list. **(Appendix 10)**

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April, May and June 2017

During April, May and June 2017 the Case investigator met with all witnesses relevant to the investigation. Witness statements were prepared and issued for agreement.

Name	Job Title	Date
Mrs Martina Corrigan	Head of Service	15 March 2017
Mr Michael Young	Consultant Urologist	23 March 2017
Mrs Claire Graham	Head of Information Governance	03 April 2017
Mr Ronan Carroll	Assistant Director	06 April 2017
Mr Eamon Mackle	Consultant Surgeon	24 April 2017
Mr Anthony Glackin	Consultant Urologist	3 May 2017
Ms Anita Carroll	Assistant Director	19 May 2017
Mr Colin Weir	Clinical Director	24 May 2017
Mr Mark Haynes	Consultant Urologist	24 May 2017
Ms Noeleen Elliott	Personal Secretary	24 May 2017
Mrs Helen Forde	Head of Health Records	05 June 2017
Mrs Heather Trouton	Assistant Director	05 June 2017
Mrs Katherine Robinson	Referral & Booking Centre Manager	05 June 2017

(Appendix 11 to 23)

14 June 2017

Dr Chada, Case Investigator wrote to Mr O'Brien requesting to meet with him on 28 June 2017 for the purpose of taking a full response in respect of the concerns identified. **(Appendix 24)**

19 June 2017

Mr O'Brien requested to reschedule the meeting to secure his preferred accompaniment to the meeting. This was facilitated. A meeting on 29 June, 30 June and 1st July was offered. Mr O'Brien requested to defer the meeting until later in July until after a period of planned annual leave, and a meeting was confirmed for 31 July 2017.

05 July 2017

Mr O'Brien advised the date of 31 July was not suitable and a date of 3 August 2017 was agreed.

03 August 2017

A first investigation meeting was held with Mr O'Brien in order to seek his response to the issues of concern. **(Appendix 25)**

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At the meeting on 3 August 2017 it was agreed that a response would not be taken in respect of term of reference number 4 in respect of private patients until patient information requested by Mr O'Brien had been furnished to him. It was agreed that a further meeting date would be arranged for this purpose once all information had been provided. Mr O'Brien's responses to the remaining terms of reference were gathered.

16 October 2017
A meeting date for the second investigation meeting was agreed for 06 November 2017.

06 November 2017
A second investigation meeting was held with Mr O'Brien in order to seek his response to the issues of concern in respect of term of reference 4. **(Appendix 26)**

At the meeting of 6 November 2017, Mr O'Brien advised Dr Chada that he wished to make comment on both his first statement and also the witness statements provided to him. He further advised that his priority for November and December was completion of his appraisal and that he would not be able to provide his comments during this period. It was agreed his timescales would be facilitated.

15 February 2018
By 15 February 2018, Mr O'Brien had not provided the comments he had previously advised he wished to make and therefore this was queried with Mr O'Brien and an update sought.

22 February 2018
No response was received and a further email reminder was sent to Mr O'Brien on 22 February 2018. On the same day, Mr O'Brien responded to advise that he had not had time to attend to the process since the meeting in November 2017. He requested a copy of the statement from the November meeting and indicated he would provide commentary on all documents by 31 March 2018.

In view of the timeframe to date, Mr O'Brien was asked to provide comments by 9 March 2018 rather than 31 March 2018.

16 March 2018
Comments on the documents were not received on 9 March 2018 and a further reminder was sent to Mr O'Brien requesting his comments no later than 26 March 2018. It was advised that the investigation report would be concluded thereafter if comments were not provided by 26 March 2018.

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26 March 2018
No comments were received from Mr O'Brien.

29 March 2018
A final opportunity was provided to Mr O'Brien to provide comments by 12 noon on 30 March 2018. It was advised that the investigation report would be thereafter drafted.

30 March 2018
No comments were received from Mr O'Brien.

2 April 2018
Comments on the statements from the meetings of 3 August and 6 November were received from Mr O'Brien. Mr O'Brien also queried requested amendments to notes of meeting on 30 December 2016 and 24 January 2017.

In the interests of concluding the investigation report without further delay, all comments from Mr O'Brien have been considered and are appended with the relevant documents.

5. Terms of Reference for the Investigation (ToR)

The terms of reference as set for the Case Investigator were as follows:

Term Of Reference 1

(a) To determine if there have been any patient referrals to Mr A O'Brien which were un-triaged in 2015 or 2016 as was required in line with established practice / process.

(b) To determine if any un-triaged patient referrals in 2015 or 2016 had the potential for patients to have been harmed or resulted in unnecessary delay in treatment as a result.

(c) To determine if any un-triaged referrals or triaging delays are outside acceptable practice in a similar clinical setting by similar consultants irrespective of harm or delays in treatment.

(d) To determine if any un-triaged patient referrals or delayed tri-ages in 2015 or 2016 resulted in patients being harmed as a result.

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Term Of Reference 2

(a) To determine if all patient notes for Mr O'Brien's patients are tracked and stored within the Trust.

(b) To determine if any patient notes have been stored at home by Mr O'Brien for an unacceptable period of time and whether this has affected the clinical management plans for these patients either within Urology or within other clinical specialties.

(c) To determine if any patient notes tracked to Mr O'Brien are missing.

Term Of Reference 3

(a) To determine if there are any undictated patient outcomes from patient contacts at outpatient clinics by Mr O'Brien in 2015 or 2016.

(b) To determine if there has been unreasonable delay or a delay outside of acceptable practice by Mr O'Brien in dictating outpatient clinics.

(c) To determine if there have been delays in clinical management plans for these patients as a result.

Term Of Reference 4

To determine if Mr O'Brien has seen private patients which were then scheduled with greater priority or sooner outside their own clinical priority in 2015 or 2016.

Term Of Reference 5

To determine to what extent any of the above matters were known to line managers within the Trust prior to December 2016 and if so, to determine what actions were taken to manage the concerns.

6. Data Gathered

ToR 1: Un-triaged Referrals

Referrals to the Urology service, in the main, come from GPs via electronic referral to the Trust's Booking and Referral Centre (R&B Centre). A small number of referrals may be

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received directly by Consultants from another Consultant, via the Emergency Department or via letter. All such referrals are expected to be logged through the R&B Centre.

The referrals are forwarded to the Consultant Urologist of the week who is responsible for triaging all referrals received during this period of time. From speaking with a range of witnesses, including a number of Consultant Urologists, this appears to be a well-known and accepted process. Red-flag referrals are expected to be reviewed and triaged within 24 hours and returned to the R&B Centre. All other referrals are generally completed within 2 to 3 days of the end of the consultant of the week period and returned to the R&B Centre.

The triage timescales of triage within 72 hours are in keeping with the Regional IEAP Standards for triage of referrals to secondary care. **(Appendix 27)**

Based on the triage decision by the Consultant Urologist, the patient will be placed on the urology waiting list according to priority i.e. red-flag, urgent or routine and in chronological order.

During the course of the investigation, it became clear that a number of people within the Trust were aware of problems in respect of Mr O'Brien's adherence to the triage process. The R&B Centre were not receiving referrals back within the agreed targets from Mr O'Brien when he was Consultant of the week. In order to manage this, a decision was taken during 2015 to introduce a default process whereby all patients were placed on the waiting list according to the GP categorisation of urgency if the referral was not received back from the Consultant Urologist. This default process was adopted and agreed by the Director of Acute Services at the time, Ms D Burns and a number of other senior Trust staff according to some witnessed interviewed. The rationale for this decision was to put in place a safety net to ensure patients were added to the waiting list. The reasons under-pinning this decision will be dealt with in section 7 of the report. Mr O'Brien's response will be dealt with in section 6 of the report.

As a consequence of the concern identified in respect of patient Patient 10 and the subsequent SAI investigation referred to in section 2, a look back exercise was undertaken to determine if there were any other un-triaged referrals that same week. It was discovered that there were others un-triaged and this in turn led to a review of all referrals. A large number of un-triaged referrals were subsequently located in an office drawer in Mr O'Brien's office by Mrs Martina Corrigan. **(Appendix 28)**

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In total, it was found that there were 783 un-triaged referrals dating back to June 2015. The review of these referrals was undertaken by the remaining Trust Consultant Urologists, to determine the appropriate urological categorisation.

Each Consultant reviewed a portion of the 783 un-triaged referrals to determine if any of the referrals had GP categorisation which would have required upgrading i.e. referrals which had come into the Trust as routine or urgent and which would or should have been upgraded based on key indicators within the referral document.

Of the 783 un-triaged referrals it was determined that 24 referrals (including patient Patient 10) warranted upgrading to red-flag status based on the information available on the initial referral received by the Trust. A full assessment of each patient was undertaken and it was found that a further 4 patients (5 in total) had a confirmed cancer diagnosis.

The 24 patient referrals are contained within **(Appendix 29).**

UROLOGY RED FLAG UPGRADES AND OUTCOMES

Hospital Number	Patient Name	Red Flag STATUS	Comments
Personal Information redacted by the USI	Patient 10	**CONFIRMED**	**Renal**
	Patient 11	**CONFIRMED**	**Prostrate**
	Patient 13	**CONFIRMED**	**Bladder**
	Patient 12	**CONFIRMED**	**Prostrate**
	Patient 14	**CONFIRMED**	**Prostrate**
	Personal Information redacted by the USI	Closed	
		Closed	
		Closed	
		Closed	
		Closed	
		Closed	
		Closed	
		Closed	
		Closed	
		Closed	
		Closed	
		Closed	
		Closed	
		Closed	

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Personal Information redacted by the USI			Personal Information redacted by the USI		Closed	
					Closed	
					Closed	
					Closed	
					Closed	
					Closed	
					Closed	

Patient 10 – is a Personal Information redacted by the USI female patient diagnosed with renal cancer. There was a 64 week delay from when the referral was received to the patient being seen. This patient also was diagnosed with breast cancer.

Patient 11 – is a Personal Information redacted by the USI male patient diagnosed with prostate cancer. There was a 207 day delay from when the referral was received to the patient being seen.

Patient 13 – is a Personal Information redacted by the USI male patient diagnosed with aggressive bladder cancer. There was a 179 day delay from when the referral was received to the patient being seen. This patient should have been on the 62 day pathway and with treatment started within that timeframe.

Patient 12 – is a Personal Information redacted by the USI male patient diagnosed with prostate cancer. There was a 151 day delay from when the referral was received to the patient being seen.

Patient 14 – is a Personal Information redacted by the USI male patient diagnosed with prostate cancer. There was a 238 day delay from when the referral was received to the patient being seen.

UROLOGY RED FLAG OUTCOMES AND DELAY

Patient 10	29-Oct-14		06-Jan-16	64 weeks
Personal Information redacted by the USI - Patient 14	06-Jun-16	15-20 June 2016	30-Jan-17	238 days
Personal Information redacted by the USI - Patient 11	18-Jul-16	28 July- 2 Aug 2016	10-Feb-17	207 days
Personal Information redacted by the USI - Patient 13	28-Jul-16	8 – 15 Aug 2016	23-Jan-17	179 days
Personal Information redacted by the USI - Patient 12	08-Sep-16	18 – 22 Sept 2016	06-Feb-17	151 days

SAI investigations are on-going in respect of the additional 4 patients with confirmed cancer diagnoses.

All referral documentation was provided to Mr O'Brien for his comment as part of the investigation. His response to this matter is contained within section 6.

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

ToR 2: Patient Hospital Notes

On 3 January 2017, Mr O'Brien returned 307 sets of patient case-notes which had been at his home. They dated back to November 2014. Most of the notes related to patients seen by Mr O'Brien at the South West Acute Hospital (SWAH) in Enniskillen. **(Appendix 30)**

There is no Trust transport between Craigavon Area Hospital and SWAH and therefore an arrangement was implemented where Mrs Martina Corrigan, Head of Service, brought the notes for the SWAH clinics to the hospital for Mr O'Brien and Mr Young's clinics and the consultants were expected to bring them back to Craigavon after the clinics.

On review of the notes, there are 13 sets of notes which were tracked out to Mr O'Brien which have not been able to be located. Mr O'Brien provided a full response to the matter in respect of the 13 sets of notes. **(Appendix 31)**

As part of the review process Mrs Martina Corrigan, Head of Service undertook a search for the notes and was satisfied with Mr O'Brien's response in that she was unable to conclusively determine why the notes were missing. Many of the missing notes date back many years and a significant number were not Mr O'Brien's patient.

Hospital Number	Name	DOB
Personal Information redacted by the USI		

ToR 3: Un-dictated patient outcome from clinics

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Most of the patient notes stored in Mr O'Brien's home were notes which had been taken to his SWAH clinics. As no transport is available between Craigavon Area Hospital and SWAH in Enniskillen, both Mr O'Brien and Mr Young who undertake clinics at SWAH undertook the practice of taking the notes from each clinic with them at the end of the clinic to be returned to Craigavon Area Hospital.

Mr O'Brien did not dictate the outcomes / letters from the SWAH clinics at the end of the clinics; instead he took the charts home to dictate them at home at another time. Mr Young dictated the outcomes at the end of each clinic and returned the notes directly to Craigavon Area Hospital the next day.

Alongside the clinic dictation, it is also the agreed practice that each Consultant should complete a clinic outcome sheet which should be returned to their secretary for immediate action of patients on to Trust waiting lists.

In January, when a large number of the patient notes from Mr O'Brien's home were returned, it was found that Mr O'Brien had a significant volume of clinic outcomes and dictation outstanding. In total it was found that dictation had not been completed for patients who had attended 66 clinics dating back to November 2014, affecting 668 patients.

A full review of the charts for each affected patient was undertaken by the remaining Trust Consultant Urologists. This review took approximately 6 months to ensure all patients were reviewed and to provide the Trust with an assurance that all necessary and appropriate actions were in place. This review was done by the Consultant Urologists during additional PA time agreed specifically for this work to be undertaken. **(Appendix 32)**

Examples of findings from the review of the patients are:

1.	Personal Information redacted by the USI	Patient seen 6 times and no letters on file for any of the attendances
2.		Letter done when patient was a private patient, no other letters on file
3.		Patient seen 14 times but no letters on file – not on a review list
4.		Patient seen on 19 September 2016, letter dictated on 28 February 2017
5.		According to PAS, patient attended on 19 June 2016 but note in the chart says DNA (discharge to GP) this has not been done.

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

6.	Personal Information redacted by the USI	Patient seen on 11 April 2016, letter dictated on 22 February 2017
7.		No Urology entries in the Chart or on PAS
8.		No Urology entries in the Chart or on PAS

Mr O'Brien provided a response to this concern and this is contained in section 6 of the report.

Private Patients

During the preliminary review of the concerns, a further concern was identified by Mr Mark Haynes, Consultant Urologist. Mr Haynes was concerned that Mr O'Brien may have added some of his private TURP patients to the Trust lists for procedures / surgery ahead of NHS patients with the same or greater clinical priority.

It was initially advised to Mr O'Brien that a review of his TURP patients had been undertaken however during the course of the investigation it was established that a full review of Mr O'Brien's private patients had been undertaken.

Of the patients reviewed, there was concern about 11 of Mr O'Brien's private patients who appeared to have had their procedure / surgery done on the NHS within much shorter timeframes than would be expected given their clinical priority. **(Appendix 33)**

Mr Michael Young, Lead Consultant Urologist was asked to review the 11 patients to determine if, in his opinion, there was a clinical need for the patients to have been treated in the timescales identified. **(Appendix 34)**

Mr Young's assessment is outlined in the table below:

Patients seen privately by Mr O'Brien and added to waiting list and came in for their procedure within a short timeframe.

Casenote	Date on Waiting List	Date Operation	Days from Added to WL to Operation Date	Is there a clinical reason why the patient should have been treated within such a short time? M Young
Personal Information redacted by the USI	22/02/2016	22/03/2016	29	No

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Personal Information redacted by the USI	25/04/2016	04/05/2016	9	Reasonable – Red Flag
	11/04/2016	15/04/2016	4	No
	01/04/2016	27/04/2016	26	No
	08/07/2016	09/08/2016	32	No
	29/07/2016	21/09/2016	54	No
	04/12/2015	24/02/2016	82	Reasonable
	11/07/2016	17/08/2016	37	No
	08/10/16	02/11/16	25	No
	31/10/16	04/11/16	5	No
	16/02/2016	24/02/2016	8	No

Mr O'Brien was provided with the list of patients and the clinical information reviewed by Mr Young in order to respond to the issue of concern. **(Appendix 35)**

Mr O'Brien's response to the concern is documented in section 6 of the report.

7. Mr O'Brien's responses to the concerns

Meeting with Mr O'Brien – 30 December 2016

This was the initial meeting with Mr O'Brien. The meeting was an opportunity to advise Mr O'Brien of the concerns and to advise him of the management action to be implemented initially to allow further scoping of the extent of the concerns.

A copy of the note of the meeting was shared with Mr O'Brien**.** Mr O'Brien wrote to Dr Wright on 21 February 2017 with a number of suggested changes to the notes. Dr Wright amended the notes to the extent he accepted the representations made by Mr O'Brien and shared an amended copy of the notes **(Appendix 6).**

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

At the time of the meeting in December 2016 it had been identified that there were significant and serious concerns in respect of Mr O'Brien's administrative practices and there was concern that patients may have come to harm as a result of those practices.

The scale of the concerns at that time were

- 318 un-triaged referrals
- An SAI investigation looking at whether or not a patient may have had a poor clinical outcome as a result of delay in triage
- A backlog of 60+ clinics dating back over 18 months with approximately 600 patients who may not have had clinic outcome dictated and therefore it was unclear as to the management plan for those patients
- An unknown number of patient notes stored at Mr O'Brien's home.

During the course of the meeting, Mr O'Brien advised that the concerns needed to be considered in the context of huge pressure on him to operate and that clinical outcomes were compromised because of a lack of capacity within the Urology service. He advised that there was an inequity within the Department specifically in respect of the length of his waiting list in comparison to some other colleagues and this created the demand on him to operate.

Mr O'Brien requested that the totality of his work should be considered, and this meant he did not have time to triage referrals other than red flag referrals. Mr O'Brien advised that the triage of non-red flag referrals was a historical hangover from a time when it was felt there was not enough work to do when on-call and this was done to justify on-call time.

Mr O'Brien noted that he had raised 2 years previously that he did not have capacity to deal with non-red flag triage. He outlined that in his view you need to speak to patients rather than ticking a box and, that to do so, takes time.

Mr O'Brien advised that he had been asking for the approximately 2 to 3 years not to see any new patients because of the immorality of not being able to do what he had pledged to do within an appropriate time frame. He stated that as a consequence of operating, other duties get neglected. He said there were not enough hours to be faultless.

During the course of the meeting Mr O'Brien was asked to return all notes he had at home as a matter of urgency. Mr O'Brien stated that he could not return them without processing them, acknowledging they needed actions taken. However he was advised that he should return them without delay. Mr O'Brien confirmed he had all notes tracked out to him and he did not believe there were any missing.

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Meeting with Mr O'Brien – 24 January 2017

A meeting with Mr O'Brien was held on 24 January 2017 during the initial 4 week immediate exclusion period to discuss with him the next steps in the case, to enable Mr O'Brien to state his case and to provide an opportunity to hear from Mr O'Brien his proposals for alternatives to formal exclusion. **(Appendix 5 – Letter of 20 January 2017)**

Mr O'Brien provided his comments to the Case Investigator in respect of the note of the meeting of 24 January. For completeness, both the note of the meeting and Mr O'Brien's comments are contained in **Appendix 6**.

At the meeting on 24 January 2017, Mr O'Brien was advised the 4 week immediate exclusion period had provided time for further scoping of the extent of the concerns.

Mr O'Brien was provided with an update on the scale of the concerns which were as follows:

- From June 2015 there are 783 un-triaged referrals which required to be tracked and reviewed to ascertain the status of the patients involved.
- There were 307 sets of patient notes returned from Mr O'Brien's home. 88 sets of notes retrieved from his office and 13 sets of notes which were tracked to Mr O'Brien were missing, dating back to 2003.
- 668 patients seen at Mr O'Brien's out-patient clinics had no outcome formally dictated – 272 from the SWAH clinic and 289 from other clinics. At this time 107 patients were still being investigated.
- A further concern had also been raised in relation to Mr O'Brien's private patients. A review had identified 9 TURP patients who had been seen privately as outpatients, then had their procedure on the NHS but whose waiting times were significantly less than those for other patients.

During the course of the meeting on 24 January 2017, Mr O'Brien referred to the issue of the triage referrals and advised that since the issue was raised with him in March 2016, he had been undertaking his own validation of referrals to him. He advised that prior to this the workload volume made it impossible to do so.

Mr O'Brien provided an explanation in respect of each of the 13 sets of missing notes. He stated that he had never lost a set of notes in his career.

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Mr O'Brien stated that he was surprised by the number of undictated outcomes from clinics in SWAH. Mr O'Brien stated he thought this number was about 110.

In respect of the concern regarding private patients, Mr O'Brien stated that he was concerned about the inference being made.

Mr O'Brien advised he would make a full response to the concerns in due course but he wished it noted that significant workload pressures and additional operating sessions completed by him over the requirement within his job plan had impacted. Mr O'Brien noted that he had worked a high number of hours each week over and above his job plan, had undertaken Chair of the MDM meetings, had spent a significant number of hours reviewing cases in preparation for these meetings, sometimes into the early hours of the morning and had used his SPA time to undertake operations or reviews of patients in an attempt to keep on top of his workload.

Furthermore, Mr O'Brien advised of a large number of patient's awaiting admission for surgery and more particularly, those patients awaiting readmission for surgery. It is his contention that this cohort of patients is the cohort at greatest risk of suffering poor clinical outcomes as a consequence of delay in admission or readmission.

Mr O'Brien advised that he had undertaken many additional elective operating sessions in recent years in an attempt to minimise the number of poorer clinical outcomes and the severity of those outcomes. He believed this was the greatest issue of concern and felt this did not appear to be an issue or concern for the investigation.

Meeting with Mr O'Brien – 09 February 2017

Dr Ahmed Khan, Case Manager met with Mr O'Brien on 9 February 2017 to discuss the matter of his return to work following the decision to proceed with a formal investigation under the MHPS Framework and to lift the immediate exclusion of Mr O'Brien. The meeting was held to discuss the management action plan being implemented on Mr O'Brien's return to work, to provide assurances regarding patient safety and safe administrative practices during the course of the investigation.

The management action plan was discussed and accepted by Mr O'Brien. **(Appendix 9)**

Meeting with Mr O'Brien – 03 August 2017

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Dr Neta Chada, Case Investigator met with Mr O'Brien on 3 August to seek a full response to the concerns identified during the course of the investigation process. Mr O'Brien has provided recent commentary in respect of the statement drafted for his agreement. Given the timing of receipt of this commentary and to avoid further delay with conclusion of the investigation, the drafted statement along with Mr O'Brien's comments have been included for completeness. **(Appendix 25)**

The statement is comprehensive and documents Mr O'Brien's responses to each of the terms of reference (except for term of reference 4). For the purpose of this section of the report, I have highlighted the salient points of Mr O'Brien's response.

Un-triaged referrals

Mr O'Brien confirmed that of the non-personalised referrals allocated to him i.e. those allocated to him as Consultant Urologist of the week, he triaged all red-flag referrals during 2015 and 2016 but did not triage the remaining referrals during 2015 and 2016 (i.e. he did not triage routine and urgent referrals). Mr O'Brien advised that in 2014 when the Consultant of the week model was introduced, he agreed with doing triage but soon found it impossible to do. He advised that he had highlighted that it was not possible to do triage when consultant of the week, and furthermore that it was unclear as to what the process was supposed to be.

Mr O'Brien advised that he was in agreement with the Consultant of the week model when it was introduced in 2014, he advised that there had been no Trust directive regarding triage but that it was the consultant clinical staff who agreed the triage process. Mr O'Brien confirmed he was present when the matter of triage was agreed with his colleagues.

Mr O'Brien confirmed that he had undertaken all red flag triage but the rest was not done because he did not have time to do so. Mr O'Brien outlined that there is a vast difference between triage and proper or advanced triage which he had raised at various meetings. He outlined his view that if consultants were not doing proper triage, why request Consultants to do it at all? Mr O'Brien stated it was his view that the triage being undertaken i.e. a look at the referral information and categorisation to determine upgrade based on key phrases or indicators, could be done by Advanced Nurse Practitioners.

Mr O'Brien confirmed he was aware that triage was the agreed system in place and outlined that he had raised it at various meetings because he found it impossible to do. He accepted that he did not specifically advise he was not undertaking triage and this is something he regrets. He outlined that as NICAN Chair he had endeavoured to get his colleagues to do advance red flag triage but this didn't happen.

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Mr O'Brien advised that he felt that how triage was being undertaken by some of his colleagues was unsafe. He further advised that he believed inpatient care has been compromised by Consultants of the week conducting triage while being the Consultant of the week and quality of patient care had suffered as a consequence.

On commenting upon the 5 cases which have confirmed cancer diagnoses, Mr O'Brien was surprised that there were such a small number upgraded. He advised that it was heartening in a number of ways to find 2 of the cases are at an early stage. He noted the irony that one of the patients may have benefitted from the delay. Mr O'Brien commented that patient Patient 13 was really the only one patient of concern.

Mr O'Brien advised that he has read the referral for patient Patient 10 and he would have kept the triage category as routine as the only way the referral could have been upgraded would have been to review the digitalised images of the patient.

Patient notes

Mr O'Brien clarified for the purposes of accuracy that 288 charts were returned from his home in January 2018, the remainder were located on shelves in his office. He confirmed that the oldest chart held at his home was from April 2015.

Mr O'Brien stated that storing the notes at home didn't affect other specialities as he would always have returned the notes when requested.

Mr O'Brien advised that he did not believe there was any issue of concern for the patients as he had processed 62% of all patients seen at the clinics and these were the most urgent patients. The charts returned unprocessed amounted to 211. Mr O'Brien advised that there was no detriment to any patient as the patient would go back onto the waiting list at the point they should have been seen. Mr O'Brien advised that it needs to be considered in context – 'what is urgent today in terms of a referral may not been seen until next August in any event'.

Un-dictated clinics

Mr O'Brien accepted that there were 41 un-dictated clinics – these outcomes were returned to Martina Corrigan in January 2017.

Mr O'Brien explained that his practice was to record the outcome for a patient at the end of their attendances. Mr O'Brien advised that he would always have given a full update to the

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patient at the clinic. He advised that he feels dictation compromises the length and therefore quality of appointment time and so he does this afterwards.

Mr O'Brien advised that the most important thing for him is theatre time, admin pales into virtual insignificance in terms of patients who are getting procedures done. Mr O'Brien further stated that he has a frustration with the preoccupation about dictating at the end of clinics by some of his colleagues.

Mr O'Brien advised that dictation was always done for urgent patient and an outcome may not have been done for every clinic attendance but there would be one outcome at the end of treatment.

Private patients

Mr O'Brien advised that he found this allegation deplorable and stated that there had been no comparable analysis done on figures which show private patients have not been given priority. Mr O'Brien wished to see the full list of patients referred to before responding to this concern.

Management knowledge of the concerns

Mr O'Brien advised that he had told a number of people within the Trust that he found triage impossible to do, which he felt was synonymous with saying that he wasn't doing it. He advised that he wished he had left the referrals back to copper fasten that he was not doing triage. He noted that he didn't do this as he was overwhelmed and asking for help was difficult.

Mr O'Brien stated that he had spoken with Michael Young about difficulties he was having with dictation and advised that Martina Corrigan knew about the charts at his home when he went off sick. Mr O'Brien stated, 'after 25 years having raised and raised issues, verbally in meetings, after a time I stopped doing it when it didn't achieve anything.'

Mr O'Brien noted the 23 March 2016 letter and advised that when this was given to him and he asked what he was to do about it – he received no reply. He stated that no particular plan was put in place to address the issue.

Mr O'Brien advised that he has always done a vast amount of additionality to his job plan which was done in place of his SPA time, admin time and his own time.

Meeting with Mr O'Brien – 06 November 2017

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Dr Neta Chada, Case Investigator met with Mr O'Brien on 6 November to seek a response to term of reference 4 and to seek any final comments in respect of any issue related to the investigation. Mr O'Brien has provided recent commentary in respect of the statement drafted for his agreement. Given the timing of receipt of this commentary and to avoid further delay with conclusion of the investigation, the drafted statement along with Mr O'Brien's comments have been included for completeness. **(Appendix 26)**

Mr O'Brien raised a number of concerns in respect of this matter, these included:

- At the outset of the investigation and at a number of subsequent meetings it had been advised to Mr O'Brien that the issue of concern related to his TURP private patients. Upon enquiry by Mr O'Brien and further investigation by the Case Investigator, it was established that a review had taken place of all Mr O'Brien's private patients. The 11 private patients highlighted as concerning were not solely TURP patients.

- The list of 11 patients provided to Mr O'Brien for comment highlighted the date upon which each patient had been entered onto the waiting list and also the date the procedure was performed. Mr O'Brien disputed the dates on which the case had been placed on to the waiting list in the majority of cases. He advised that, for example, in one case there was a difference between the date a patient was added to the waiting list versus the date of consultation when a decision to proceed to surgery was made.

- Concern that another clinician could have arrived at a judgement regarding the clinical justification for admission, after a period of time, on the basis of a letter alone.

- Concern that a comparative analysis of the periods of time awaited by those patients admitted for procedure having had a previous outpatient consultation and those who had not, had not been undertaken.

In response to Mr Young's assessment of clinical need and the timescales identified Mr O'Brien provided a comprehensive response for each patient which is included in **Appendix 35**.

The table below highlights Mr O'Brien's analysis of the dates and waiting times in RED.

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Patients seen privately by Mr O'Brien and added to waiting list and came in for procedure within a short timeframe.

Casenote	Date on Waiting List	Date Operation	Days from Added to WL to Operation Date	Is there a clinical reason why the patient should have been treated within such a short time? M Young
Personal Information redacted by the USI	22/02/2016 (20/02/2016)	22/03/2016	29 (31)	No
	25/04/2016	04/05/2016	9 (46)	Reasonable – Red Flag
	11/04/2016	15/04/2016	4 (349)	No
	01/04/2016	27/04/2016	26 (25)	No
	08/07/2016	09/08/2016	32	No
	29/07/2016 (20/07/2015)	21/09/2016	54 (428)	No
	04/12/2015 (21/11/2016)	24/02/2016	82 (94)	Reasonable
	11/07/2016 (23/07/2016)	17/08/2016	37 (25)	No
	08/10/16	02/11/16	25	No
	31/10/16 (01/10/2016)	04/11/16	5 (34)	No
	16/02/2016 (30/01/2016)	24/02/2016	8 (25)	No

Mr O'Brien's comments in respect of witness statements

Mr O'Brien provided comments in respect of the witness statements gathered as part of the investigation. His comments are attached in full at **Appendix 23**.

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

The key issue outlined by Mr O'Brien in respect of many of the witness statements was surprise at the fact many witnesses reported having knowledge of concerns regarding his administrative practices but not addressing these with him directly and managers having been aware of the issues without addressing it directly with him.

General comments

Mr O'Brien raised concern at the outset about the Trust's decision to immediately exclude him from work, and what process was being followed. He also queried on a number of occasions why the Trust had moved to manage the concerns formally without giving him recourse to an informal process. Furthermore Mr O'Brien raised concern about the timescales for the preliminary screening of the concerns and also about the timescale of the investigation process. Responses were provided to Mr O'Brien in respect of these matters as they were raised.

8. Investigation Findings

As Case Investigator, I have been requested to investigate 5 specific terms of reference. I have reviewed and gathered a large volume of information as part of the investigation; however my findings from the investigation will focus strictly on the terms of reference provided to me.

The following are the findings from the investigation into concerns:

Term Of Reference 1

(a) To determine if there have been any patient referrals to Mr A O'Brien which were un-triaged in 2015 or 2016 as was required in line with established practice / process.

(b) To determine if any un-triaged patient referrals in 2015 or 2016 had the potential for patients to have been harmed or resulted in unnecessary delay in treatment as a result.

(c) To determine if any un-triaged referrals or triaging delays are outside acceptable practice in a similar clinical setting by similar consultants irrespective of harm or delays in treatment.

(d) To determine if any un-triaged patient referrals or delayed tri-ages in 2015 or 2016 resulted in patients being harmed as a result.

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

It is accepted by all, including Mr O'Brien, that a triage process was agreed sometime in 2014 when the service introduced the Urology Consultant of the Week model. Mr O'Brien describes agreeing and being supportive of the model in 2014 however he advised that very quickly after its introduction, he began to raise issue with the process, indicating to his colleagues that he was finding it impossible to do.

Mr O'Brien advises that he found it difficult to complete triage when he was the Consultant of the Week due to significant other workload pressures including ward rounds and also because of the high volumes of referrals each week.

Mr O'Brien's preference was that advanced triage should be done for red flag referrals only. Advanced triage is different from the agreed triage model being undertaken by the Consultant Urologists. The triage model agreed involves reviewing the referral information submitted to determine if there are key indicators which would highlight a referral categorisation requires to be upgraded. Advanced triage involves assessment of the required tests / investigations which should be undertaken prior to any attendance at a Consultant clinic for initial assessment or review. This allows the necessary information to be available to the Consultant when the patient is in attendance. Mr O'Brien was unable to get agreement with his colleagues to introduce advanced triage for red flag referrals.

Mr O'Brien described a situation where he would regularly raise the issue about triage at meetings and indicate he was finding it impossible to do the triage as Consultant of the weekj. Mr O'Brien's Consultant colleagues agreed that they had been present when he had raised this issue at meetings, though indicated they did not know he was not doing it.

The investigation further highlighted that it was a widely known fact among some staff within the Acute Services Directorate, that Mr O'Brien's triage was often not returned to the Referral and Booking Centre. Mrs Katherine Robinson, Referral and Booking Centre Manager reported that she had been aware over a number of years that Mr O'Brien had not returned triage decisions as was the expected practice. She reported raising the concern at Acute Services meetings and directly with 2 Directors dating back to 2014. Mrs Robinson reported that the problem only existed with Mr O'Brien and all other Urology consultants completed triage. There were periods of time when Mrs Robinson and others chased up the triage from Mr O'Brien however she reported that in 2014 she was advised to book the longest waiting patients onto the lists. She advised in 2015 a default system was set up such that if triage was not returned within 3 days the R&B Centre staff added the patients to the waiting lists according to the GP prioritisation.

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Mrs Heather Trouton, Assistant Director and Mrs Martina Corrigan, Head of Service with responsibility for urology both advised that it was a known problem and frustration that Mr O'Brien did not routinely return all of the triage. They both advised that because of the concern that triage was not being returned, a default process was implemented, agreed at Director level by former Director of Acute Services, Mrs Debbie Burns. The default process was to ensure all patients were added to the urology waiting lists without any being missed and the patients were added to the waiting list according to the GP categorisation on the referral received by the Trust.

Mrs Corrigan provided me with e-mail examples of when she had chased outstanding triage with Mr O'Brien during 2015 and 2016 and Mrs Robinson advised that other Consultants were sometimes delayed with triage, though it was done but the problem with Mr O'Brien was persistent.

I interviewed Mr Michael Young who was the lead Urologist in 2014 / 2015 and he advised that at a point in 2014 he had assisted Mr O'Brien by doing his triage for him when Mr O'Brien had raised the issue about competing work and other professional priorities and indicating he could not get triage completed. Mr Young assisted Mr O'Brien with triage for a period of between 6 and 8 months.

Mr Eamon Mackle was the Associate Medical Director with responsibility for Urology up until mid-2016. Mr Mackle reported that he had experienced some workplace difficulties with Mr O'Brien dating back a number of years. Mr Mackle reported that Mr O'Brien had previously raised a complaint of bullying against Mr Mackle in or around 2012 and as a result Mr Mackle reported being very cautious in dealing with issues with Mr O'Brien.

Mr O'Brien disputes that a bullying complaint was raised against Mr Mackle. Mr Mackle's perception however is relevant as it would seem Mr Mackle took a step back from management of concerns in relation to Mr O'Brien as a consequence of this. (Mr Mackle informed me other managers had also advised him to take a step back, and other managers interviewed also understood Mr Mackle was advised to step back.) This is a theme throughout the witness statements. It is evident that many witnesses were aware Mr O'Brien was not undertaking triage as per the agreed process during 2014 and 2015 but there is little evidence to highlight clearly the actions taken by managers or senior clinicians to address the concerns with him during that period.

On 23 March 2016, Mr Mackle and Mrs Corrigan (on behalf of Mrs Trouton) met with Mr O'Brien to outline a range of concerns to him. The letter of 23 March which was given to Mr

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O'Brien provides a clear account of the concerns at that time. Within the letter of 23 March, it seeks action to be taken by Mr O'Brien to address the concerns.

It is Mr O'Brien's contention that no support or management plan was discussed with him to assist him to address the concerns highlighted. I was unable to find any supporting evidence to suggest that any of Mr O'Brien's managers had met with him to discuss what was expected of him in terms of addressing the concerns. In fact, it would appear that when this letter was issued to Mr O'Brien, the extent of the issues of concern had not been assessed. Most witnesses described an awareness of the concern but described shock at the actual extent of un-triaged referrals discovered in December 2016. The 23 March 16 was a missed opportunity by managers to fully review and understand the extent of the issues. There was no management follow up to the letter of 23 March 16 with Mr O'Brien.

Nonetheless,, the responsibility for triage of the referrals was that of Mr O'Brien's. He is clear that he was aware of the agreed process and that during the course of at least 2015 and 2016, he undertook red flag triage only. All other referrals were set aside and triage was not completed.

I am in no doubt that Mr O'Brien knew a default process was happening, otherwise it would beg the question as to what he believed was happening to those patients.

There is no dispute to the fact that Mr O'Brien complained many times about triage. It is however accepted by Mr O'Brien, that he never said he was not completing triage. His colleagues were aware that he complained about doing triage but they did not have knowledge of the fact that he was not undertaking any routine or urgent referral triage. As a senior experienced Consultant, there was a responsibility on Mr O'Brien to make it clear and known that he was not doing triage and to seek assistance.

Mr O'Brien did however provide a context to why he was unable to triage routine and urgent referrals. Mr O'Brien outlined that the workload within the urology service and his own personal workload was unmanageable with long review lists. Mr O'Brien's review list, along with Mr Young's were longer than more recently appointed Consultants and he had requested on a number of occasions to refrain from seeing any new patients. This is something that did not happen. I accept that workloads within Urology, like many other specialties are heavy, and it can be difficult to manage all aspects of the workload.

I did however refrain from exploring this in any significant depth as the issue of concern relates to the fact that Mr O'Brien failed to properly highlight to the Trust that he was not undertaking this agreed aspect of his role. While there are differing views on what is a

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

manageable workload, all other Urology Consultants, managed triage alongside their other competing priorities. At no point did Mr O'Brien make it clear that he was only undertaking red-flag triage.

Therefore, in response to the specific term of reference:

It is accepted by Mr O'Brien that he did not undertake non-red flag referral triage during 2015 and 2016 and he also accepted that there were 783 un-triaged referrals during this period.

As outlined above, the reason for triage by the Consultant Urologist, is to ensure that, as the specialist, they review the referral information to ensure all referrals are properly categorised prior to being added to the waiting lists. The fact that this was not completed had the potential for all 783 patients to have been added to the incorrect waiting list.

We now know that of the 783 patients, 24 would have been upgraded to red flag status by other consultant urologists (and this has now been actioned.) The fact that they weren't upgraded on receipt of referral means the timescales for assessment and implementation of their treatment plans was delayed.

Of the 24 patients upgraded, we know that 5 of these patients have a confirmed cancer diagnosis. All 5 patients have been significantly delayed commencing an appropriate treatment plan.

Term Of Reference 2

(a) To determine if all patient notes for Mr O'Brien's patients are tracked and stored within the Trust.

(b) To determine if any patient notes have been stored at home by Mr O'Brien for an unacceptable period of time and whether this has affected the clinical management plans for these patients either within Urology or within other clinical specialties.

(c) To determine if any patient notes tracked to Mr O'Brien are missing.

Witnesses indicated it was well known Mr O'Brien did not always return case notes. This was a particular issue in relation to SWAH clinics, as noted above. Managers were not aware of the number of notes, and nor could medical records staff identify that there were a large volume of notes tracked out to one individual.

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

I interviewed the Head of Information Governance for the Trust, Mrs Claire Graham and she referenced GMC guidelines in relation to note keeping and storage of notes. In particular she highlighted the regional guidance on Good Management of Notes/Records, as well as Health Informatics Unit guidelines, duty of confidentiality principles and data/information protection guidelines. Mrs Graham advised that when pulled from medical records, it was expected, in line with best practice, that case notes would be returned immediately after use. She highlighted that a large volume of notes being kept in a private home is a serious data protection/ information governance risk for the Trust.

I also interviewed the Head of Health Records, Mrs Helen Forde and the R&B Centre Manager, Mrs Katherine Robinson. I was able to establish that there is no clear system for tracking notes through PAS. Notes may be tracked out on PAS to a staff member without knowledge of their location. There is no mechanism for medical records staff to be able to determine that a bulk of records is tracked out to one individual for long periods of time.

I was advised that when notes were sought from Mr O'Brien for other clinics these were usually returned promptly. There was really only an issue if someone was admitted as an emergency, as notes were not available because they were not on the hospital site. It was indicated that at times Datix reports were completed by medical records staff in relation to notes not being returned. This would have been escalated to Martina Corrigan who addressed the issue with Mr O'Brien upon which the notes would have been returned. Martina Corrigan indicated the letter to Mr O'Brien in March 2016 did ask for all notes to be returned. She believed at that time 30 case notes were returned. Managers indicated they had no idea of the scale of records in Mr O'Brien's home. No check or review was done to determine the extent of the problem in March 2016 or at any other time prior to this investigation.

Mr O'Brien acknowledged he had returned the bulk of thecase notes to the Trust in January 2017 when the issue of concern was addressed under the MHPS process. He believed this had not had an impact on care from other specialities as he had always returned notes when they were sought for other clinics.

On returning the notes, Mr O'Brien had attempted to process as many as he could. He focussed on those he deemed most urgent. He indicated that those he had not processed still had lengthy delays after they were returned. He reported there was no detriment in any event to patients, as they were placed on the waiting list for procedure/investigation at the point they would have been when seen at clinic.

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13 sets of notes are still missing. Dr O'Brien confirmed he did not have these and this has since been accepted by the Trust and the review team.

Mr O'Brien accepted he had kept notes at home but asserted that this did not impact on patient's clinical management plans/care.

Term Of Reference 3

(a) To determine if there are any undictated patient outcomes from patient contacts at outpatient clinics by Mr O'Brien in 2015 or 2016.

(b) To determine if there has been unreasonable delay or a delay outside of acceptable practice by Mr O'Brien in dictating outpatient clinics.

(c) To determine if there have been delays in clinical management plans for these patients as a result.

Mrs Robinson reported that she became aware in December 2016 from Noeleen Elliott, Mr O'Brien's secretary, that there were clinics which had not been dictated by Mr O'Brien. She reported this to be unusual for a Consultant. Mrs Robinson reported that Ms Elliot as Mr O'Brien's secretary would have known the extent of dictation not completed and that she should have been raising this with managers in the Acute Services Directorate. Ms Elliott, indicated that when she arrived to work with Mr O'Brien, the lack of clinics being returned seemed to be a long-standing way he worked and therefore she felt this issue was known. She therefore did not raise or report the issue.

When I interviewed Mr O'Brien he accepted that he did not dictate an outcome for every attendance by every patient at every clinic. I noted with Mr O'Brien that undictated clinics mean GPs don't know what is happening with their patients and there is nothing on NIECR for other Specialists to look at. Martina Corrigan indicated there had been a complaint from a GP and contact from an MLA as a GP didn't know what was happening with a patient.

Mr O'Brien acknowledged there were 66 undictated clinics and no dictated outcomes for these. There were no outcome sheets for 68 clinics. He noted he may have typed updates on the CAPP system for cancer patients, or they may have been discussed at MDM. Mr O'Brien stated that GPs have access to CAPP and that he personally explains all matters to the patient. Mr O'Brien reported that he didn't feel letters were that important. He went as far to say that he was frustrated by the obsession regarding dictation of outcomes for every attendance.

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Mr O'Brien advised that he had requested not to be put on day surgery the morning after a SWAH clinic so he could get administrative work done. This was facilitated. Dictation was done for urgent patients. Mr O'Brien reported that he tended to dictate letters at the end of the care episode rather than after each attendance and he indicated he was unaware of any obligation to dictate on each contact. Mr O'Brien outlined that he didn't have enough time for administration. He explained he has undertaken additional clinics and theatre work, which he felt were more important and he did not believe this had resulted in delays in treatment.

Mr O'Brien at this time was not using digital dictation and there was no way of reporting on his dictation of clinics.

Mr O'Brien's Consultant colleagues undertook an extensive review exercise to ensure all patient's seen had an outcome dictated and a clear management plan for treatment. This piece of work was undertaken at significant additional cost to the Trust.

I appreciate that there are significant waiting times for routine assessments in Urology and that the affected patients have all been placed on the waiting list at the point they would have been had the dictation been undertaken in a timely manner. However, the absence of these patients on the waiting lists meant the Trust did not have a proper picture of waiting times or length of lists. It is the responsibility of a medical practitioner to ensure all patient notes / dictation are contemporaneous in line with GMC requirements.

Term Of Reference 4

To determine if Mr O'Brien has seen private patients which were then scheduled with greater priority or sooner outside their own clinical priority in 2015 or 2016.

1. **Patient –** Personal Information redacted by the USI

This patient had an NHS/HSC operation completed 29 days (based on the findings of the review)(31 days based on Mr O'Brien's assessment) after a private consultation with Mr O'Brien.

Mr O'Brien advised that the timeframe was justified because of the patient's anxieties about a possible cancer and the fact that his mother was gravely ill at the time.

Mr Young advised there was no clinical justification for the timeframe.

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From the information available, it would appear that this patient was seen in a timeframe which is significantly shorter than a patient referred directly to the urology service as a red-flag referral. Mr O'Brien's justification for the shorter timeframe was because of the patient's anxieties rather than because he believed there was a clinical indication of cancer. In fact, Mr O'Brien commented that he tried to convince the patient his swelling was benign but was unable to convince him.

2. Patient – Personal Information redacted by the USI

This patient had an NHS/HSC operation completed 4 days (based on the findings of the review)(349 days based on Mr O'Brien's assessment) after a private consultation with Mr O'Brien.

The patient was initially referred to Mr O'Brien privately in December 2014. Mr O'Brien met and assessed the patient privately on Personal information redacted by USI when a treatment plan was implemented for urgency and urge incontinence. A letter on file dated 11 April 2016 indicates that Mr O'Brien had recently again spoken to the patient and was made aware that the patient's symptoms persisted, to the extent that it was severely impacting on his quality of life and ability to care Personal information redacted by USI. It was for this reason, Mr O'Brien arranged for the patient to have a procedure on Personal information redacted by USI as an additional patient in SPA time.

From the date of the initial referral – Mr O'Brien's assessment of the timeframe of 349 days is correct. From the date of the most recent telephone assessment – in or around 4 days is correct.

Mr Young advised there was no clinical justification for the timeframe.

This patient appears to have had an NHS/HSC procedure undertaken within days of a second private contact with Mr O'Brien. Whilst the impact on the patient in terms of his quality of life appears to have been severely impacted, there would appear to be little clinical urgency for this patient to have been seen in such a short timeframe. Mr O'Brien justifies the short timescale because the patient was seen as an additional patient within his SPA.

While SPA time should not be substituted for clinical activity time, additional patients added to Mr O'Brien's operating lists should in all instances come from the Trust's waiting list in chronological order.

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3. **Patient –** Personal Information redacted by the USI

This patient had an NHS/HSC operation completed 26 days (based on the findings of the review)(25 days based on Mr O'Brien's assessment) after a private consultation with Mr O'Brien.

The patient was an Personal Information old lady assessed by Mr O'Brien privately on Personal information redacted by USI. A CT scan confirmed the patient had a 1.2 cm kidney stone impacted in her upper left ureter causing intermittent renal outlet obstruction. She had an operation undertaken on 27 April 2016.

Mr Young advised there was no clinical justification for the timeframe.

4. **Patient –** Personal Information redacted by the USI

This patient had an NHS/HSC operation completed 32 days (based on the findings of the review)(investigations after 45 days and operation after a further 32 days based on Mr O'Brien's assessment) after a private consultation with Mr O'Brien.

The patient was a Personal Information old man referred privately to Mr O'Brien for urinary symptoms including urge incontinence and nocturia. He was referred twice by his GP in February and June 2016. Mr O'Brien met with the patient initially on Personal information redacted by USI. Mr O'Brien advised that he expedited the patient's investigations and operation as his symptoms resulted in the patient and his wife sleeping in separate rooms result in martial strain.

Mr Young advised there was no clinical justification for the timeframe.

Mr O'Brien does not advise of a clinical justification for the expedition of this patient's investigations or operation.

5. **Patient –** Personal Information redacted by the USI

This patient had an NHS/HSC operation completed 54 days (based on the findings of the review)(after 428 days based on Mr O'Brien's assessment) after a private consultation with Mr O'Brien.

The patient was seen by Mr O'Brien in July 2015. At this time, a clinical management plan was in place for the patient. According to the 11 September 2016 letter to the patient's GP,

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Mr O'Brien advised the patient that he 'would be better served by having his prostate gland resected'. It is not clear if the patient was added to a Trust waiting list at that time.

Following further correspondence to Mr O'Brien from a Continence Nurse Specialist in or around 5 September 2016, he arranged for the patient to be admitted to the Urology Department on Personal information redacted by USI for resection of his prostate gland.

Mr Young advised there was no clinical justification for the timeframe.

6. **Patient –** Personal Information redacted by the USi

This patient had an NHS/HSC operation completed 37 days (based on the findings of the review)(after 25 days based on Mr O'Brien's assessment) after a private consultation with Mr O'Brien.

The patient was assessed by Mr O'Brien on Personal information redacted by USI when he reported that he found an 'indwelling urethral catheter to be particularly uncomfortable'. Mr O'Brien arranged for the patient to be admitted to the Urology Department on Personal information redacted by USI for prostatic resection.

Mr Young advised there was no clinical justification for the timeframe.

7. **Patient –** Personal Information redacted by the USI

This patient had an NHS/HSC operation completed 25 days (based on the findings of the review)(after 25 days based on Mr O'Brien's assessment) after a private consultation with Mr O'Brien.

The patient was reported as doing well on Personal information redacted by USI at the time of his discharge from Enniskillen Hospital. Mr O'Brien reported on 8 October 2016 that the patient remained well apart from discomfort associated with an indwelling urethral catheterisation. Mr O'Brien reported 'in view of the significant morbidity suffered as a consequence of bladder outlet obstruction, I have arranged for him to be admitted…..on Personal information redacted by USI for prostatic resection that day'.

Mr Young advised there was no clinical justification for the timeframe.

8. **Patient –** Personal Information redacted by the USI

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This patient had an NHS/HSC operation completed 5 days (based on the findings of the review)(after 34 days based on Mr O'Brien's assessment) after a private consultation with Mr O'Brien.

This patient was assessed by Mr O'Brien privately on Personal information redacted by USI. The patient was a Personal year old male who had a previous successful surgery in 2013. In October 2016, the patient reported urethral discomfort caused by continued catheterisation. Mr O'Brien reported that he expedited the patient for admission on Personal information redacted by USI to minimise the risk of recurrence of the previous morbidity.

Mr Young advised there was no clinical justification for the timeframe.

9. Patient – Personal Information redacted by the USI

This patient had an NHS/HSC operation completed 8 days (based on the findings of the review)(after 34 days based on Mr O'Brien's assessment) after a private consultation with Mr O'Brien.

This patient is Personal Information redacted by the USI of Mr O'Brien's Personal Information redacted by the USI. The patient reported left flank pain around Christmas 2015 and Mr O'Brien reviewed her privately on Personal information redacted by USI Personal Information redacted by. The patient was assessed within the Trust by a Clinical Nurse Specialist on Personal information redacted by USI Personal information redacted by Mr O'Brien reports that no other patient was displaced.

Mr O'Brien reported 'finding she had a moderately severe hypersensitivity of her bladder' he performed effective hydrostatic dilatation of her bladder in addition to left uretheroscopy at an additional operating session on Personal information redacted by USI.

Mr Young advised there was no clinical justification for the timeframe.

Urology Waiting Times for 2015 and 2016 were:

	NEW OUTPATIENTS			**SURGICAL PROCEDURES**		
	RED FLAG	URGENT	ROUTINE	RED FLAG	URGENT	ROUTINE
APRIL 2015	14 DAYS	16 WEEKS	53 WEEKS	48 DAYS	82 WEEKS	97 WEEKS
APRIL 2016	26 DAYS	40 WEEKS	73 WEEKS	65 DAYS	119 WEEKS	124 WEEKS

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I am not persuaded by the justifications provided by Mr O'Brien for why the 9 private patients highlighted above were seen in the timeframes outlined. I would conclude that these patients seen privately by Mr O'Brien were scheduled for surgeries earlier than their clinical need dictated. These patients were advantaged over HSC patient's with the same clinical priority.

Mr O'Brien's explanation for patient Personal Information redacted by the USI was that he undertook surgery for this patient, a Personal information redacted by USI, in an additional theatre session and therefore no HSC patient was affected. If an additional session was available in Theatre, patients from the waiting list should have been seen in chronological order.

Term Of Reference 5

To determine to what extent any of the above matters were known to line managers within the Trust prior to December 2016 and if so, to determine what actions were taken to manage the concerns.

It was confirmed by a range of witnesses that they were aware of the difficulties in respect of Mr O'Brien's administrative practices.

Senior managers indicated they were aware of issues with regards to triage but not the extent of the issues. There had been attempts to raise this before 2016 with Mr O'Brien and in response, things would have improved for a while but then reverted again. I believe managers must have known there were significant ongoing issues of concern, given that a default system was put in place in 2015. However it was noted the default system meant this issue was no longer escalated to senior managers as the default system meant the triage was allocated as per the GP's impression. It was noted senior managers agreed with Mr Young that he would undertake Mr O'Brien's triage for 6-8 months whilst Mr O'Brien chaired a regional group. Clinics were also shortened to allow more admin time, extra PAs were paid for, admin time and no day surgery was scheduled after a SWAH clinic. It was indicated MDM letters which were always dictated were very long and detailed, and if theatres were unused Mr O'Brien would ask to increase his theatre time, i.e. additional time for his admin was being used in other ways.

Senior managers were aware Mr O'Brien took clinic notes to his home after the SWAH clinics and there were delays in notes being brought back. However, there is not a robust system in place for determining how many charts are tracked out to one consultant, nor how long the notes were gone for; as such managers were not aware of the extent of the problem.

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The above issues were raised in the correspondence to Mr O'Brien in March 2016. However there appears to have been no management plan put in to place at that time and Mr O'Brien seems to have been expected to sort this out himself with no arrangements for monitoring if changes to practice were being made and sustained.

Mr O'Brien indicated he had raised issues about triage and the fact it could not be done in the manner expected, at various meetings over many years. He felt he was not listened to. Other consultant urologists interviewed reported the triage role could be very demanding, especially if the emergency work was busy, but they were completing it within a reasonable time frame. It would seem Mr O'Brien continually complained about the difficulties with triage but it remained unknown to his colleagues that he was not undertaking all triage.

Senior managers appear not to have known about the undictated letters. Reliance on a medical secretary to flag that dictation was not being done was not appropriate or sufficient. This is now hopefully addressed through use of digital dictation.

Senior managers also appear not to have known that private patients may have been scheduled with greater priority or sooner outside their own clinical priority in 2015 and 2016.

9. Conclusions

Having considered the information as outlined above I have concluded:

Mr O'Brien is an experienced and highly respected senior colleague. He is a dedicated doctor who strives to provide a high quality service to all patients. He is frustrated by the lengthy waiting times for assessment and treatment/surgery.

There were 783 un-triaged referrals of which 24 were upgraded and a further 4 with confirmed diagnoses of cancer (plus the original SAI patient.) There was therefore potential for harm of 783 patients.

It does seem that Mr O'Brien liked to do things his own way. He was in agreement with the triage process initially but found he was unable to manage it and stopped doing so. He believed advanced triage should be done instead. He raised the issues about triage at meetings but at no time did he advise anyone that he was not doing it. Nonetheless, it is

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clear managers knew there was a significant problem with Mr O'Brien completing triage, given that a default system was put in place to address this very issue. It seems managers were not aware of the extent of the undone triage. Failure to triage has resulted in delays of diagnosis and treatment, given the diagnosis of cancer in five patients reviewed. This must be interpreted as harm.

Mr O'Brien stored excessive numbers of case notes at his home for lengthy periods. 288 charts were brought by him from his home and returned in January 2017. This is outside normal acceptable practice. There were 13 case notes missing but the review team is satisfied with Mr O'Brien's account that he does not have these.

There were 66 clinics (668 patients) undictated and 68 with no outcome sheets, some going back a few years. This is unacceptable practice. Mr O'Brien gave an explanation of doing a summary account of each episode at the end. He indicated patients were added to waiting lists at the point they should have been in any event. It was difficult to be clear if this resulted in delays in treatment given the lengthy waiting time in this specialty in any event. Nonetheless, I feel this delay with clinic letters was unhelpful in keeping GPs up to date with what was happening with their patients as often, despite lengthy discussions with the patient, they would go to the GP for further explanations/ clarification which the GP could not then provide. Further, it means the waiting list was not an accurate reflection of waits.

From the information available it does seem some patients were added to the theatre list schedule earlier than their clinical priority would have dictated.

Many of the problems outlined in the terms of reference were known to managers before 2016 and as a consequence I feel that there were earlier opportunities to address concerns (prior to 2016) and these opportunities were not taken in a consistent, planned or robust manner. Mr O'Brien indicated he raised concerns about triage repeatedly, and that managers were aware of the fact he had notes in his home. Nonetheless, as a senior and experienced Consultant, it was incumbent upon Mr O'Brien to ensure it was fully and clearly known that he has stopped undertaking all triage.

Whilst, there is little doubt Mr O'Brien is a skilled and conscientious doctor, a number of managers and colleagues reported he was felt not to be a team player, and chose to work in his own way, e.g. preferring to add on theatre lists rather than complete outstanding administration. I would conclude that Mr O'Brien did not always work to the Trust's expectations/requirements.

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In January 2017, as part of the MHPS process, a management plan was put in place in order to safeguard patients and ensure there was no further risk to patient's while these matters were investigated. From January 2017, Mr O'Brien has worked rigidly to the action plan out in place and has met all requirements of the action plan on an on-going basis. I can only conclude therefore, that Mr O'Brien is capable of adhering to the required acceptable administrative practices continuing.

At no point during the investigation has any concern been highlighted about Mr O'Brien's hands on patient care / clinical ability.

Lastly, during interviews and in correspondence, Mr O'Brien has displayed some lack of reflection and insight into the potential seriousness of the above issues. His reflection on the patients with delayed diagnoses was disappointing and is noted above. He did not seem to accept the importance of administration processes – he did not feel regular dictation was important and he does his own thing about replacing administration time with extra operating lists, whilst at the same time reporting lack of administration time. He felt he couldn't do the triage in the way it was expected, but was also clear that he didn't agree with it anyway. I believe it appropriate and relevant to raise this with the case manager.

Dr Neta Chada
Consultant Psychiatrist / Associate Medical Director
Case Investigator

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

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Maintaining High Professional Standards Formal Investigation

Case Manager Determination

Dr Ahmed Khan, Case Manager

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

1.0 Case Manager Determination following Formal Investigation under the Maintaining High Professional Standards Framework in respect of Mr Aiden O'Brien, Consultant Urologist

Following conclusion of the formal investigation, the Case Investigator's report has been shared with Mr O'Brien for comment on the factual accuracy of the report. I am in receipt of Mr O'Brien's comments and therefore the full and final documentation in respect of the investigation.

2.0 Responsibility of the Case Manager

In line with Section 1 Paragraph 38 of the MHPS Framework, as Case Manager I am responsible for making a decision on whether:

1. No further action is needed
2. Restrictions on practice or exclusion from work should be considered
3. There is a case of misconduct that should be put to a conduct panel
4. There are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer
5. There are concerns about the practitioner's clinical performance which require further formal consideration by NCAS (re-named as Practitioner Performance Advice)
6. There are serious concerns that fall into the criteria for referral to the GMC or GDC
7. There are intractable problems and the matter should be put before a clinical performance panel.

3.0 Formal Investigation Terms of Reference

The terms of reference for the formal investigation were:

1. (a) To determine if there have been any patient referrals to Mr A O'Brien which were un-triaged in 2015 or 2016 as was required in line with established practice / process.

   (b) To determine if any un-triaged patient referrals in 2015 or 2016 had the potential for patients to have been harmed or resulted in unnecessary delay in treatment as a result.

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(c) To determine if any un-triaged referrals or triaging delays are outside acceptable practice in a similar clinical setting by similar consultants irrespective of harm or delays in treatment.

(d) To determine if any un-triaged patient referrals or delayed tri-ages in 2015 or 2016 resulted in patients being harmed as a result.

2. (a) To determine if all patient notes for Mr O'Brien's patients are tracked and stored within the Trust.

   (b) To determine if any patient notes have been stored at home by Mr O'Brien for an unacceptable period of time and whether this has affected the clinical management plans for these patients either within Urology or within other clinical specialties.

   (c) To determine if any patient notes tracked to Mr O'Brien are missing.

3. (a) To determine if there are any undictated patient outcomes from patient contacts at outpatient clinics by Mr O'Brien in 2015 or 2016.

   (b) To determine if there has been unreasonable delay or a delay outside of acceptable practice by Mr O'Brien in dictating outpatient clinics.

   (c) To determine if there have been delays in clinical management plans for these patients as a result.

4. To determine if Mr O'Brien has seen private patients which were then scheduled with greater priority or sooner outside their own clinical priority in 2015 or 2016.

5. To determine to what extent any of the above matters were known to line managers within the Trust prior to December 2016 and if so, to determine what actions were taken to manage the concerns.

4.0 Investigation Findings

In answering each of the terms of reference of the investigation, the Case Investigator concluded:

1. (a) It was found that Mr O'Brien did not undertake non-red flag referral triage during 2015 and 2016 in line with the known and agreed process that was in place. In January 2017, it was found that 783 referrals were un-triaged by Mr O'Brien. Mr O'Brien accepts this fact.

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(b) It was found that there was the potential for 783 patients to have been added to the incorrect waiting list. A look back exercise of all referrals by other Consultant Urologists determined that of the 783 un-triaged referrals, 24 would have been upgraded to red-flag status, meaning the timescales for assessment and implementation of their treatment plans was delayed. All un-triaged referrals were added to Trust waiting lists based on the GP referral assessment.

(c) It was found that all other Consultant Urologists undertook triage of all referrals in line with established practice.

(d) It was found that of the 24 upgraded patient referrals, 5 patients have a confirmed cancer diagnosis. All 5 patients have been significantly delayed commencing appropriate treatment plans.

2. (a) It was found that in January 2017 Mr O'Brien returned 307 sets of patient notes which had been stored at his home. Mr O'Brien accepts that there were in excess of 260 patient notes returned from his home in January 2017.

   (b) The notes dated as far back as November 2014. It was found that Mr O'Brien returned patient notes as requested and he asserts therefore there was no impact on patient care.

   (c) It was found that there are 13 sets of patient notes missing. The Case Investigator was satisfied these notes were not lost by Mr O'Brien.

3. (a) It was found that there were 66 undictated clinics by Mr O'Brien during the period 2015 and 2016. Mr O'Brien's accepts this.

   (b) It was accepted by Mr O'Brien that he did not dictate at the end of every care contact but rather dictated at the end of the full care episode. This is not the practice of any other Consultant Urologist. The requirements of the GMC is that all notes / dictation are contemporaneous.

   (c) There are significant waiting list times for routine Urology patients. It is therefore unclear as to the impact of delay in dictation as the patients would have had a significant wait for treatment. The delay however meant that the actual waiting lists were not accurate and the look back exercise to ensure all patients had a clear management plan in place was done at significant additional cost and time to the Trust.

6. It has been found that Mr O'Brien scheduled 9 of his private patient's sooner and outside of clinical priority in 2015 and 2016.

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7. Concerns about Mr O'Brien's practice were known to senior managers within the Trust in March 2016 when a letter was issued to Mr O'Brien regarding these concerns. The extent of the concerns was not known. No action plan was put in place to address the concerns. It was found that a range of managers, senior managers and Directors within the Acute Service Directorate were aware of concerns regarding Mr O'Brien's practice dating back a number of years. There was no evidence available of actions taken to address the concerns.

Other findings / context

Other important factors in coming to a decision in respect of the findings are:

Triage

1. Mr O'Brien provided a detailed context to the history of the Urology service and the workloads pressures he faced. Mr O'Brien noted that he agreed to the triage process but very quickly found that he was unable to complete all triage. Mr O'Brien noted that he had raised this fact with his colleagues on numerous occasions to no avail. Mr O'Brien accepts that he did not explicitly advise anyone within the Trust that he was not undertaking routine or urgent referral triage. Mr O'Brien did undertake red-flag triage.

2. It was known to a range of staff within the Directorate that they were not receiving triage back from Mr O'Brien. A default process was put in place to compensate for this whereby all patients were added to the waiting lists according to the GP catergorisation. This would have been known to Mr O'Brien.

3. Mr Young is the most appropriate comparator for Mr O'Brien as both have historical long review lists which the newer Consultants do not have. Mr Young managed triage alongside his other commitments. Mr Young undertook Mr O'Brien's triage for a period of time to ease pressures on him while he was involved in regional commitments.

Notes

1. There was no proper Trust transport and collection system for patient notes to the SWAH clinic in place.

2. There was no review of notes tracked out by individual to pick up a problem.

3. Notes were returned as requested by Mr O'Brien from his home.

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4. It was known that Mr O'Brien stored notes at home by a range of staff within the Directorate.

Undictated clinics

1. Mr O'Brien's secretary did not flag that dictation was not coming back to her from clinics. Mr O'Brien's secretary was of the view that this was a known practice to managers within the Directorate.

2. Mr O'Brien indicated that he did not see the value of dictating after each care contact.

3. Mr O'Brien was not using digital dictation during the relevant period and therefore the extent of the problem was not evident.

5.0 Case Manager Determination

My determination about the appropriate next steps following conclusion of the formal MHPS investigation:

- There is no evidence of concern about Mr O'Brien's clinical ability with patients.

- There are clear issues of concern about Mr O'Brien's way of working, his administrative processes and his management of his workload. The resulting impact has been potential harm to a large number of patients (783) and actual harm to at least 5 patients.

- Mr O'Brien's reflection on his practice throughout the investigation process was of concern to the Case Investigator and in particular in respect of the 5 patients diagnosed with cancer.

- As a senior member of staff within the Trust Mr O'Brien had a clear obligation to ensure managers within the Trust were fully and explicitly aware that he was not undertaking routine and urgent triage as was expected. Mr O'Brien did not adhere to the known and agreed Trust practices regarding triage and did not advise any manager of this fact.

- There has been significant impact on the Trust in terms of its ability to properly manage patients, manage waiting lists and the extensive look back

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exercise which was required to address the deficiencies in Mr O'Brien's practice.

- Mr O'Brien did not adhere to the requirements of the GMC's Good Medical Practice specifically in terms of recording his work clearly and accurately, recording clinical events at the same time of occurrence or as soon as possible afterwards.

- Mr O'Brien has advantaged his own private patients over HSC patients on 9 known occasions.

- The issues of concern were known to some extent for some time by a range of managers and no proper action was taken to address and manage the concerns.

This determination is completed without the findings from the Trust's SAI process which is not yet complete.

Advice Sought

Before coming to a conclusion in this case, I discussed the investigation findings with the Trust's Chief Executive, the Director of Human Resources & Organisational Development and I also sought advice from Practitioner Performance Advice (formerly NCAS).

My determination:

1. No further action is needed

Given the findings of the formal investigation, this is not an appropriate outcome.

2. Restrictions on practice or exclusion from work should be considered

There are 2 elements of this option to be considered:

a. A restriction on practice

At the outset of the formal investigation process, Mr O'Brien returned to work following a period of immediate exclusion working to an agreed action plan from

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

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

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

b. An exclusion from work

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

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

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

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

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

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Performance Advice (NCAS) as part of this determination. At this point, I have determined that there is no requirement for formal consideration by Practitioner Performance Advice or referral to GMC. The Trust should conclude its own processes.

The conduct concerns by Mr O'Brien include:

- Failing to undertake non red flag triage, which was known to Mr O'Brien to be an agreed practice and expectation of the Trust. Therefore putting patients at potential harm. A separate SAI process is underway to consider the impact on patients.

- Failing to properly make it known to his line manager/s that he was not undertaking all triage. Mr O'Brien as a senior clinician had an obligation to ensure, this was properly known and understood by his line manager/s.

- Knowingly advantaging his private patients over HSC patients.

- Failing to undertake contemporaneous dictation of his clinical contacts with patients in line with GMC 'Good Medical Practice'.

- Failing to ensure the Trust had a full and clear understanding of the extent of his waiting lists, by ensuring all patients were properly added to waiting lists in chronological order.

Given the issues above, I have concluded that Mr O'Brien's failings must be put to a conduct panel hearing.

4. There are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer.

There are no evident concerns about Mr O'Brien's health. I do not consider this to be an appropriate option.

5. There are concerns about the practitioner's clinical performance which require further formal consideration by NCAS (now Practitioner Performance Advice)

Before coming to a conclusion in this regard, I sought advice from Practitioner Performance Advice.

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The formal investigation report does not highlight any concerns about Mr O'Brien's clinical ability. The concerns highlighted throughout the investigation are wholly in respect of Mr O'Brien's administrative practices. The report highlights the impact of Mr O'Brien's failings in respect of his administrative practices which had the potential to cause harm to patients and which caused actual harm in 5 instances.

I am satisfied, taking into consideration advice from Practitioner Performance Advice (NCAS), that this option is not required.

6. There are serious concerns that fall into the criteria for referral to the GMC or GDC

I refer to my conclusion above. I am satisfied that the concerns do not require referral to the GMC at this time. Trust processes should conclude prior to any decision regarding referral to GMC.

7. There are intractable problems and the matter should be put before a clinical performance panel.

I refer to my conclusion under option 6. I am satisfied there are no concerns highlighted about Mr O'Brien's clinical ability.

6.0 Final Conclusions / Recommendations

This MHPS formal investigation focused on the administrative practice/s of Mr O'Brien. The investigation report presented to me focused centrally on the specific terms of reference set for the investigation. Within the report, as outlined above, there have been failings identified on the part of Mr O'Brien which require to be addressed by the Trust, through a Trust conduct panel and a formal action plan.

The investigation report also highlights issues regarding systemic failures by managers at all levels, both clinical and operational, within the Acute Services Directorate. The report identifies there were missed opportunities by managers to fully assess and address the deficiencies in practice of Mr O'Brien. No-one formally assessed the extent of the issues or properly identified the potential risks to patients.

Default processes were put in place to work around the deficiencies in practice rather than address them. I am therefore of the view there are wider issues of concern, to be considered and addressed. The findings of the report should not solely focus on one individual, Mr O'Brien.

In order for the Trust to understand fully the failings in this case, I recommend the Trust to carry out an independent review of the relevant administrative processes

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with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. The review should look at the full system wide problems to understand and learn from the findings.

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Hynds, Siobhan

From: Hynds, Siobhan [redacted]
Sent: 09 February 2017 12:23
To: Carroll, Ronan; Corrigan, Martina; Khan, Ahmed; Weir, Colin
Subject: Return to Work Action Plan February 2017 FINAL
Attachments: Return to Work Action Plan February 2017 FINAL.docx

Importance: High

Ronan / Martina

Thank you for your assistance with this action plan. Please see attached final draft for your review. This is the basis of what will be discussed with Mr O'Brien at our meeting with him today.

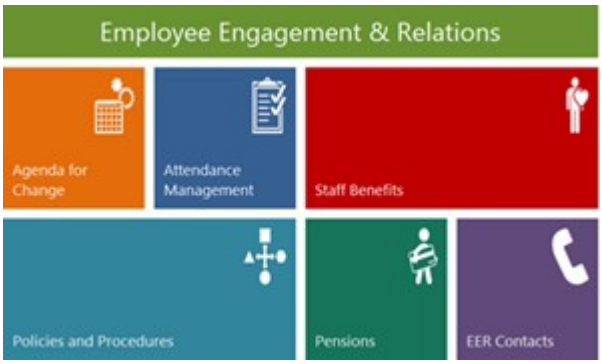
Dr Khan / Colin – for your review and comment please.

Many thanks

Siobhan

Mrs Siobhan Hynds
Head of Employee Relations
Human Resources & Organisational Development Directorate
Hill Building, St Luke's Hospital Site
Armagh, BT61 7NQ

Tel: [redacted] Direct Line: [redacted]
Mobile: [redacted] Fax: [redacted]



Click on the above image for SharePoint: Employee Engagement & Relations information

'You can follow us on Facebook and Twitter'

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Witness Statement

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

1. My name is Mr Mary Haynes. I am employed by the Southern Health and Social Care Trust as a Consultant Urologist. I was appointed in May 2014 as a Consultant within the Southern Trust having previously worked as a Consultant in Sheffield since April 2010.

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

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

4. I explained that each Consultant takes all GP referrals to the urology service for a week at a time when they are the Consultant of the Week. Additional referrals can come in for named Consultants but these don't necessarily go through the Referral and Booking Centre and wlll go directly to Consultants. The number of these type of referrals vary.

5. I was initially unaware of any un-triaged referrals. There were long waiting lists and lots of red flags were seen. It became apparent to me as routine referrals came through to be seen that they hadn't been triaged. Patients were booked onto waiting lists irrespective of not being triaged so it wasn't immediately apparent that triage was not being done. It did become apparent however when patient's came to clinics but that could be 70 weeks later because of the waiting list.

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6. I know we all work at different speeds and Mr O'Brien works differently to me. I was aware he was not getting through triage like I was but I was not aware that he hadn't gotten through any of it.

7. The bulk of referrals are routine. I think it is good practice to do triage within 24 hours of receipt of the referral but the reality is that the routine waiting list is 70 weeks so a routine patient isn't going to be seen anyway even if triage is done within 24 hours. I became aware of issues about Mr O'Brien's triage when on occasions GPs sent in a second letter and they were then being triaged by someone different..

8. I recall one specific issue – I always go through my patient lists before a clinic and I looked at this particular clinic and a patient was referred for a renal cyst. It became apparent to me that there was a radiology mistake. The patient referral suggested a benign renal cyst and an MRI was recommended. On looking at the report, it said that the lower pole renal cyst was benign but there was no mention of a mid pole cyst. The abnormal cyst was not commented on and because benign cysts would normally be discharged without being seen by urologists, the patient would not have been seen. The patient wasn't triaged and was put on a routine waiting list.

9. Had I received the referral I would have picked it up. I can't say if everyone would have picked it up. There was an opportunity to pick up the issue with the radiology discrepancy but because triage wasn't done it wasn't picked up.

10. I think triage is a nonsense. I don't know why secondary care take responsibility for re-categorising primary care assessment. It is a GP issue. I don't think we should be checking the GP got it right. It takes an inordinate amount of Consultant time. There are generally between 10 to 20 upgraded per week. In the main doing triage is fine. I am not talking about advance triage just checking the GP referral.

11. I am aware that there have been un-triaged referrals because of the SAI process. We were probably all aware of seeing the odd untriaged referral but when they are being seen by 6 different people, seeing the odd one didn't seem like that much. It turns out we were all getting them, so it wasn't just the odd one.

12. Before I met with Patient 10 in the clinic I got the MRI re-reported and I explained to the patient that there as a misreported scan. I was very open and honest with the patient. A CT scan was done which showed an enlarged lymph node. The patient was diagnosed and treated for breast cancer secondaries and then also kidney cancer. I completed an IT1 form because of this case and as a result the SAI process happened. It was Chaired by Mr Glackin.

13. Because we take responsibility for triage there was potential for harm for all patients not triaged.

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14. Ideally all triage should be completed within 24 hours. I feel this is reasonable. The reality is that on-call week is busy and comes down to what is reasonable for that week. I might not get all triage done and might have to complete some of it the following week. Some Consultants work quicker than others and so each Consultant has to take responsibility for the referrals during their week on-call, otherwise it would roll into the next week and the next Consultant can't pick up outstanding triage.

15. In my view, what's reasonable depends upon the original referral category so for example red flags should be done within 24 hours. For urgent and routines within 3-7 days is fine.

16. I know at least one patient, Patient 10, who could have come to harm because Mr O'Brien did not triage and I believe there is another delayed cancer diagnosis for a bladder cancer patient so potentially, yes, patients have come to harm. As it turned out Patient 10 had the breast secondaries picked up because of the delay.

17. In respect of TOR 2, I have completed IR1's in the past because of notes. I recall 2 patients both of whom were seen in clinic by Mr O'Brien where there was no dictation. I picked up one patient because I was asked by Martina Corrigan. The 2nd was a lady from Personal information redacted by HSI seen in clinic who was told she was coming to me. It didn't happen and so the GP sent another referral in. the first referral had not been triaged anyway. When I took her to theatre to do a nephrectomy there were no notes. I put an IR1 in about that.

18. I am also aware that there were times when notes were not available. This is when I was doing backlog review clinics. I have seen patients with no dictation from previous attendances and no notes available. That's very difficult. At times I was told the notes were not available so I said I wouldn't see patients without notes. (There would have been no letter on ECR either.)

19. At one point notes were found in Enniskillen clinic and there was a referral to me done 4 to 5 months after I operated on the patient. There was clearly no check that things were improving. When notes were returned in December I had already operated on the patient. There was a letter done then, dated December though the letter didn't take account for the surgery already done. (ie the dictated letter was done prior to notes being brought in to the hospital in December and not at the time.) That shows a lack of insight.

20. Mr O'Brien's patients were added to the waiting lists at the time they should have joined based on the GP referral. Unlike the other Consultants, Mr O'Brien managed his own waiting list. Mr O'Brien would have all his patient's organised himself, his secretary did not do this. It was not always clear why he added people to his waiting lists as he did. He did all the phoning/ planning and arranging himself. Other consultants let their secretary do that. No-one knows whats on his wating list as he manages it himself.

21. I know there has been an issue with undictated clinics and I know this stretches back further than 2015. I know of one patient who attended clinic 6 times dating back to 2013 and there was no no

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no dictation done except by a registrar on one occasion. The GP cannot know what the clinical management plan was for their patient without an outcome.

22. From SWAH there appeared to be no dictation, no outcome sheets and no notes brought back.

23. It appeared to me to be accepted practice that a senior member of the team did not do dictated outcomes from clinics. Many people knew Mr O'Brien stored notes at home but there was no action taken. It was also accepted that Mr O'Brien would transport files in his car from clinics and then would have these at home. We have created this issue. It was the Trust process and is still the Trust process. Everyone knew they were with him and were having to get him to bring the notes in if they were needed. It only applies to the SWAH clinics as there is transport to all other clinics. Mr Young does the SWAH clinic also but I think he takes the notes home and then drops them back again.

24. You can't run a safe practice without contemporaneous notes. I have looked up the duties of a doctor as required by the GMC and it doesn't specifically state a doctor has to do a letter for every attendance. I thought however it was accepted practice by the Trust. Maybe they didn't know the extent of it. The impression I have is that management knew about the issue of notes. The secretaries knew. Medical records knew.

25. My impression is that when a patient needed something done it was done but there have definitely been delays for patients. There certainly has been the potential for the delay of clinical management plans.

26. In terms of Mr O'Brien's private patients, it seemed to me that Private patient's appeared not to wait very long. I was aware of patient's seen privately who then had their operation out with the timescale for the same problem for an NHS patient. I raised this in an e-mail in June 2015 and also December 2015 to Michael Young and Martina Corrigan. It was an irritation for me that I had patients waiting much longer for the same problem. His waiting times seemed out of keeping with everyone elses. I believe Mr Young spoke to him about it. It is difficult to challenge a view and opinion with Mr O'Brien.

27. I am aware the previous AMD Mr Mackle raised issues with Mr O'Brien and this had become very difficult. Operationally Martina Corrigan knew of the issues and I anticipate she escalated these concerns. The problems were well known in medical records. Other people must have known such as anesthetists, he was taking people to theatre without clear notes and at times with no pre-op done. He has been here a long time and its just been accepted. I haven't worked anywhere else where a consultant would have been able or allowed to say I am not doing that, or have that accepted.

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

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

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

SIGNATURE	
DATE	

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Corrigan, Martina

From: Haynes, Mark <Personal Information redacted by the USI>
Sent: 11 June 2020 12:47
To: OKane, Maria; Carroll, Ronan; Corrigan, Martina; McClements, Melanie
Subject: FW: Patients to be added to Urgent Bookable List
Attachments: Personal Information redacted by the USI 001.jpg; Patient 1 001.jpg; Personal Information redacted by the USI 001.jpg; Personal Information redacted by the USI .jpg; Patient 105 001.jpg; Patient 104 001.jpg; Personal Information redacted by the USI 001.jpg; Personal Information redacted by the USI 001.jpg; Personal Information redacted by the USI .jpg

Afternoon

Attached are the green forms as mentioned and highlighted are cases in particular that should have been added to the waiting list at the date indicated. Also attached (in addition to the WL forms) is a copy of the full urology WL as of 11/5/20. As far as I can tell the patients highlighted should have been added to the waiting list on the date shown, but are not on the waiting list and I believe have been added to the waiting list more recently (on the back of the email below).

While it would appear he has a system whereby he is aware of these cases, standard procedure is that a patient is added to the PAS WL at the time of listing, not at the time of offering a date for surgery and the concern would be that there are other patients who are not administratively on the WL (on PAS) but should be. On the mild side this distorts our WL figures, as a risk I would be concerned that patients get lost.

Mark

	Personal Information redacted by the USI				
Patient 113		18/07/2019	Malignant	URO	Replacement of Le
Personal Information redacted by the USI		05/11/2019	? Malignant	URO	Bilateral Ureteroly
Patient 1		01/06/2020	Malignant	URO	TURP
Personal Information redacted by the USI		04/06/2020	Malignant	URO	Bilateral Ureterograp
		15/09/2019	Benign	URO	Right Rigid & Flexib
Patient 105		11/09/2019	Benign	URO	Removal / Replace Lithotripsy
Patient 104		11/02/2020	Benign	URO	Removal / Replace Lithotripsy
Personal Information redacted by the USI		13/05/2020	Benign	URO	Right Ureteroscopi
		14/05/2020	Benign	URO	Removal / Replace
		15/05/2020	Benign	URO	Removal of Bilater

From: O'Brien, Aidan
Sent: 07 June 2020 22:25
To: Neville, Linda; McIlveen, Jacqueline
Cc: Sector, Independent; Glackin, Anthony; Haynes, Mark; Elliott, Noleen
Subject: Patients to be added to Urgent Bookable List

Dear Linda and Jacqueline,

I added a list of ten patients to the existing list of patients for urgent admission and submitted it to Tony Glackin on Thursday 04 June 2020.

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Mark Haynes has already arranged to have the first of those patients, Patient 113 admitted to Personal Information redacted by the USI Hospital on Wednesday Personal information redacted by USI.
I have scanned and attached completed Green Forms for the remaining nine patients.
I have copied them to Noleen, my secretary, who will return to work on Tuesday 09 June 2020.
Please let me know if I can be of any further assistance.
I hope the above will facilitate their admissions.

Thank you,

Aidan.

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

WIT-55711

Patient Details – Affix Address Label or write details	
Name:	Personal Information redacted by the USI
D.O.B.:	
H&C No	

Date of Clinic / Decision to list	05 Nov 2019
Consultant	A O'BRIEN
Specialty	UROLOGY

*** FOR URGENT BOOKABLE LIST ***

Please DO NOT list a Patient for surgery if further tests or assessments are needed

Diagnosis:	RETROPERITONEAL FIBROSIS / RETROPERITONEAL SARCOMA
Procedure:	BILATERAL URETEROLYSIS & RETROPERITONEAL BIOPSY
Estimated Duration of Surgery:	3 HOURS
Additional Comments / Instructions:	FOR ADMISSION TO CRAIGAVON AREA HOSP

Urgency *Please tick appropriate box*	
Red Flag	✓
Urgent	
Routine	
Planned	

Anaesthetic Type *Please tick appropriate box*	
General / Spinal	✓
Sedation	
Local	

IF NOT suitable for day of surgery admission – please state & give reason

Intended Management *Please tick appropriate box*	
Day Case	
Inpatient	✓

Patients should be listed as a day case if the intention is for no overnight stay following surgery. It does not matter which ward or unit they are admitted to.

Please note, that unless indicated below, for scheduling purposes the patient will be shared across the Trust.

Please detail if the patient is required to be admitted to:	
Specific Site Requirement	CAH
Specific Unit Requirement	1 WCA
Specific Consultant	A O'BRIEN

Is the Patient on any Anti-Coagulation Or Anti-Platelet Therapy? No ☑ Yes ☐

If yes, please indicate if patient is on any of the medications below and the action required:

- **Warfarin?** ☐

- **Aspirin 300mg?** ☐

PLEASE TURN OVER & indicate the bleeding risk of the procedure.

Please advise whether the Patient should either:

a. Reduce to 75mg daily 7days prior to surgery ☐
b. Continue to take as normal ☐
c. Shoulder arthroscopy, thyroid, parotid or parathyroid surgery – stop all aspirin 7 days prior to surgery ☐

- **Clopidogrel** or **Prasugrel?** ☐

Please advise:

a. Patient has had stenting within the past year thus Surgeon should contact Cardiologist to advise ☐
b. Patient should discontinue 7days prior to surgery ☐

- **Dabigatran, Rivaroxaban or Apixaban?** ☐ **Please refer to Trust Guidance and SPC.**

Latex Allergy? No ☑ Yes ☐ **MRSA?** No ☑ Yes ☐

Diabetic? No ☑ Yes ☐ If yes, how is the diabetes controlled? Insulin ☐ Tablet ☐ Diet ☐

A decision to add a patient to the waiting list must be discussed and countersigned by the Consultant in charge.
If the Consultant is not available, then arrangements should be made to discuss decisions at a suitable point thereafter.

Doctor's Signature	Personal information redacted by USI	**Print Name**	AIDAN O'BRIEN	**Date**	07.06.20
Countersigned (Consultant)				**Date**	

Received from Mr McConnell gy Services Inquiry.