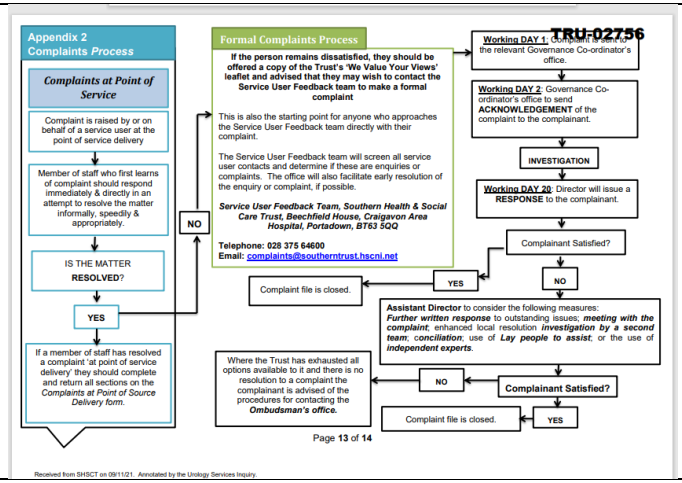
		Report in draft 5.11.18 Report being drafted 10.12.18 Personal rang to say she would like to be involved with the review. Awaiting Personal contacting the trust. Ask what way would like to proceed. 5.11.18 Report being drafted 07/01/2019 Report drafted and being sent to Mr McElvanna and Dr Bhatt for approval 15/01/2019 as before. Personal requests a meeting 21/01/2019 Report sent to review team for approval 22.1.19 Report now with review team, Roisin to request dates from Dr Bhat to meet with Personal information 4.2.19 Roisin awaiting dates from Dr Bhat for meeting. 8.2.19 Further reminder to Dr Bhat re meeting. 11.2.19 Email sent to Dr Bhat re meeting with family, awaiting response to set up meeting with Personal 26.2.19 AMcVey updated and emailed Dr Bhat for update re date for meeting Personal 11.3.19 Dr Bhat emailed response to AMcV on 4.3.19 advising he had not had a chance to look at the draft report due to clinical commitments. Once he had reviewed and made changes he would meet with family. Connie Connolly to take forward 25/3/19 Dr P Murphy to liaise with Dr Bhat re date for meeting. 15/04/2019 Dr Bhat has given dates, Roisin to arrange a meeting. 16/4/19 Dr Bhat is meeting Personal information 9/4/19. 20.05.19 - Report almost finalised. 03.06.2019 Patricia emailed Anne McVey,Dr Patricia McCaffrey, Dr Una Bradley, Dr Philip Murphy a copy of draft report. Await decision as to report to the board or not. 20.05.19 - Report almost finalised. 03.06.2019 Patricia emailed Anne McVey,Dr Patricia McCaffrey, Dr Una Bradley, Dr Philip Murphy a copy of draft report. Await decision as to report t board or not. 10.06.19 - Agreement that this is translated to an SAI Level 1.	TRU-03348 TRU-03652 TRU-03796 TRU-03984 TRU-04006
September – October 2018	Screening Report SEC ED	Re: Personal Information redacted by the USI (SAI) PEG tube insertion - perforation 11/09/2018- Report being final 25/09/218- Amendments of report with Dr R Thompson. Mr Gilpin feels case should be presented to the Coroner 01/10/2018 Report to be amended as per Mr Thompson	TRU-02911
September – October 2018	Screening Report SEC ED	Re: Personal Information redacted by the USI (SAI) PEG tube insertion - perforation 11/09/2018- Report being finalised 25/09/2018- report finalised and being prepared for sending to HSCB. Mr Gilpin feels case should be presented to the Coroner. 01/09/2018 Report finalised	TRU-02911
September 2018	Trust Governance Committee Meeting – Quarterly Report	Re: Litigation Claims Notes that the top 5 medical negligence incidents are: 1. Failure to diagnose/delay in diagnosis (89 with 42 of them related to cancer and clinical services) 2. Fail/delay treatment (70 with 26 of them related to cancer and clinical services) 3. Other pregnancy and Childbirth 4. Unknown	TRU-20793

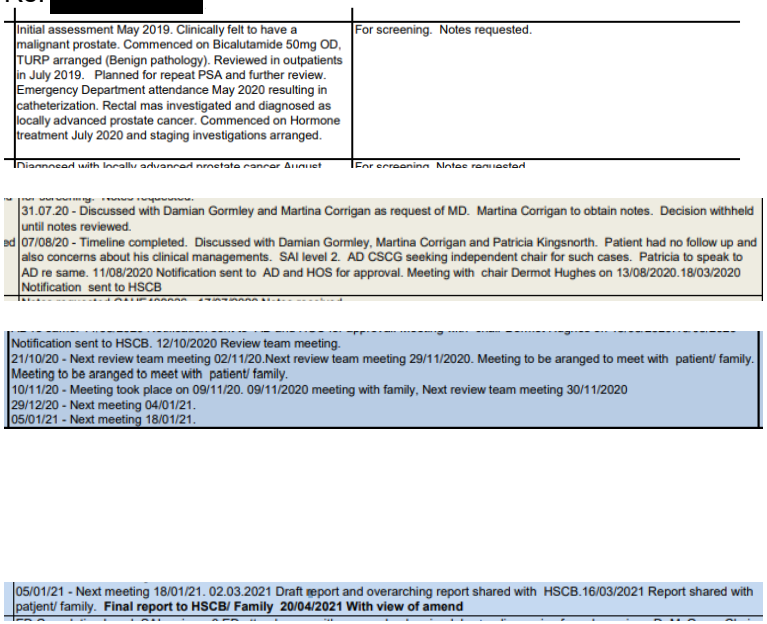
		5. Other	
October 2018	Screening Report SEC	Re: Personal Information redacted by the USI (Screening) Patient admitted to CAH on Tuesday 30 October 2018 for a bowel surgery procedure 'Sigmoid colectomy'. Family feel that a proper discharge plan was not provided. Family were never given the opportunity to be involved in patient's after care plan, or provided with a named person within the HSC and CAH to whom we could talk to about all aspects of my father's hospital stay and his discharge. An appropriate plan was not put in place as there was lack of communications and involvement with us as family members with all stages of his planning and providing good information to allow us to make good care planning decisions and choices. Family believe that short comings in the nursing and medical care meant that their father's deterioration physical health was not noticed and acted upon appropriately to address his bowel obstruction that resulted in necrosis. The correct conclusions were not drawn upon and as a result their father was sent home to die. For screening. Medical notes request from Villa 3. Timeline to be completed. For screening. Medical notes request from Villa 3. Timeline to be completed. 14/05/2019 Dicussed at screening, Mr Carroll reports for surgical M&M this week, await outcome. 28/05/19 Mr Carroll advises Richard Thompson will have report of M&M, same requested. 14/05/2019 Dicussed at screening, Mr Carroll reports for surgical M&M this week, await outcome. 28/05/19 Mr Carroll advises Richard Thompson will have report of M&M, same requested. 11/06/19 M&M report "*Death at home 1 day after discharge 8 days following a sigmoid colectomy. Patient apparently well on discharge then vomited at home and arrested. PM report discussed, PM has concluded that patient died from aspiration pneumonia secondary to a small bowel obstruction. No learning points. Outcome 1.*" *25/06/2019 Screening cancelled* *02/07/19 Advised by Ronan Carrol we are dealing with incident as a complaint and to check with Amie Nelson on progress. Paula has emailed Amie* *25/06/2019 Screening cancelled* 02/07/19 Advised by Ronan Carroll we are dealing with incident as a complaint and to check with Amie Nelson on progress. Paula has emailed Amie 09/07/19 Colette advise to proceed as a complaint.**update** from R Carroll who now advises this is an SEA and the review team nominations are Mr Eamon Mackle and Dorothy Sharpe. Notification to be done. Charts to be copied. Complaint on hold.	TRU-03901 TRU-03972 TRU-04083 TRU-04102
December 2018	Screening Report SEC	Re: Personal Information redacted by the USI This patient was booked 18 months ago for TURP on Mr O'Donoghue's list but is now not medically fit for surgery due to heart failure. 11/12/18 patient was from Ward 1 Elective . SMA Email from Mr Carroll - Tks Trusy I don't think this requires screening Mark? I have looked at this datix and fully investigated it. I have discussed the incident with Dr Cullen and he requested that it is passed onto Dr Bunting to see if some learning can be gained. Pre-op could not have done any more to optimise this patient. The raised BNP was known, it was due to the patient having AF, it was not new heart failure or existing heart failure not detected by pre-op; the wording of the datix may have lead the reader to think that the heart failure was not known / detected at pre-op. From review of the notes it was the patient's decision to not go ahead with surgery on the morning of admission after discussion with anaesthetist. Please see the datix for full details.	TRU-03377
December 2018	Screening Report SEC	Re: Personal Information redacted by the USI (Complaint) Patient admitted for partial nephrectomy 10.12.2018. Post operatively reports she was in severe pain. Presented to CAH ED on 23/12/2018 and reports she was admitted with a urinary leak and infarcted kidney and sepsis. Patient proceeded to total nephrectomy. Patient would 'like a further investigation into her first surgery as to why she ended up with a total nephrectomy'. For screening.	TRU-04611
2019	Using the Structured Judgement Review Method – Data	Re: National Mortality Case Record Review Programme: Structured Case Note Review Data Collection.	TRU-17384 – TRU-17395

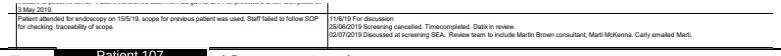
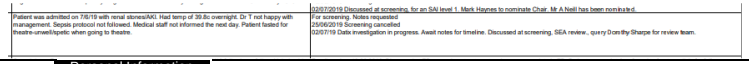
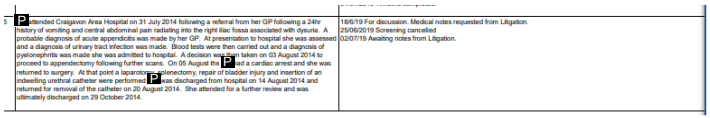
	Collection Form		
Jan 2019	Policy for the Management of HSC Complaints	7 Line Managers are responsible for: • seeking informal resolution of complaints raised at service level within identified timescales, if possible, as a rapid response and personal contact often results in effective complaints resolution; • ensuring that the Trust's Complaints Guidance and Procedure is included in the induction of their staff, and that staff are trained and empowered to deal with complaints as they arise; • supporting, advising and assisting staff to resolve the issues giving rise to the complaint or enquiry, when possible; ensuring all formal complaint letters received by staff are forwarded immediately to the Service User Feedback Team; • contributing to the investigation of complaints and enquiries and making sure statements and reports address all of the issues raised; • ensuring that statements / reports are returned to the Complaints Department within the required timescales; • ensuring informal complaints are recorded on the Trust's Point of Service Delivery Form/ Datix and retained on file with a copy forwarded immediately to the Service User Feedback Team; • introducing service improvements and making sure that all relevant information is disseminated throughout the service/team; and • ensuring completion of the online form for recording of compliments and the return for gifts received. 8 All Trust staff are responsible for: • attempting to resolve complaints, as they arise, in an informal, sensitive and confidential manner; and record on Trust's Point of Service Delivery Form/ Datix. • ensuring that the Trust's complaints posters and leaflets are available and accessible to service users to encourage all types of user feedback (see Sharepoint for complaints leaflet in a variety of languages); • referring the matter as soon as possible to their line manager if unable to deal with complaints raised directly with them or seeking advice from their Directorate Governance team on how to proceed; • keeping their line manager updated on complaints and enquiries they are currently dealing with and outcomes including improvements made; • contributing to the investigation of complaints and enquiries within the service/team and returning statements, reports and other information, within requested timescales; and • ensuring when they receive a written compliment it is shared with their manager and colleagues and reported using the online form for recording compliments. • ensuring completion of the monthly return for Gifts received.	TRU-02744 – TRU-02757

January 2019	Policy for the management of health and social care complaints		TRU-02756
February 2019	CSCG Report to Governance Committee	Notes that waiting lists, delay/cancellation of outpatient appointments was the fifth most common subject of complaints	TRU-21328
March 2019	Trust Governance Committee Meeting – Quarterly Report	Re: Litigation Claims Notes that in previous governance reports, it has been shown that a failure to diagnose/delay in diagnosis are the top reasons recorded as to why Clinical and Social Care Negligence claims have been taken against the Trust. A high level review of this has been undertaken to determine if the claims are linked to lengthy waiting lists. A review of the information contained on the Claims Management Database suggests that the majority of claims have been taken due to a diagnosis not being made earlier and are linked to allegations such as: 1. Not being examined properly to enable a diagnosis to be made 2. A failure to properly investigate the cause of an illness 3. Misinterpretation of x-rays or 4. A misdiagnosis of illness … The very high level review undertaken identified the below two examples which specifically refer to waiting list issues:	TRU-20828

		[First example relates to hip replacement] 2. A claim has been lodged related to a delay in Urology Services. The patient alleges that he was referred by his GP for a camera test however that there was a significant delay with same. The patient has since been diagnosed with inoperable prostate cancer. Investigations into this claim are ongoing. Further in-depth work is required, in conjunction Governance colleagues to determine risks associated with increasing patient waiting times on Trust waiting lists….	
March 2019	Screening Report SEC	Re: Patient 92 (Screening) Inpatient admission 29/11/17 - 7/12/17. FU CT Renal in 3 months. CT performed 13/3/18 (reported 20/3/18) showed suspected renal cancer. GP referral 17/7/18 as no review / FU had occurred after CT scan. Subsequently underwent surgical treatment of renal cancer. | For discussion. 19.03.2019 Discussed with Mr R Carroll and D Scullion, notes to be requested and timeline to be completed. 18 cal | 08/04/2019 Time line completed 07/05/2019 Discussed at sceening, to be forwarded to Mark Haynes for an opinion SAI or not? 14/05/2019 Discussed at screening. Carly has emailed Mark for an opinion. 14/05/2019 Discussed at screening. Carly has emailed Mark for an opinion. 28.05.19 - Level 1 SEA Meeting to arranged. Review team to include Chair-Dr Damian Gormley, Katherine Robinson, Wendy Clayton.	TRU-03694 TRU-03948 TRU-03971
March 2019	Screening Report SEC	Re: Personal Information redacted by the USI (Lit) Patient had planned surgery for repair of umbilical hernia 12/3/19. During procedure needle broke. Decision to close wound. Xray carried out following same. Patient informed. Patient was readmitted to surgical ward on 13/3/19 and attended theatre for wound exploration and retrieval of needle on 15/3/19. | For screening. Medical notes obtained and timeline commenced. n For screening. Medical notes obtained and timeline commenced.Time line completed. 07/05/2019 Discussed at screening, to forward to Mark Haynes for opinion. 14/05/2019 ,Email response from Mark Haynes to proceed as SAI as a never event. 14/05/2019 Discussed at screening Mr Carroll advised he wil discuss with Mr Mark Haynes 14/05/2019 Discussed at screening Mr Carroll advised he wil discuss with Mr Mark Haynes. 28/05/19 Level 1 SAI. Review team to include a radiographer, Mr Colin Weir SEC. Need yo email Mr Imran Yousif for nomination and advise Mr Weir he has been nominated by Mr Haynes. been nominated by Mr Haynes. 11.06.19 - Wait nomination for radiology, added to Radiology screening. (05/07/19) 02/07/2019 Review team Colin Weir and Marti McKenna. Prepare charts for review team. Paula has emailed Mr Weir, Carly has emailed Marti McKenna. 16.07.19 - Mr Carroll advises Mr Weir on A/L. 30.07.19 - Radiology not required for review team. Dates to be circulated for 1st meeting. 27.08.19 - First meeting of review team on 25/09/19. 30.09.19 - Report in draft. 12.11.19 - Report in draft. 26.11.19 - Report in draft. 24/12/2019 Final review team meeting to be arranged. 14/01/2019 - Final review meeting scheduled for 11/02/2019. 18/02/2019 For presentation at ACG. Surgery to present report.	TRU-03748 TRU-03927 TRU-03972 TRU-04934
March – September 2019	Screening Report	Re: Patient 15 GP routine referral to Urology 30/08/2015. Raised PSA. Seen bty Urology 8/2/2016. Appears a 6 month delay in diagnosis. Referral wasn't upgraded through triage process. | K R to – double check falls in urology SAI – Dr Wright and Dr Johnston have agreed to it can be included in original SAI 14/3/18 – Added to Urology Time Line Aaknowledgement letter not sent yet. HSCB Notification to be completed. 25/09/2018- Report sent to Julian Johnston (Chair) for approval.	TRU-02911

		26/11/2018 Meeting with Dr Johnston 11/12/2018	TRU-03193
		's a K R to – double check falls in urology SAI – Dr Wright and Dr Johnston have agreed to it can be included in original SAI 14/3/18 – Added to Urology Time Line Acknowledgement letter not sent yet. HSCB Notification to be completed. 25/09/2018- Report sent to Julian Johnston (Chair) for approval. 23.11.18 Further meeting arranged for 11.12.18 @ 2pm. 25.2.19 Mr Haynes advises he is to review reports.	TRU-03610
		25/09/2018- Report sent to Julian Johnston (Chair) for approval. 23.11.18 Further meeting arranged for 11.12.18 @ 2pm. 25. Mr Haynes advises he is to review reports. 07/05/2019 Patricia to email Mark Haynes for an update. 14/05/2019 Ronan and Patricia to discuss. Patricia to meet with Trudy	TRU-03922
		14/05/2019 Ronan and Patricia to discuss. Patricia to meet with Trudy 01/07/2019 Report with Julian Johnston to amend and Trudy to liaise with Dr Johnston. 16/07/19 Wait update from Trudy 08/10/2019 Email sent to Trudy for update on report 09/10/19 Connie spoke with Trudy Reid. DR J Johnston is to send the report to M Haynes then to Mr O'B for factual accuracy. 17/09/19 Presented at ACG. Amendments to be made by Mr Haynes. 05/10/2019 Email sent to Mr Haynes for update on report. 09/10/19 Connie spoke with Trudy Reid. DR J Johnston is to send the report to M Haynes then to Mr O'B for factual accuracy. 29.10.19 Report shared with Mr O'Brien yesterday. 05/11/19 await Mr O'Brien's response. 19/11/19 No update 03/03/2020 Patricia to meet with Mark Haynes re letters to family	TRU-04934
		26.05.20 - Final report has now been provided to Patricia. Patricia to link with Mark Haynes family.09/06/2020 Report shared with HSCB, letters to be sent to family.	TRU-06027
		26.05.20 - Final report has now been provided to Patricia. Patricia to link with Mark Haynes with a view to issuing letters to family.09/06/2020 Report shared with HSCB, letters to be sent to family. 07/07/20 Discussed at screening. Patricia advised letters need signed off asap. 04/08/20 - Patricia to follow up with Mark Haynes letter to be issued.	TRU-07148
		21.10.2020 – Notes it can be taken off SAI list.	TRU-08703
		Discussion re notification considering patient has deceased and the report did not find anything wrong with the patient's care. It is understood that a concensus was required from the group regarding notification. Ronan and Damian felt the family should be notified, however Ronan stated that a concensus from the group was required. Patricia to link with Melanie, Maria and Mark. 10/02/21 - Agreement that family would be notified. Update to be secured from Martina Corrigan.	TRU-11290

April 2019	DOH Guidance in Relation to the Health and Social Care Complaints Procedure	Notes: *"All HSC Trusts including the Northern Ireland Ambulance Service (NIAS) must provide the Department with quarterly statistical returns on complaints.* *HSC Trusts must provide their Management Boards and the HSC Board with quarterly complaints reports outlining the number and types of complaints received, the investigation undertaken and actions as a result including those relating to regulated establishments and agencies, and, where appropriate, out-of-hours services, pilot schemes and HSC prison healthcare…"*	TRU-02758 – TRU-02866
May 2019	Screening Report SEC	Re: Patient 9  Initial assessment May 2019. Clinically felt to have a malignant prostate. Commenced on Bicalutamide 50mg OD, TURP arranged (Benign pathology). Reviewed in outpatients in July 2019. Planned for repeat PSA and further review. Emergency Department attendance May 2020 resulting in catheterization. Rectal mas investigated and diagnosed as locally advanced prostate cancer. Commenced on Hormone treatment July 2020 and staging investigations arranged. — For screening. Notes requested. 31.07.20 - Discussed with Damian Gormley and Martina Corrigan as request of MD. Martina Corrigan to obtain notes. Decision withheld until notes reviewed. 07/08/20 - Timeline completed. Discussed with Damian Gormley, Martina Corrigan and Patricia Kingsnorth. Patient had no follow up and also concerns about his clinical managements. SAI level 2. AD CSCG seeking independent chair for such cases. Patricia to speak to AD re same. 11/08/2020 Notification sent to AD and HOS for approval. Meeting with chair Dermot Hughes on 13/08/2020.18/03/2020 Notification sent to HSCB Notification sent to HSCB. 12/10/2020 Review team meeting. 21/10/20 - Next review team meeting 02/11/20.Next review team meeting 29/11/2020. Meeting to be aranged to meet with patient/ family. Meeting to be aranged to meet with patient/ family. 10/11/20 - Meeting took place on 09/11/20. 09/11/2020 meeting with family, Next review team meeting 30/11/2020 29/12/20 - Next meeting 04/01/21. 05/01/21 - Next meeting 18/01/21. 05/01/21 - Next meeting 18/01/21. 02.03.2021 Draft report and overarching report shared with HSCB.16/03/2021 Report shared with patjent/ family. **Final report to HSCB/ Family 20/04/2021 With view of amend**	TRU-07013 TRU-07228 TRU-10059 TRU-15246
May 2019	Timeline	Re: Patient 9 May 2019 – Attended ED re urinary problems and severe pain May 2019 – Outpatient appointment with Mr O'Brien and plan was for 50mg Bicalutamide and TURP on 12 June 2019 June 2019 – Admitted for TURP and TROC. He was to be reviewed in September 2019	TRU-07159 – TRU-07161

		May 2020 – Attended ED with running to toilet a lot but unable to pu – in a lot of pain and not passed any urine today with a bowel blockage also. May 2020 – Virtual appointment with Mr O'Brien and was advised that GP is to prescribe Bicalutamide 50mgs in addition to Tamsulosin 400mgs and reviewed in Surgical Assessment unit on 18 May for removal of catheter May 2020 – Ambulatory care unit CAH. Had catheter removed and attended clinic for post voids. Unable to void and was uncomfortable. Had 500mls in his bladder and therefore cathertised him again. PSA was recently 9.5ng/ml and his DRE felt malignant. Booked for an MRI of prostate and discussed with Patient 9 his symptoms. Has also written to GP to see if they could follow this up as red flag. July 2020 – MDM Discussion. Has locally advanced prostate cancer at the very least. Commenced on ADT and a bone scan arranged. Further MDM discussion and possible referral to Oncology July 2020 – Outpatient clinic with Mr O'Donoghue. Plan was to start om LHRH analogue and will discuss further at MDT once scan results come to hand. It is most likely that if he doesn't have metastatic disease he will be referred to oncology July 2020 – ED attendance with urinary retention and ongoing problem with catheter which was changed earlier in day and now not passing urine. Taken to theatre from ED for open insertion of a suprapubic catheter and admitted to 4S.	
June 2019	Screening Report SEC	Re: Personal Information redacted by the USI (Screening) 	TRU-04083
June 2019	Screening Report SEC	Re: Patient 107 (Screening) 	TRU-04083
June 2019	Screening Report SEC	Re: Personal Information redacted by the USI (Screening) 	TRU-04083 TRU-

		2/07/19 Awaiting notes from Litigation. 9/07/19 Discussed at screening with Mr Carroll who advises SAI. Review team to include Mr A Neill and Dorothy Sharpe. Notes on L Drive. Need timeline nd charts prepared. Need a datix. 0/07/19 Email to Amie Nelson for Datix.	04102
June 2019	Screening Report SEC	Re: Patient 112 Patient was discussed at Uro-oncology MDM 03.10.2019 and it would appear outcomes from previous Uro-oncology MDM 27/06/2019 have not been actioned. Agreement by multidisciplinary team at MDM 03/10/2019 that chair should request review of process that has lead to this delay. Patient will be seen in clinic next week to expedite process. For screening. Notes requested.08/10/19 Discussed, Ronan advised he has an email from Mr O'B re patient follow up. Ronan to send Governance the email. Email for discussion next week. esponse: For screening. Notes requested 08.10.19 - Discussed, Ronan advised he has an email from Mr O'B re patient follow up. Ronan to send Governance the email. Email for discussion next week. 15.10.19 - Discussed at screening, advised Mark Haynes to decide if SAI/SEA . 12.11.19 - No response from M Haynes. No update. Barry Conway to be asked for an admin representative from the tracker team. 13.11.19 - Barry has nominated Vicki Graham to sit on review team. 19/11/19 Need confirmation from Mark Haynes re decision if SAI/SEA. 26.11.19 - Awaiting response from Mark Haynes. 17/12/2019 Need confirmation re decision if this is SAI/ SEA ?. 28/01/2020 Discussed at screening, Mark Haynes to make decision. 03/03/2020 SAI/SEA ?? 10/03/2020 Patricia has discussed with M Haynes, advised to ask Mr Ted McNaboe to review case for decision. Email sent to Ted. 21.04.20 - Mr McNaboe asked for an update. Unable to respond at present due to Covid-19 pressures. 20.05.2020 Discussed at screening Ronan to follow up with consultant. 16/06/20 - await feedback from Ronan. 03.09.19 - For screening. Notes requested. 16/06/20 - await feedback from Ronan. 07/07/2020 Discussed at screening. Ronan to follow up. 16/07/2020 Require alternative doctor review this case to decide if SAI or not. Ronan to advise. 11/08/2020 Discussed at screening Patricia to speak to Martina Notes reviewed and determined SAI, LEVEL ? External chair Dr Dermot Hughes has agreed to chair. 08/09/20 - Hold notification. Ronan and Patricia to discuss. 15/09/20 - Issue is should chemotherapy treatment have taken precedence over urology treatment - information not fed back to MDM. 15/09/20 - Issue is should chemotherapy treatment have taken precedence over urology treatment - information not fed back to MDM. 23.09.2020 Discussed at screening, Case reviewed, we need more information from notes, would benefit from urology external opinion. 13/10/20 -For screening to send details to Ronan. 21/10/20 - Patricia to speak to Mr Young regarding this case. 21/10/20 - Patricia to speak to Mr Young regarding this case. 01/12/2020 Need a decision if this is a SAI. 02/12/20 -Patricia to speak to Hugh Gilbert regarding this case. 15/12/220 Mr Hugh Gilbert reviewing case. Email sent to Denise Newell for images. 06/01/20 - David to follow up with Denise Newell.	TRU-04447 TRU-06054 TRU-07146 TRU-07231 TRU-07692 TRU-08702 TRU-10056
Undated	Timeline	Re: Patient 112 March 2019 – Attended ENT. Had pathology samples sent to labs. April 2019 – CT scan – identified a lesion on right kidney measuring 4.9cm. Also found enlarged	TRU-08716 – TRU-08717

		lymph node biopsy performed. Confirmed low grade follicular lymphoma. June 2019 – PET scan haematology – identified right renal mass measuring 6.5cms. Discussed at urology MDM and plan for Mr O'Brien to review and advised renal biopsy with factor V111 July 2019 – Discussed at haematology MDM. Plan requires treatment for CEOP + Rituximab/Obintuzimab. Await urology opinion for kidney lesion August 2019 – See at urology clinic. Advised by MDD to consider percutaneous needle biopsy of renal lesion would be appreciated and prudent. Dr Drake advised to initiate treatment of lymphoma due to its relatively high activity on PET CT. Patient doing well and already had first cycle of chemo. Sept 2019 – CT scan noted increase in right renal lesion October 2019 – Clinic letter for GP from August 2019. Seen an urology clinic by Dr Haynes. Noted CT scan report and advised radical nephrectomy – placed on waiting list in BCH. Jan 2020 – Admitted for right nephrectomy in BCH February 2020 – Discussed at Urology MDM. For surgical follow up.	
June 2019	Screening Report	Re: Personal Information redacted by the USI Patient seen at clinic 9/3/19 Letter dictated Letter only typed 11/06/19 results only put through with letter on 11/06/2019 elevated PSA - could be Prostate Carcinoma Referred urgently yo Urology — 17/06/2019 - For Screening Massive blood loss initiated due to puncture of iliac artery during PCI procedure — 17/06/2019- For screening	TRU-04028
June 2019	Screening Report	Re: Personal Information redacted by the USI (Complaint) Patient attended CAH for a procedure on 12th June to have her gallbladder removed. She thought the operation was going to be keyhole but it was not and she was 'opened up'. She was kept on the ward until 18th June and was then advised that she needed to go for surgery again to reconstruct her bile duct in the Mater Hospital and she was emergency blue lighted in an ambulance and had to undergo another operation. Only now, 4 months after the surgery is she starting to feel better. Patient is not happy with response to complaint. Has come back with additional information about treatment and care and wants Governance team to investigate. For screening	TRU-04611
June 2019	Screening Report	Re: Personal Information redacted by the USI Red Flag GP referral December 2017 to general surgery. Downgraded at triage. Appears to have met red flag criteria. Patient subsequently diagnosed with cancer, delay in diagnosis from Dec 2017 to May 2019 — 18/06/2019 - For screening	TRU-04039

		Brown. 18/06/2019 - For screening 25/06/2019 Screening cancelled. Timeline to be done. 02/07/2019 Discussed at screening, for an SAI level 1. Mark Haynes to nominate Chair. Mr A Neill has been nominated. Need another nomination for review team. For screening. Notes requested	TRU-04102
Undated	Screening Report SEC	Re: Personal Information redacted by the USI TRAUMA CASE- being treated in DHH which had no working CT scanner and no critical care facility to manage case. 5 AMBULANCE TRANSFERS = DHH to CAH, CAH TO DHH, DHH TO CAH, CAH TO DHH, DHH TO CAH before definite care achieved. Significant failures in Trust processes and failure in clinical decisions leading to a significant delay in patient receiving surgery and significant harm to the patient who may not survive For screening. 23.10.19 - Discussed at screening. DHH CT scanner not working, multiple trips to CAH and DHH. No senior doctor was contacted, should patient have stayed in CAH after first CT scan considering traumatic injury. CT scan of chest was not done following request. Why Need to review protocol for when CT scanner is down in DHH, taken into consideration resources available in CAH, who takes responsibility for patients. ? To find out why CT was not done. 30.10.19 - Discussed at screening, appropriate tests requested in ED, multiple transfer to CAH for CT scan, CT Chest not carried out as requested. Patient was admitted under surgical team that morning and wasn't reviewed until the following morning and further CT requested. For presentation at ED M&M. Advised for surgical screening. 04.11.19 - Discussed at screening, advised Mark Haynes needs to review and decide if SEA/SAI. 12.11.19 - No response from M Haynes. No update. 21.11.19 - Dr Imran Yousif will be radiology rep. 26.11.19 - Awaiting confirmation of surgical rep. 17/12/2019 - Awaiting confirmation SEA/ SAI and surgical rep. 13.02.20 - Email to Mr Weir to advise he has been nominated as surgical chair. 18/02/2020 Discussed at surgical M&M, confirmed a level 1 SAI. 06/05/2020 First meeting 28/04/2020, report in draft. Ist draft shared with review team, await response. 26.05.20 - Awaiting feedback from review team. 22.06.2020 Need copy of call and send to MTC. Email sent to Wendy Clayton await response. 06/07/2020 Draft shared with review team, awaiting dates for meeting. 14/07/2020 Review team emailed for dates for meeting to review final draft. 21/07/2020 Meeting with review team 20.07.2020 amendments to be made, 28.07.20 - for August ACG. 11/08/2020 Advised surgeon to present report at meeting on 14/08/2020. 18/08/2020 Report approved following amendments. to review final draft. 21/07/2020 Meeting with review team 20.07.2020 amendments to be made, 28.07.20 - for August ACG. 11/08/2020 Advised surgeon to present report at meeting on 14/08/2020. 18/08/2020 Report approved following amendments. 08/09/20 - Report shared with HSCB and family in draft. 22/09/2020 Await response from family.	TRU-04477 TRU-07231 TRU-07692
July 2019	Screening Report SEC	Re: Personal Information redacted by the USI	TRU-04308

		Personal Information redacted by the USI old gentleman admitted via ED on 25 July 2019 with UTI and was admitted to Urology on 3 South. Patient had a DNAR in place and that he passed away in hospital on Personal Information redacted by the USI **Background**: Pers old man admitted with haematuria secondary to having his long term catheter replaced the day before. On presentation to Emergency Department, he was hypotensive and spiking temperatures with raised inflammatory markers so he was commenced on IV Tazocin and Iv Gentamicin for a Urinary tract infection. On Pers whilst the nursing staff were in the bay, noted the patient to be of poor colour. Whenever they went over to him they noticed he was not making any respiratory effort and that he had [illegible]. The medical team were informed immediately and verification of life extinct was confirmed at 17:05 o Perso events relayed to Consultant Mr O'Brien- advised that we could not be clear that the cause of death was a urinary tract infection and advised speaking to coroner. Discussion with coroner's office - spoke to Maria as unclear cause of death. Discussed with Coroner Mr McCrisken who advised a post mortem. **Screening update**: For screening. Copy of notes requested from litigation	TRU-04326
August 2019	Screening Report SEC	Re: Personal Information redacted by the USI Pt had endoscope on the Personal at 10.45pm. Pt found in the single female toilet at 19:40pm. Pt found deceased, missing from Ward from 14:15pm. the Personal Information case should pr 13/08/2019 For screening	TRU-04260 TRU-10197

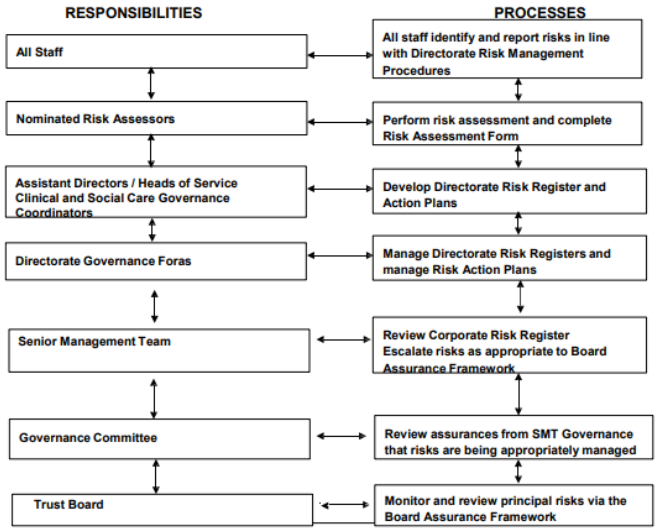
		Discussed at screening, to complete a new SAI, new review team to include cardiologist. To ask Dr McEneaney. 04/08/20 - Meeting of review team to be organised. Dates offered and awaiting response from Dr McEneaney. 11/08/2020 David advised Dr McEneney advised unable to participate in review. Ronan advised we need to provide Dr McEneaney a list of questions the family have asked relevent to cardiology 14/08/2020 Email sent to Dr McEneaney with family questions and proposed meeting 9/9/2020. 18/08/2020 Waiting on response from Dr McEneaney. 08/09/20 - Meeting of review team on 09/09/20. 15/09/20 - Meeting postponed as relatives wish to submit further questions. Meeting to be rearranged for week commencing 5 October 2020. 22/09/2020 reminder email to be sent to family for list of questions. 06/10/2020 Review team meeting 12/10/2020. 21/10/20 - Meeting cancelled as family have not provided questions. David rang family. Questions to be provided by 26 October 2020. 27/10/2020 No response to date from family 03/11/2020 No response from family. 10/11/20 - David emailed family. Questions to be provided by 13/11/20. If not proceed with original questions. 16/11/20 - Further meeting of review team to be planned. 17/11/2020 Additional questions received from family, review team meeting to be scheduled. 02/12/20 - Review team meeting at 3.30pm. 08/12/20 - Next review team meeting on 15/12/20. 29/12/20 - Draft report circulated. Awaiting comments from Dr McEneaney. 06/01/21 - Ronan to link with Dr McEneaney for comments. 12/01/21 - Comments provided. Amie to input and review team to finalise.	
September 2019	CSCG Report to Governance Committee	Notes that the subjects of complaints for the period of April – June 2019 in comparison with other quarters are: 1. Staff Attitude/Behavior 2. Communication/Information 3. Quality of Treatment & care 4. Professional Assessment of Need 5. Waiting Times, Outpatient Departments 6. Waiting List, Delay/Cancellation outpatient appointments 7. Waiting times, A&E Departments	TRU-21407
September 2019	Screening Report SEC Radiology	Re: Patient Personal Information redacted by the USI (SAI) Missed diagnosis of Gallbladder CA — 11/09/2018- Report was presented at ACG 7/9/18. AMD's/AD's suggest an Additional recommendation. Recommendation 2 The SHSCT should ensure that the WHO check list includes a question regarding all relevant results being signed off . Email to Mr Gudyma and Dr I Yousif for approval. 18/09/2018. Trudy Reid contacted Mr Pers to discuss his requirements of SAI. 25/09/2018- Amendments made to report and sent back to Mr Gudyma and Dr I Yousif for approval Missed diagnosis of Gallbladder CA - meeting held - report to be drafted. — Screening 21/11/17 SAI to be reviewed by Radiology - SAI notified - meeting Wednesday 17 January 2018 Writing report 21/05/2018- report to be shared with Dr Yousaf and back to Acute Clinical Governance Meeting in June, before being sent to HSCB Letter to be sent to Mr Pers 21.5.2018 – Report to be shared with Dr Yousaf and back to Acute Clinical Governance meeting in June, Before being sent to HSCB Letter to be sent to Mr Pers 29.5.18 Letter issued by registered post. 07/06/2018 – Dr Yousif to review report and discrepancy meeting for approval 26/06/2018 Further reminder to Dr Yousuf 3.7.18 – Letter to patient advising of SAI on 25.5.18. SAI still under investigation.	TRU-02910 TRU-02942 TRU-03166

		11/09/2018- Report was presented at ACG 7/9/18. AMD's/AD's suggest an Additional recommendation. Recommendation 2 The SHSCT should ensure that the WHO check list includes a question regarding all relevant results being signed off . Email to Mr Gudyma and Dr I Yousif for approval. 18/09/2018. Trudy Reid contacted Mr [redacted] to discuss his requirements of SAI. 25/09/2018- Amendments made to report and sent back to Mr Gudyma and Dr I Yousif for approval 12/11/2018- Email on 22/10/18 to Dr Gudyma to check if he had a chance to share this report for factual accuracy with the staff involved. Mr Gudyma will discuss at Patient Safety meeting 16/11/18. 13/11/2018 Email to Mr Gudyma as a reminder report need to be shared with those involved. 13.11.18 Trudy Emailed - discuss case with Ronan Carroll & Mr Mark Haynes 23.11.18 Further reminder to Dr Gudyma to confirm if staff have seen report prior to presenting to HSCB and family 10.12.18 Trudy to discuss with Mr Haynes 17/12/18 Discussed with Manos report sent to Manos 18/12/18 Discussed with Mr Weir report to be sent to Mr Weir 02/01/2019 Following discussion with Mr Haynes Trudy forwarded report to Mr Epanomeriakis and Mr Weir. Mr E has responded and Mr Gudyma has reviewed comments and happy to keep report . Awaiting Mr weir. Already approved SMT Governance. For HSCB following Mr Weir response. 08/01/2019 No update 15.1.19 Discussed at screening Mr Weir currently [redacted] 25.2.19 Mr Haynes advises Mr Weir returns to work in March and can review report. 11.3.19 Report sent to Mr Weir. 19/3/19 Email from Mr Weir who has questions needing addressed. To discuss with Patricia on her return from leave next week.	TRU-03193 TRU-03398 TRU-03476 TRU-03688
September 2019	Policy	Risk Management Strategy 2019 - 2022 Aims & Objectives *"The aim of the Trust Risk Management Strategy is to:* 1. *Cultivate and foster an "open and fair" culture in order to encourage openness, honestly, reporting and facilitate learning for all staff* 2. *Ensure a systematic approach to the identification, assessment and analysis of risk, and the allocation of resources to eliminate, reduce and control risk.* 3. *Mitigate risks and/or manage those risks which are deemed as acceptable* *The objectives of the Risk Management Strategy which underpin the above aims are to:*	TRU-02666-TRU-02707

1. *Manage risks to the quality of services provided and the safety of service users, clients, visitors, staff and contractors*
2. *Manage risks associated with the corporate functions of Human Resources, Finance and Informatics*
3. *Manage risks associated with service continuity*
4. *Manage risks associated with the reputation, community expectation and equity of services of the Trust*
5. *Minimise damage and financial losses that arise from avoidable, unplanned events*

described in the sub-sections which follow. A summary of the responsibilities and processes associated with risk management in the Trust is illustrated in Figure 5.

Figure 5 - Governance Arrangements in place to manage risk in the Trust



Trust Board:

1. Demonstrate its commitment to risk management through the endorsement of the Risk Management Strategy
2. Ensure, through the Chief Executive, that the responsibilities and structure for risk management outlined in this document are fully introduced
3. Oversee risk assurance processes
4. Consider strategic and corporate level risks, including agreeing the related risk control measures and monitoring implementation of same

		5. Ensure that the Trust has robust and effective arrangements in place for clinical and social care governance and risk management 6. Ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organization **Governance Committee:** 1. There are effectively and regularly reviewed structures in place to support the effective implementation and development of integrated governance across the Trust 2. Risk management is a planned and systematic approach to identifying, evaluating and responding to risks and providing assurance that response are effective 3. Principal risks and significant gaps in controls and assurances are considered by the Trust board 4. Timely reports are made to the Trust Board 5. There is sufficient independent and objective assurance as to the robustness of key processes across all areas of governance **Senior Management Team:** 1. Ensure that the Trust has an effective Corporate Risk Register 2. Review the Corporate Risk Register and ensure and that risks are escalated to the Board Assurance Framework as appropriate 3. Receive completed investigation reports of serious adverse events 4. Receive completed reports of findings of Root Cause and Systems Analysis 5. Implement and keep under review the Integrated Governance Framework 6. Receive assurance of the adequacy of systems for quality assurance, managing risk/risk management strategies/interventions, control of the environment 7. Receive assurance regarding the implementation of activities associated with action plans for the Controls assurance programme, HPSS Quality Standards, RQIA Recommendations etc 8. Accept and review reports and strategy documents pertaining to risk management and governance for endorsement by the governance committee 9. Assess the adequacy of the Governance Sub Committees to provide accountability and assurance that governance arrangements are effective	
Sept 2019	Risk Management Strategy 2019 – 2022	*"Issues of concern should be highlighted through existing professional and or line management lines of accountability and expect timely feedback on what has been done to address their concerns. Where individual staff continue to have specific concerns of risks which may impact on the delivery of safe and effective care, they have a duty to highlight them through the Trust's whistle blowing policy and to expect timely feedback on what has happened as a result."*	TRU-02687

<table>
<tr>
<td>September 2019</td>
<td>Risk Management Strategy 2019 – 2022</td>
<td>
The key elements for risk identification are detailed below:-
<table>
<tr><th>External Scrutiny and Inspection</th><th>Occurrences</th><th>Internal Assessments</th></tr>
<tr><th>Prospective</th><th>Retrospective</th><th>Prospective</th></tr>
<tr><td>Internal Audit Reports

External Audit Reports

Accreditation Bodies Report

RQIA reports

Reports from Professional Bodies

Health and Safety Executive Reports/Visits

Environmental Health Reports Independent Reviews Coroner's Reports

Contract management meeting reports from external providers

Contract management meeting reports from external contractors

All internal C&SCG data e.g. safety thermometer, waiting time report etc.

NCEPOD enquiries/reports</td><td>Adverse Incident Reporting

User Views

Complaints

Locally resolved expressions of dissatisfaction

Legal Claims

Patient and Client Satisfaction Measures

Employee Satisfaction Measures

Measures of psychological safety

Sickness and Absence Records

Staff Turnover

Levels of Agency Utilisation

Medical Device and Equipment Alerts

Introduction of new Standards and Guidelines

Outcome of Audit</td><td>Controls Assurance – Self Assessments

Performance reporting

Specialist Committees e.g. Infection Control Health & Safety etc.

Risk Assessments (including H&S; business/project planning e.g. new activities, services; referrals)

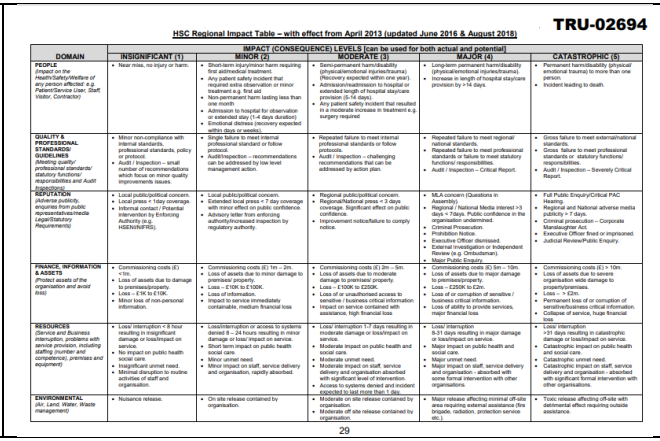
Management of relationship risk – i.e., service partners/key suppliers taking into account the behaviour and risk priorities of those partners

Networking – use of media reports and information from other Trusts

Other self-assessment tools - Health and Social Care Quality Standards Audit Commission.</td></tr>
</table>

"For each risk identified an assessment will be made of the likelihood of the risk occurring and the consequence or impact if this were to happen. The assessment will be made taking into account the effectiveness of controls that are already in place to mitigate the risk.

Figure 4 should be used to assign a descriptor for this perceived risk. This should be determined by <u>either</u> frequency or <u>likelihood.</u>
<table>
<tr><th colspan="4">Risk Likelihood Scoring Table</th></tr>
<tr><th>Likelihood Scoring Descriptors</th><th>Score</th><th>Frequency
(How often might it/does it happen?)</th><th>Time framed Descriptions of Frequency</th></tr>
<tr><td>Almost certain</td><td>5</td><td>Will undoubtedly happen/recur on a frequent basis</td><td>Expected to occur at least daily</td></tr>
<tr><td>Likely</td><td>4</td><td>Will probably happen/recur, but it is not a persisting issue/circumstances</td><td>Expected to occur at least weekly</td></tr>
<tr><td>Possible</td><td>3</td><td>Might happen or recur occasionally</td><td>Expected to occur at least monthly</td></tr>
<tr><td>Unlikely</td><td>2</td><td>Do not expect it to happen/recur but it may do so</td><td>Expected to occur at least annually</td></tr>
<tr><td>Rare</td><td>1</td><td>This will probably never happen/recur</td><td>Not expected to occur for years</td></tr>
</table>
</td>
<td>TRRU-02691 - TRU-02686</td>
</tr>
</table>

September 2019	Risk Management Strategy 2019 – 2022		TRU-02694

TRU-02694

HSC Regional Impact Table – with effect from April 2013 (updated June 2016 & August 2018)

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	MINOR (2)	MODERATE (3)	MAJOR (4)	CATASTROPHIC (5)
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Minor permanent harm lasting less than one month. • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision by 4-14 days. • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly) • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (e.g. Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Breach in confidence/ access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Breach in confidence of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competences), premises and equipment)*	• Loss/ Interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation – absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation – absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc.).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

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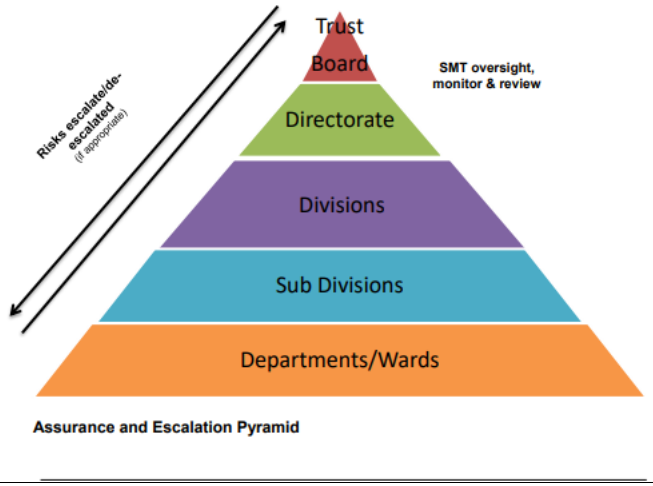
TRU-02694

September 2019	Risk Management Strategy 2019 – 2022	**Green Risks (Low)** Identified risks which fall in the green area are deemed as low (acceptable) risks and may require no immediate action, but must be monitored regularly to assess if and when action is required. These risks must be entered onto the local Risk Register. Risk Management Strategy – September 2019 33 Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry. **TRU-02699** **Yellow Risks (Medium)** Identified risks which fall in the yellow area are deemed medium risk to the Trust but require action to reduce the risk. Responsibility for taking action would normally remain at a local level within the appropriate Directorates / Service Areas and be entered on the Team / Service Risk Register. Where these risks cannot be managed locally they should be forwarded to the appropriate Directorate Governance Fora for consideration for further local action, resourcing or acceptance by the Directorate Governance Fora for the Directorate Risk Register. These risks must be entered on the local risk register and where appropriate the Directorate Risk Register for information and monitoring purposes. **Amber Risks (High)** Identified risks which fall in the amber area are deemed high risk to the Trust and require prompt action to reduce the risk to an acceptable level. When risks cannot be reduced locally they should be submitted to the Directorate Governance Fora for consideration and recommended action, i.e. further local action, resourcing or acceptance. Where these risks cannot be managed within the Directorate they should be referred to the Senior Management Team for consideration and/or addition to the Corporate Risk Register. These risks must be entered on the local risk register and where appropriate the Directorate Risk Register. **Red Risks (Extreme)** Identified risks which fall in the red area are deemed extreme risk to the Trust and must be reported to the appropriate Director and Chief Executive. Immediate action is required to reduce the level of risks to an acceptable level. The appropriate Director will ensure the implementation of a time monitored action plan with regular reports to the Chief Executive and Governance Committee. SMT will be the gate keepers of the Corporate Risk Register and will use the following criteria to inform their decision making in escalating risks to the Corporate Risk Register. • The risk represents an issue that has the potential to hinder achievement of one or more of the corporate objectives • The risk cannot be addressed at directorate level • It requires further control measures to reduce or eliminate the risk • It is likely to require considerable input of resources to resolve the risk (finance, people, time, etc) These risks will be entered onto the Directorate, and if appropriate the Corporate Risk Risk Management Strategy – September 2019	TRU-02698 – TRU-02700

September 2019	Risk Management Strategy 2019 – 2022		TRU-02704
22.09.2019	Email correspondence between Mr Haynes, Mr O'Brien and Ms Corrigan	Raising and highlighting the issue of administrative staff asking patients whether they still want to go ahead with surgery. Noting that it is not providing the patient's with an opportunity to make an informed decision but also offers a service that the Trust cannot deliver e.g. timely review appointment	TL4 page 2068 – 2074 AOB-09344 – AOB-09350
23.09.2019	Email from Ms Clayton to Mr O'Brien, Ms Corrigan and Mr Haynes	List of patients (urgent) who had been contacted re their procedures and therefore potentially taken off waiting list without consultant's consent. This was a process in which the Trust administrative team seem to have taken to reduce waiting lists	TL4 Page 2084 – 2110 AOB-09360 – AOB-09385
24.09.2019	Email chain between Mr O'Brien & Mr Haynes and Other Consultants	Re: Concern/Issue to highlight the need to ensure any patient is optimally prepared for any procedure	TL4 page 2121 – 2140 AOB-09394 –

			AOB-09413
24.09.2019	Email from Mr Haynes to Ms Clayton	Re: Cancellations of waiting list patients Noting that all patients who have been cancelled will need to come in for review. It was highlighted that none of the decisions made are free of clinical consequence and all carrying a minimum risk of emergency admission and one case carrying the risk of life threatening sepsis/death	TL4 Page 2153 – 2159 AOB-09426 – AOB-09432
24.09.2019	Email from Mr O'Brien to Mr Haynes	Re: Cancellation of waiting list patients Noting that Mr O'Brien has experienced the same thing during his 27 years. Noted that the GP was believing that the patient was discharged with their consent when in fact, the patient was oblivious to that being so	TL4 page 2162 – 2164 AOB-09435 – AOB-09437
24.09.2019	Email from Ms Clayton to Mr Haynes and Mr O'Brien	Re: Cancellations of waiting list patients Enclosing communication from the board to the Ads and HOS on 16 July. Noted that were concentrating on OPD admin validation and have nearly completed sending letters to all urgent and routine patients who are waiting over 52 weeks. If they decide they do not want their appointment then a letter is sent to their GP to advise on this.	TL4 page 2165 – 2192 AOB-09438 – AOB-09465
24.09.2019	Email from Mr Haynes to Mr O'Brien	Re: Cancellation of waiting list patients Mr Haynes notes that he will have major concerns raised with him at his quarterly liaison meeting, demanding to know why he organised this and to provide answers. Mr Haynes noted that it pisses him off but at least he knows beforehand (he didn't previously when a different specialty "validation exercise" was raised)	TL4 page 2213 – 2216 AOB-09486 – AOB-09489
25.09.2019	Email from Ms Corrigan to Consultants	RE: Cancellation of waiting list patients Highlighting to all consultants the issue. Ms Corrigan noted that she had approved this admin validation exercise initially when she thought it was just to check if patients were deceased, living at	TL4 Page 2222 – 2227

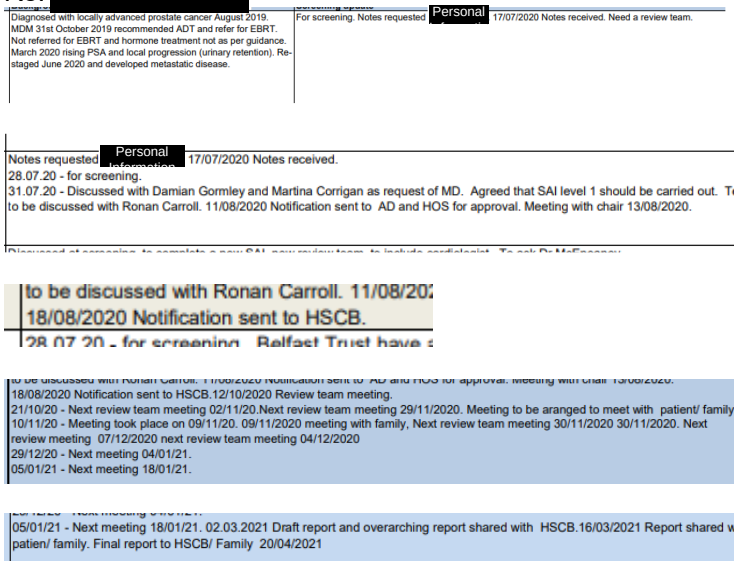
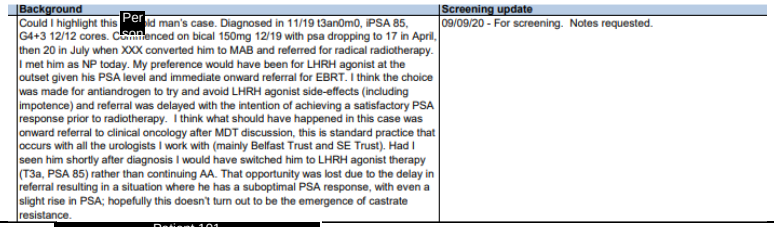
<table>
<tr><td></td><td></td><td>same address etc. However, when she found that they were sending letters to patients, Ms Corrigan immediately put a stop to it. However, Ms Corrigan noted that there has now been some fall out from this exercise.</td><td>AOB-09495 – AOB-09500</td></tr>
<tr><td>September 2019</td><td>Screening Report</td><td>Re: Personal Information redacted by the USI
<table><tr><td>Ureteric Stent inserted September 2019. No plan made for stent change or removal. Had this not been identified risk patient would have re-presented after period of time with stent encrustation requiring significant surgery to manage.</td><td>10/02/21 - For screening - notes requested. Will these be structured reviews or SAI in light of communication from Brid Farrell HSCB. There is a lot of systemic learning coming out of the current SAI Reviews. Under normal circumstances these would be Level 1 SAI. Further discussions required at urology meeting in relation to what tool should be used for investigation. Ronan to ask Martina if patients have been notified of incidents and obtain an update on status.</td></tr></table></td><td>TRU-11285</td></tr>
<tr><td>Undated</td><td>Screening Report</td><td>Re: Personal Information redacted by the USI

Ureteric Stent inserted September 2019. No plan made for stent change or removal. Had this not been identified risk patient would have re-presented after period of time with stent encrustation requiring significant surgery to manage.
<table><tr><td>9/9/19</td><td>Noted left hydronephrosis plan for ureteric stents</td><td></td></tr><tr><td>25/9/19</td><td>Admitted to theatre on day elective list for bilateral ureteroscopy and insertion of ureteric stents. Plan follow up in urology clinic in 3 months.</td><td></td></tr><tr><td>26/9/2019</td><td>Discharged following procedure. Planned follow up in 3 months at consultant urology clinic</td><td></td></tr><tr><td></td><td>Lost to follow up until August 2020</td><td></td></tr><tr><td>4.8.2020</td><td>Letter to patient advising that stents should have been removed after 6 months. Plan for MRI scan and removal of stents made.</td><td></td></tr><tr><td></td><td>No information – additional notes requested.</td><td></td></tr><tr><td></td><td></td><td></td></tr></table></td><td>TRU-11602</td></tr>
<tr><td>18.10.2019</td><td>SAI</td><td>Delay in screening

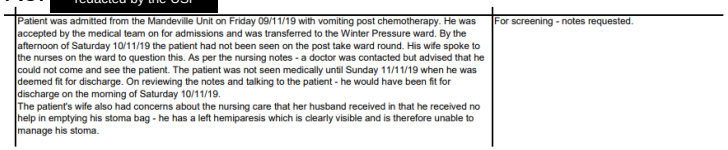
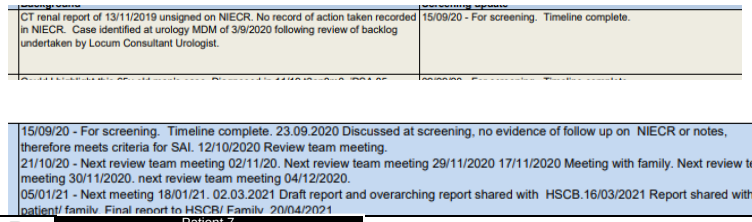
Patient diagnosed with advance prostate cancer on August 2019. Appropriateness of hormone treatment identified in June 2020</td><td>TRU-21591</td></tr>
<tr><td>31.10.2019</td><td>SAI</td><td>Delay in Screening

Patient diagnosed with benign prostate cancer October 2019. Lost to follow up appointment. Present to ED in May 2020 and diagnosed with advanced prostatic cancer.</td><td>TRU-21592</td></tr>
<tr><td>31.10.2019</td><td>SAI Notification Form</td><td>Re: Patient 9

Description: In May 2019 Patient 9 had an assessment which indicated he had a malignant prostate. Patient 9 was commenced on androgen deprivation therapy. Reviewed in July 2019 in outpatients and planned for repeat PSA and further review. Patient lost to review and attended Emergency Department in May</td><td>TRU-07162 – TRU-07164</td></tr>
</table>

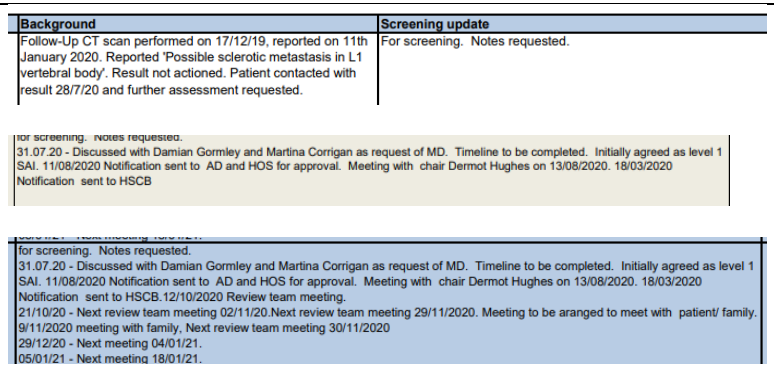
		2020. Rectal mass investigated and diagnosed as locally advanced prostate cancer.	
October 2019	Screening Report	Re: Patient 1  Diagnosed with locally advanced prostate cancer August 2019. MDM 31st October 2019 recommended ADT and refer for EBRT. Not referred for EBRT and hormone treatment not as per guidance. March 2020 rising PSA and local progression (urinary retention). Re-staged June 2020 and developed metastatic disease. For screening. Notes requested Personal 17/07/2020 Notes received. Need a review team. Notes requested Personal 17/07/2020 Notes received. 28.07.20 - for screening. 31.07.20 - Discussed with Damian Gormley and Martina Corrigan as request of MD. Agreed that SAI level 1 should be carried out. Team to be discussed with Ronan Carroll. 11/08/2020 Notification sent to AD and HOS for approval. Meeting with chair 13/08/2020. to be discussed with Ronan Carroll. 11/08/202 18/08/2020 Notification sent to HSCB. 28.07.20 - for screening. Belfast Trust have 18/08/2020 Notification sent to HSCB.12/10/2020 Review team meeting. 21/10/20 - Next review team meeting 02/11/20.Next review team meeting 29/11/2020. Meeting to be aranged to meet with patient/ family 10/11/20 - Meeting took place on 09/11/20. 09/11/2020 meeting with family, Next review team meeting 30/11/2020 30/11/2020. Next review meeting 07/12/2020 next review team meeting 04/12/2020 29/12/20 - Next meeting 04/01/21. 05/01/21 - Next meeting 18/01/21. 05/01/21 - Next meeting 18/01/21. 02.03.2021 Draft report and overarching report shared with HSCB.16/03/2021 Report shared with patien/ family. Final report to HSCB/ Family 20/04/2021	TRU-06885 TRU-07143 TRU-07228 TRU-10059 TRU-15246
November 2019	Screening Report – SEC	Re: Patient 101  Background Could I highlight this Personal old man's case. Diagnosed in 11/19 t3an0m0, iPSA 85, G4+3 12/12 cores. Commenced on bical 150mg 12/19 with psa dropping to 17 in April, then 20 in July when XXX converted him to MAB and referred for radical radiotherapy. I met him as NP today. My preference would have been for LHRH agonist at the outset given his PSA level and immediate onward referral for EBRT. I think the choice was made for antiandrogen to try and avoid LHRH agonist side-effects (including impotence) and referral was delayed with the intention of achieving a satisfactory PSA response prior to radiotherapy. I think what should have happened in this case was onward referral to clinical oncology after MDT discussion, this is standard practice that occurs with all the urologists I work with (mainly Belfast Trust and SE Trust). Had I seen him shortly after diagnosis I would have switched him to LHRH agonist therapy (T3a, PSA 85) rather than continuing AA. That opportunity was lost due to the delay in referral resulting in a situation where he has a suboptimal PSA response, with even a slight rise in PSA; hopefully this doesn't turn out to be the emergence of castrate resistance. Screening update 09/09/20 - For screening. Notes requested.	TRU-07553
Undated	Timeline	Re: Patient 101 August 2019 – Red Flag GP referral to urology due to high PSA 76.92. No urinary symptoms. 3 year history of lower back and R hip pain. PR craggy prostate. To review clinic 09 Jan 2019 and colonscopy on 27 January 2019 September 2019 – Letter to GP from urology. Patient had contacted as no OPD appointment and concerned regarding diagnostic implications of elevated PSA. US of urinary tract and bone scan	TRU-07698 - TRU-07699

		ordered. Patient advised of probable malignancy of prostate gland. August 2019 – US urinary tract. Reported minimally enlarged prostate gland. Vol 24mls bladder voiding complete on micturition. No evidence of upper urinary tract pathology October 2019 – Radioisotope bone scanning. No evidence of skeletal metastatic disease. Increase uptake of radioisotope characteristic of degenerative change. Patient 101 unable to attend review until November 2019 November 2019 – Review appointment. OPD exam. Plan is to have U&E, Bone profile, PSA, Testosterone, MRI prostate, TRUS biopsies, MDM and letter to GP re findings. November 2019 – Prostatic MRI scan and biopsy scan. Pathology report shows prostatic adenocarcinoma of Gleason score 4+3=7 is present in 12 out of 12 cores with maximum tumour length of 12mm. Tumour occupies 80% of total tissue volume. No evidence of extracapsular infiltration or lymphovascular infiltration. Evidence of perineural infiltration. November 2019 – Discussed at MDM urology. Plan that high risk prostate cancer without evidence of metastases on bone scan. Normal renal function. Review with consultant to request CT CAP and consider early referral to oncology December 2019 – Review with consultant. Letter to GP with plan. PSA 85.17. Bicalutamide 150mgs once daily and tamoxifen 10mg once. Next review 24 Jan 2020 with repeat PSA one week prior to review date. Jan 2020 – PSA 29.99. Plan PSA in March, review and reduce tamoxifen to 10mg alternative days March 2020 – Letter to GP with update and plan from review clinic held on Jan 2020. PSA repeat for April 2020. July 2020 – Letter to GP from urology. PSA decrease in April 2019 to 17.71. PSA in July 2019 increase to 20.97. Consultant advised patient of results and patient keeping well. Requires addition of LHRH agonist. Prescribed Decapeptyl 11.25mgs. Appointment with practice nurse for LHRH injection IM and every 3 months. Remain on medication until satisfactory response achieved or following review with clinical oncology. Referral sent to oncology on 11 July 2020 to proceed with radical radiotherapy. Placed on review list at CAH urology for Jan 2021 July 2020 – Consultant telephone call to Patient to advise of treatment plan	

		August 2020 – Review by Oncology – Letter from Professor SJ. To continue treatment LHRH agonist injections 3 monthly for 3 years. Will consent him for radical radiotherapy. Advised that Bicalutamide dose is reduced from 150mgs to 50mgs per day. Stop tamoxifen. PSA checked today	TRU-11604
November 2019	Screening Report MUSCH	Re: Personal Information redacted by the USI  Patient was admitted from the Mandeville Unit on Friday 09/11/19 with vomiting post chemotherapy. He was accepted by the medical team on for admissions and was transferred to the Winter Pressure ward. By the afternoon of Saturday 10/11/19 the patient had not been seen on the post take ward round. His wife spoke to the nurses on the ward to question this. As per the nursing notes - a doctor was contacted but advised that he could not come and see the patient. The patient was not seen medically until Sunday 11/11/19 when he was deemed fit for discharge. On reviewing the notes and talking to the patient - he would have been fit for discharge on the morning of Saturday 10/11/19. The patient's wife also had concerns about the nursing care that her husband received in that he received no help in emptying his stoma bag - he has a left hemiparesis which is clearly visible and is therefore unable to manage his stoma. For screening - notes requested.	TRU-04569
November 2019	Screening Report SEC	Re: Patient 7  CT renal report of 13/11/2019 unsigned on NIECR. No record of action taken recorded in NIECR. Case identified at urology MDM of 3/9/2020 following review of backlog undertaken by Locum Consultant Urologist. 15/09/20 - For screening. Timeline complete. 15/09/20 - For screening. Timeline complete. 23.09.2020 Discussed at screening, no evidence of follow up on NIECR or notes, therefore meets criteria for SAI. 12/10/2020 Review team meeting. 21/10/20 - Next review team meeting 02/11/20. Next review team meeting 29/11/2020 17/11/2020 Meeting with family. Next review tear meeting 30/11/2020. next review team meeting 04/12/2020. 05/01/21 - Next meeting 18/01/21. 02.03.2021 Draft report and overarching report shared with HSCB.16/03/2021 Report shared with patient/ family. Final report to HSCB/ Family. 20/04/2021	TRU-07689 TRU-15256
Undated	Timeline	Re: Patient 7 June 2016 – GP referrals red flag to haematology and urology. CT scan carried out for suspicious left	TRU-07695 – TRU-

		renal lesion. CT shows mesenteric lymphadenopathy with misting. Lymphoma listed as differential July 2016 – Letter to GP from Haematologist re investigation for elevated GGT – possible renal cyst. CT of renal tract showed 17mm renal cyst and 20mm renal lesion in left lower pole and some sub centimeter left mesenteric lymphadenopathy with mist appearance of the omentum…. Full CT staging to be arranged with discussion with radiology. July 2016 – Review with consultant urologist. July 2016 – CT scan of neck, chest abdomen and pelvis July 2016 – Discussed at Urology MDM. Plan is to manage by active surveillance in first instance. August 2016 – Review with consultant urologist. Patient remained well and happy to have left renal lesion and mesenteric lymphadenopathy reassessed with CT scan of abdomen and pelvis in November 2016. Review arranged for December 2016. August 2016 – Review with Consultant Haematologist. Recent CT showed no evidence of lymphoadenopathy and discharged from clinic January 2017 – Review with consultant surgeon uro-oncology. Requesting CT discussed as requested by radiology. Recent report shows increase in left lower pole RCC by few mm but stable mesenteric lymph nodes… March 2017 – CT chest with contrast April 2017 – Letter to GP re results of CT which showed mild apical plural thickening bilaterally and the 4mm right basal pulmonary nodule described in previous CT has now resolved. Awaiting MRI of kidney and discussion at MDM with review after May 2017 – MRI of kidney showed no change in size of left renal lesion when compared with CT in December 2016. For discussion at MDM regarding timing and modality of reimaging as remains on active surveillance June 2017 – Review and letter to GP from Urology. Further renal CT to be performed in November 2017 and review in December 2017 January 2018 – Review and letter to GP re renal CT scan in November which showed no change. Advised that patient should have partial nephrectomy. For discussion at regional small renal masses	07697

		MDM when CT scan of August 2018 is available. Patient advised to attend practice nurse for renal function to be reassessed in July 2018 to facilitate CT scan in August 2018 June 2018 – GP referral to cardiology September 2018 – Review and letter to GP from urology. CT scan from July 2018 showed left renal lesion 3mm. Discussed at MDM and plan that patient remains on active surveillance or proceed with partial nephrectomy. Patient undecided but concluded that a further increase in lesion in renal CT due in March 2019 that he would proceed with partial nephrectomy March 2019 – Review at clinic and letter to GP. Mass in left kidney unchanged on CT compared to July. CT to be performed in November 2019 July 2019 – GP referral routine to general surgery for months of intermittent right lower abdominal swelling September 2020 (?typo) -Letter to patient from urology advising of MDM review. Lesion 3.5mm slowly increasing from 2017. Surgery advised. Up to date CT of kidneys and chest requested and review at clinic after. Repeat kidney function requested at OPD or with GP November 2019 – Review at cardiology. No change to cardiac management January 2020 – Letter to GP from cardio January 2020 – Review at surgical clinic and letter to GP. Confirmed right inguinal hernia and agreed to treat on an expectant basis and advice should hernia incarcerate. Review is more symptomatic August 2020 – Letter to GP from urology. CT renal with contrast carried out in November 2019 shows a stable appearance elsewhere 3.1com lesion L kidney from July 2018 unchanged on CT March 2019. Advised a follow up CT in 12 months and placed on W/L August 2020 – Letter to GP from Urology. CT renal with contrast report. Patient has 3.1cm left kidney mass from July 2018 and this mass is increasing a little bit very slowly in size. Appearance didn't change. Placed on MDM list for discussion	
December 2019	Screening Report	Re: Patient 5	TRU-07013

			TRU-07228 TRU-10059
Undated	Timeline	RE: Patient 5 January 2019 – Discussed at Urology MDM and plan was that Patient 5 had large right renal tumour with no definite evidence of metastatic disease and is to be reviewed by Mr O'Brien on 18 Jan 2019 18 Jan 2019 – advised to have MRI scan to determine whether any extensive involvement of major vessels in abdomen by tumour arising from right kidney. A radioisotope renogram was also requested to quantify the function of left kidney. Patient was also referred to Dept of Cardiology to arrange an echo. Mr O'Brien also arranged a consultation with Anaesthesia to discuss and assess risks posed by surgery. February 2019 – NM Renal DMSA shows photopenia at lower pole of right kidney corresponding with tumour. February 2019 – MRV Inferior Vena Cava shows large 14cm mass in right kidney and likely tumour in right renal vein. February 2019 – Anaesthetic review referral. February 2019 – MDM discussion and plan for Mr O'Brien to discuss with patient and family if surgery is in his best interest February 2019 – Notes that patient to be admitted to department on Wednesday 6th March for right radical nephrectomy.	TRU-07150 – TRU-07155

		March 2019 – Patient admitted for radical nephrectomy for suspected renal cell carcinoma. March 2019 – MDM Discussion plans for Mr O'Brien to arranged a CT in 3 months. March 2019 – Telephone call with consultant which notes that patient has not been feeling well. Advised that anaemia likely to be contributing to that. Mr O'Brien had written to Dr Garland requesting that he issue folic acid tablets to patient also. Mr O'Brien also notes that patient has been referred for CT scan of chest, abdomen and pelvis. June 2019 – CT scan shows no evidence of disease recurrence December 2019 – CT scan shows possible sclerotic metastasis in L1 vertebral body. July 2020 – Virtual clinic (Mr Haynes). Apologies for delay in reverting to patient with scan results. Notes that there is an in determinate area of possible abnormality within one of the bones of patient's spine which requires further assessment with a follow up CT and bone scan. Requested a blood test with GP. August 2020 – CT bone scan booked	
January 2020	Screening Report SEC	Re: Patient 8 Patient underwent TURP on 29/1/20. Pathology reported incidental prostate cancer. No follow-up or action from pathology result until brought to my attention. Outpatient review arranged on 11/8/20 | 08/09/20 - For screening. Notes requested. SAI Level 1. Notification form to be completed. Copy of notes to be Dermot Hughes. 08/09/20 - For screening. Timeline complete. 23.09.2020 Discussed at screening.Notes reviewed no evidence of follow up or action from pathology report, meets criteria for SAI. 12/10/2020 Review team meeting. 21/10/20 - Next review team meeting 02/11/20. Next review team meeting 29/11/2020. Meeting to be aranged to meet with patient/ family. 10/11/20 - Meeting planned for 11.11.20. 09/11/2020 meeting with family, Next review team meeting 30/11/2020 next review team meeting 04/12/2020 29/12/20 - Next meeting 04/01/21. 05/01/21 - Next meeting 18/01/21. 05/01/21 - Next meeting 18/01/21. 02.03.2021 Draft report and overarching report shared with HSCB. 30.03.2021 Patient has accepted draft report and wishes for final report to be issued.	TRU-07553 TRU-10059 TRU-15256
Undated	Timeline	Re: Patient 8 Patient had originally been placed on waiting list for a prostatic resection in October 2014. Admission had been arranged for 18/12/2019 but cancelled due to industrial action. Admission rearranged for 29/01/2020. Patient underwent TURP on 29/01/2020. Pathology reported incidental prostate cancer. No follow-up or action from pathology result until brought to AMD's attention. Outpatient review arranged on 11/08/2020	TRU-07700

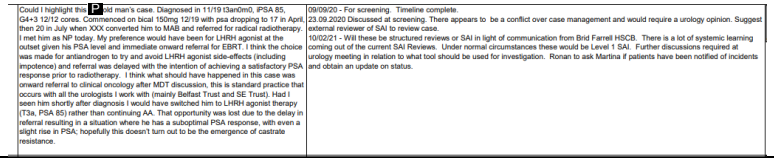
		January 2020 – TURP taken place with Mr O'Brien. Shows modest enlargement of both lateral prostatic lobes. Marked internal sphincteric bladder neck hypertrophy. Bladder neck and prostate resected. 24F catheter. Placed on list for review April 2020. Plan is to remove catheter when urine clear and discharge home. August 2020 – Outpatient clinic with Mr Haynes. Review was arranged as made aware of his pathology which had shown an incidental prostate cancer. Patient 8 has done well following his TURP with an improvement in his urinary symptoms and has good control. Explained the pathology and findings of an incidental prostate cancer and explained a further assessment for up to date PSA and MRI scan of the prostate.	
10.01.2020	Memo to All Medical Staff	Re: Volume of Unsigned Test Results on Craigavon Area Hospital Wards "*As you may be aware there is a significant volume of physical copies of unsigned x-rays and blood results present on wards in Craigavon Area Hospital which date from as long ago as June 2018.* *As you will be aware the ultimate responsibility for ensuring that results are acted upon, rests with the person requesting the test, the ordering clinician should not assume that others who can view the result will take action."*	TL2 page 63 – 66 AOB-04520 – AOB-04523
March 2020	Screening Report	Re: Personal Information redacted by the USI Urology - MDM 19/3/2020. subsequent letter 2/7/20 refers to contacting the patient but no contemporaneous note of this and no letter. | 10/02/21 - For screening - notes requested. Will these be structured reviews or SAI in light of communication from Brid Farrell HSCB. There is a lot of systemic learning coming out of the current SAI Reviews. Under normal circumstances these would be Level 1 SAI. Further discussions required at urology meeting in relation to what tool should be used for investigation. Ronan to ask Martina if patients have been notified of incidents and obtain an update on status.	TRU-11285
Undated	Screening Report	Re: Personal Information redacted by the USI Personal Information old lady – urology – MDM 19/3/2020. Subsequent letter 2/7/20 refers to contacting the patient but no contemporaneous note of this and no letter. 22 October 2019 – GP red flag referral with haematuria, noted to be a heavy smoker November 2019 – Attended for cystoscopy, noted bladder abnormal and likelihood of bladder cancer. Left side of the tumour looks muscle invasive. Introduced to specialist nurse for preop assessment. Plan for CT scan and discussion with MDT. Referred to cancer tracker for MDT once results are available. 11 December 2019 – Admitted for endoscopic resection of bladder tumour under GA. Confident all tumour was resected.	TRU-11585 – TRU-11587

		13 December 2019 – Medically fit for discharge home. Plan for MDM discussion 19 December 2019 – Case discussed at MDM plan for review by consultant to arrange early endoscopic reassessment and resection 3 January 2020 – Clinic Letter – seen at clinic and results discussed. Histological examination showed high grade moderately differentiated papillary transitional cell carcinoma. No evidence of infiltration. Plan to be admitted on 11 March 2020 for cystoscopy and endoscopic resection of any tumour found that day. 19 March 2020 – Case discussed at MDM noted patient has intermediate risk non muscle invasive bladder cancer. Consultant to ring patient and recommend treatment with a course of MMC – intravesical mitomyscin C therapy 28 June 2020- Letter to GP explaining that the MMC chemo therapy was recommended but due to covid 19 this service was suspended. Had noted patient is well and plan for MMC therapy in July 2020 and plan for flexible cystoscopy in October 2020. October 2020 – Attended for 6 week course of MMC chemotherapy. Completed 24.11.2020	
13.03.2020	Email correspondence between Mark Haynes and Consultants	Re Covid "As of Monday a daily surgical meeting will be reviewing planned activity in the context of available nursing staff and any national/regional guidance and determining on the basis of clinical need, which elective procedures will take place in any capacity we may have. These decision will be difficult and will have consequences on the patients. Treatment delays will happen and patients will likely have progression of their underlying disease, particularly if the situation continues for the anticipated 10-14 weeks until peak infection rates"	SUP2 page 81 AOB-04334
April 2020	Screening Report	RE: Personal Information redacted by the USI Urology - MDM 9/4/20. No documentation in notes of patient contact or review until 7/7/20 (dictated 29/6/20) when letter refers to a number of telephone consultations. No documentation of these consultations either in notes or in contemporaneous letters. 10/02/21 - For screening - notes requested. Will these be structured reviews or SAI in light of communication from Brid Farrell HSCB. There is a lot of systemic learning coming out of the current SAI Reviews. Under normal circumstances these would be Level 1 SAI. Further discussions required at urology meeting in relation to what tool should be used for investigation. Ronan to ask Martina if patients have been notified of incidents and obtain an update on status.	TRU-11285
Undated	Screening Report	Re: Personal Information redacted by the USI Jan 2014: Prostate. Benign Nodular hyperplasia. BHSCT PSA NOV 2013 – 8.49 DEC 2013 – 8.66 OCT 2016 – 9.98 NOV 2020 – 1.53	TRU-11585

		Feb 2019 : GP red flag referral to urology for painless haematuria for 2 weeks. Previous TURP 2014 independent sector March 2019 : US Urinary Tract – mild left hydroneprhosis April 2019 : OPD urology – flex endoscopy – nodular regrowth of previously resected prostate gland. Plan – resection and CT urogram. PSA 10.79 Letter to GP in Dec 2019 indicated BD chose to defer surgery until after the summer holidays. Nov 2019 : Elective TURP Nov 2019: Histology shows features in keeping with prostatic adenocarcinoma with an overeall Gleason score 3+4 =7 and Gleason grade group of 2. The tumour occupies approximately 40% of total tissue submitted. Perinureal invasion is present. DIAGNOSIS: PROSTATE. TURP. PROSTATIC ADENOCARCINOMA	
Undated	Screening Report ED	Re: Personal Information redacted by the USI Personal Information old patient referred by GP to CAH ED query torsion to testicle. Patient presented with trauma injury to testicles, complaining of pain, bp raised on observation. Review by urology doctor, advised pain relief and discharged home, mum advised when to return, arrangements made for follow bp in 2 days time, attended ED again for bp check as previously arranged BP normal. Returned again 2 days later severe pain, swelling and redness. Emergency surgery performed which confirmed left testicualr torsion of 360 and complete dead left testicle. Orchidectomy peformed. Letter of complaint recieved from mum not happy that torsion was not identified on first presentation.	TRU-04881
07.05.20	Complaint letter	RE: Personal Information redacted by the USI (Consultant Mr Young & Reg Mr Elbaroni) removed. Personal thought his dad was joking with him . My husband came home to get some clean clothes for Personal and we decided i would stay with Personal as i wanted to speak to the registrar to find out what and why things went the way they did. In the morning it was a different consultant . I told him that I'd like to make a formal complaint . He told me i was within my rights and that he would get a form for me to fill out. I explained to him that I'd put myself at risk by coming to the hospital straight away when it first happened to give Personal Information the best chance of saving the testical. That no scan had been done and this wouldnt have happened and my child would still have two testicals. The consultant said yes i hold my hands up this could of been prevented . Personal has been through so much in his short life . He has had so many surgeries to Personal Information Personal he really didnt need to go through all of this . I am on immune suppressants for my rheumatoid arthritis and i was told to stay in my home for 12 weeks by a letter from my doctor i have to shield. Up until now i havent left the house . I have been so careful with keeping myself safe at this time. Now because of neglect i had to expose myself twice .	TRU-04954 – TRU-04957
13.05.2020	Email correspondence between Mr	Re: Patient update **Mr O'Brien:** *"I have been tracking this man since his admission on 01 April 2020…. I note that*	TL2 page 903 – 904

	O'Brien and Mr Glackin	*Bicalutamide has been discontinued. I noted that he is on the list for urgent review by you in three months time. I just though I should bring it to your attention that the presumptive diagnosis is prostatic carcinoma, and just in case he does not get reviewed in a timely manner…"* **Mr Glackin:** *" Thanks for bringing this to my attention. It raises several important issues regarding handover across site and between specialities…."*	AOB-05360 – AOB-05361
13.05.2020	Email from Mr Glackin to Urology Consultants	RE: Notes and transfer of patient between teams and sites *"A patient under our care with a new clinical diagnosis of prostate cancer who ended up going from DHH to CAH for covid and then Lurgan for rehab has no documentation on ECR relating to his prostate cancer or chronic retention management plan by our team. This could easily have been missed and a significant delay incurred…"* **[unsure of whose patient this refers to]**	TL2 page 905 AOB-05362
14.05.2020	Email from Mr Henderson to Mr Glackin	RE: Complaint *"Recently one of our registrar was told by a consultant colleague of yours (via their reg on that evening this week) that the child is under 5yrs old and cannot be seen locally for their testicular pain and that torsion is rare in this age group and therefore were to be sent to RBHSC. As I have been trained by RBHSC surgical colleagues in this area during my PEM time as a trainee in RBHSC, I assessed the child as I was on the floor at the time and was highly inappropriate that this child needed to be moved down the road. They were discharged directly from Blossom…"*	TL2 page 918 – 919 AOB-05375 – AOB-05376
20.05.2020	Email from Ms Corrigan to Ms Mills	Re: Cancellation of patient procedure due to pacemaker "*I am confused about cancelling due to the pacemaker as this has been sorted with patient having pacemaker sorted pre-surgery next Thursday"*	TL2 Page 949 – 951 AOB-05406 – AOB-05408
22.06.2020	Email from Mr Haynes to Ms Murray	Re: Urology Inpatients **Ms Murray:** *"I understand with the new model of having inpatients in DHH is difficult setting up this new system, given you commitments to the surgical lists, and it is unclear how long it will be going on for – but there has been significant confusion regarding daily reviews of such patients when there is no one available to do so from the urology team. Is it possible to ensure a daily morning review of all urology patients Especially of any patients in the HDU that are very ill"* **Mr Haynes:** *"I was unaware of the presence of any urology inpatients in DHH HDU when I was there*	TL2 Page 1068 AOB-05525

		today and was phoned after I had left the site…"	
30.06.2020	Email chain between Mr O'Brien, Ms Elliot and Ms Poland	Re: Organisation prior to Mr O'Brien's retirement *"When taking calls for Noleen can you be mindful that telling the patients that mr O'Brien has retired and you don't know who will be looking after their treatment may cause them alarm…"* *"Just on the back of this Leanne could you lead on looking at what needs done for Mr O'Brien and divide up/ This will lead to less risk of anything being missed"*	TL2 page 1086 – 1087 AOB-05543 – AOB-05544
28.07.2020	SAI Notification Form	Re: Patient 5 Description: Patient 5 had a follow up CT scan of chest and abdomen and pelvis performed on 17 December 2019 which was reported on 11 January 2020. The indicate for this was restating of current renal carcinoma. Patient 5 had a right radical nephrectomy March 2019. The report noted possible sclerotic metastasis in L1 vertebral body. Result was not actioned. Patient contacted with result on 28 July 2020 and further assessment required	TRU – 07156 – TRU-07158
Undated	Records for Patient	Re: Personal Information redacted by the USI	TRU-05044 – TRU-05183
19.08.2020	SAI	Delay in screening Patient diagnosed with prostate cancer. Follow up CT scan in January 2020 was not followed up	TRU-21593
September 2020	Trust Governance Committee Meeting – Quarterly Report	Re: Litigation Claim Notes that nature of claims up to September 2020 are: 1. Failure to diagnose 2. Birth Injury 3. Failure to provide treatment 4. Failure to supervise 5. Failure to prevent 6. Failure to provide appropriate advice on medication	TRU-20928
September 2020	CSCG Report to Governance	Notes: *" The Trust has a greater number of high severity problems which appears to suggest that complaints*	TRU-21627

		are mots often being made when something has gone very wrong for the complainant. Within the current COVID-19 pandemic the Trust finds itself balancing the stress and strain on staff, against the increasing demand and pressure for services to be "stood up" and delivered in an effective manner. This stress and strain may be evidenced through the current staff survey currently being undertaking by the Trust, which will assist with the identification of improvements and learning, as well as supports. Through this investment, it would be hoped to see a decreased in complaints made regarding communication towards service users. Additional staffing levels, which were already under pressure have been further affected by the current pandemic, which has required large numbers of staff to be redeployed or/ and self-isolate, having a further impact on service delivery"	
09.09.2020	Screening Report	Re: Patient 101  Could I highlight this P[redacted]ient man's case. Diagnosed in 11/19 t3an0m0. IPSA 85, G4+3 12/12 cores. Commenced on bical 150mg 12/19 with psa dropping to 17 in April, then 20 in July when XXX converted him to MAB and referred for radical radiotherapy. I met him as NP today. My preference would have been for LHRH agonist at the outset given his PSA level and immediate onward referral for EBRT. I think the choice was made for antiandrogen to try and avoid LHRH agonist side-effects (including impotence) and referral was delayed with the intention of achieving a satisfactory PSA response prior to radiotherapy. I think what should have happened in this case was onward referral to clinical oncology after MDT discussion, this is standard practice that occurs with all the urologists I work with (mainly Belfast Trust and SE Trust). Had I seen him shortly after diagnosis I would have switched him to LHRH agonist therapy (T3a, PSA 85) rather than continuing AA. That opportunity was lost due to the delay in referral resulting in a situation where he has a suboptimal PSA response, with even a slight rise in PSA; hopefully this doesn't turn out to be the emergence of castrate resistance. 09/09/20 - For screening. Timeline complete. 23.09.2020 Discussed at screening. There appears to be a conflict over case management and would require a urology opinion. Suggest external reviewer of SAI to review case. 10/02/21 - Will these be structured reviews or SAI in light of communication from Brid Farrell HSCB. There is a lot of systemic learning coming out of the current SAI Reviews. Under normal circumstances these would be Level 1 SAI. Further discussions required at urology meeting in relation to what tool should be used for investigation. Ronan to ask Martina if patients have been notified of incidents and obtain an update on status.	TRU-11286
23.09.2020	SAI	Delay in Screening Patient underwent TURP on 29 January 2020. No follow up on pathology result which showed prostate cancer	TRU-21593
October – December 2020	CSCG Report to Governance Committee	Notes: In October – December 2020 data 81.1% of problems are system which given current waiting times and access to services being limited is to be expected in the current circumstances.	TRU-21677
11.10.2020	Letter of complaint	Re: Personal Information redacted by the USI "*My name is* Personal Information redacted by the USI*, date of birth* Personal Information redacted by the USI*, NHS number* Personal Information redacted by the USI*, Hospital Number* Personal Information redacted by the USI*. On or about 15th September 2020 I underwent surgery at Craigavon Area Hospital in order to install a stoma. The following days were filled with intense pain and suffering; the stoma did not function and there were no signs of improvement or recovery. During these days, when I was receiving no relief from the stoma, the medical staff continued to ply me with Movicol, which only seemed to worsen the issue. I became pyrexic, hypoxic, hypotensive and tachycardic. On or about Saturday 19th September 2020, having undergone a CTAP, I underwent a further surgery in order to resolve the matter. During this surgery it was discovered that the initial stoma installation procedure was incorrectly conducted, with the stoma having been formed from the distal end of the colon as opposed to the proximal end. This, in essence, meant that there was no possible way in which I could have passed waste during the days in which I was frequently given laxatives. As you will no doubt be aware, this could have proved fatal.*	TRU-08708 – TRU-08709

		The negligence in the conduct of the initial surgery of Tuesday 15th September 2020, and the treatment afterwards, put my life in jeopardy. Following the second surgery my wife received a call from Craigavon Area Hospital informing her that this was the cause of the pain and discomfort, with the individual on call telling her that it was "their fault". Following this second surgery, which was required only to resolve the mistakes of the surgical team in the initial surgery of 15th September 2020, I conveyed to the ICU on or about Saturday 19th September 2020. My Daughter phoned the hospital on the evening of Saturday 19th September 2020 and was informed that I was critical; that I was requiring assistance to breathe, that I had high blood pressure, and irregular heartbeat, and that I was sedated. She was further informed that the Hospital would phone each morning with an update. No such call ever occurred, with my Wife or Daughter instead having to telephone the hospital to request information. I spend a period of 4 days in ICU, during which my family were, for the most part, kept in the dark about my situation. It has been accepted by the Hospital that there was an error in conduct in the initial surgery on or about Tuesday 15th September 2020. This is confirmed in the discharge letter I received. As a result of this negligence, I spent three days in intense pain and suffering. I then underwent a second and entirely avoidable surgery, which led to a prolonged period of sedation, inability to breathe by myself, hypotension and a stay in ICU. As a result of this, I suffered considerable physical and mental distress and trauma, which I continue to experience. I wish to make a formal complaint regarding the conduct of my initial surgery on or about 15th September 2020, which was the sole reason for the conducting of a second surgery on or about 19th September 2020, and the treatments I received following the initial surgery on or about 15th September 2020. I understand that a full response to this complaint is to be received by myself within 20 working days. I look forward to this response."	
20.10.2020	SAI	Delay in Screening Patient diagnosed with prostate cancer Gleason 7. MDM 08/08/19 - significant lower urinary tract symptoms but declined investigations. On maximum androgen blockade. No onward oncology referral was made	TRU-21643-TRU-21644
21.10.2020	Screening Report SEC	Re: Personal Information redacted by the USI **Background**: Complaint from patient. Underwent surgery to have stoma fitted. On the days after suffered intense pain, stoma did not function and there was no signs of improvement. After a further CTAP patient underwent further surgery. Initial stoma was formed at the distal end of the colon as opposed to the proximal end of the colon. Currently being investigated under complaints procedure. **Screening update**: 21/10/20 - for screening. Potential level 1 SAI. Notes requested for review prior to appointment of panel. 21/10/20 - for screening. Potential level 1 SAI. Notes requested for review prior to appointment of panel. 27/10/2020 Notes received. 28/10/2020 - Discussed at screening LEVEL I SAI, surgical issue, no need for anesthetics to be on this case, to select next surgeon off the list to review case. 03/11/2020 Notification to be completed.	TRU-08702 TRU-09086 TRU-10057

		03/11/2020 Notification to be completed. Need to agree a second panel member for SAI review. 16/11/20 - Need to agree second panel member. 01/12/2020 Ronan has nominated David Mark, Richard Thompson to chair. 02/12/20 - First meeting of review team to be organised. 08/12/20 - No update. 01/12/2020 Meeting with patient. 15/12/20 - Mr Thompson advised not to chair as has had no training. Need a new chair. 06/01/20 - David to forward to Ronan current list of Surgeons who have had SAI training.	
21.10.2020	Screening Report SEC	Re: Patient 3 Diagnosed with penile cancer, recommended by caner MDM for CT scan of Chest, Pelvis and Abdomen to complete staging. Same delayed by 3 months. — 21/10/20 - Datix to be completed. 21/10/20 - Datix to be completed.02/11/2020 Review team meeting. Next review team meeting 29/11/2020. Meeting to be aranged to meet with patient/ family. 10/11/20 - Meeting planned for 11.11.20. 09/11/2020 meeting with family, Next review team meeting 30/11/202030/11/2020. Next review meeting 07/12/2020 next review team meeting 04/12/2020 29/12/20 - Next meeting 04/01/21. 05/01/21 - Next meeting 18/01/21. 05/01/21 - Next meeting 18/01/21. 02.03.2021 Draft report and overarching report shared with HSCB.Final report to HSCB/ Family 20/04/2021	TRU-08702 TRU-10059 TRU-15256
28.10.2020	Letter of Complaint	Re: Personal Information redacted by the USI *"Please accept this as a formal complaint of lack of services and communication for the NHS care of my mum. Please escalate this as a matter of priority.* *My mum has now had bowel cancer for over a year which was misdiagnosed last year with the Consultant team she was under stating she had haemorrhoids and nil further was required accept an operation to treat this at some stage in the future. At that time I specifically requested a colonoscopy which was declined.* *As my mum continued to have symptoms she finally had a colonoscopy around 8 weeks ago which showed colon-rectal cancer with no metastatic spread evident from MRI and CT. Directly following colonoscopy I specifically requested that her Consultant confirm that they would be happy to refer her to the Marsden at which time they agreed (Around 8 weeks ago). When seen by Mr Epanomeritakis he confirmed this agreement and it has taken nearly 4 weeks, with me following this up every other day, to finally receive the letter denying my mum's care which I note was dated over a week ago on 22nd October.* *My mum is residing at my home for the foreseeable future and as such is not able to attend any care in NI.* *I would now like a formal clinical investigation as to why a colonoscopy was not carried out in the first instance.* *I will also be looking a remuneration for having to pay my mum's care given the length of time of delay and increased likelihood of metastatic spread.*	TRU-09278 – TRU-09279

		I require my mum's reports for a private appointment with the Marsden. Please send these either to my private or NHS email address today. I shall forward on the requirements of this once confirmed with the Marsden. *I can not be more disappointed in a service I work very hard for."*	
29.10.2020	SAI	Delay in Screening *"Patient diagnosed with a slow growing testicular cancer (Seminoma) had delayed referral to oncology and therefore delay in commencing chemotherapy"*	TRU-21642
29.10.2020	SAI	Delay in Screening *"Diagnosed with penile cancer, recommended by cancer MDM for CT scan of Chest, Pelvis and Abdomen to complete staging. Same delayed by 3 months."*	TRU-21642
12.11.2020	SAI	Delay in Screening Diagnosed with high grade prostate cancer July 2019. MDM outcome to commence an LHRHa, arrange a CT chest and bone scan and for subsequent MDM review. MDM recommendations not followed. Patient now deceased	TRU-21642
16.11.2020	Screening Report SEC	Re: Personal Information redacted by the USI **Background**: Please accept this as a formal complaint of lack of services and communication for the NHS care of my Mum. Please escalate this as a matter of priority. My Mum has now had bowel cancer for over a year which was misdiagnosed last year with the Consultant team she was under stating she had haemorrhoids and nil further was required accept an operation to treat this at some stage in the future. At that time I specifically requested a colonoscopy which was declined. As my Mum continued to have symptoms she finally had a colonoscopy around 8 weeks ago which showed colon-rectal cancer with no metastatic spread evident from MRI and CT. Directly following colonoscopy I specifically requested that her Consultant confirm that they would be happy to refer her to the Marsden at which time they agreed (around 8 weeks ago). When seen by Mr Epanomeritakis he confirmed this agreement and it has taken nearly 4 weeks, with me following this up every other day, to finally receive the letter denying my Mum's care which I note was dated over a week ago on 22nd October. My Mum is residing at my home for the foreseeable future and as such is not able to attend any care in NI. I would now like a formal clinical investigation as to why a colonoscopy was not carried out in the first instance. **Screening update**: 16/11/20 - For Screening. Notes requested	TRU-09264
16.11.2020	Screening Report SEC	Re: Personal Information redacted by the USI Patient admitted with abdominal pain. USS confirmed gallstones and oedematous pancreas. Initial diagnosis and treatment being gallstone pancreatitis. Rapid deterioration and transfer to ICU. CT following day reported as normal pancreas, but free fluid and ischaemic changes in small bowel. Laparotomy confirmed oedematous pancreas and patchy ischaemia of small bowel with patchy areas of mesenteric necrosis. No intervention performed. Outlook looked very grave. With post op ICU treatment the patient improved to a degree that the patient was awake needing no inotropic support. Transfer to the surgical ward. The following morning the patient vomited, aspirated and needed transfer to ICU for intubation. After continued deterioration and increasing need for inotropic support. She eventually died later that day. 16/11/20 - For Screening. Notes requested	TRU-09264 TRU-

		16/11/20 - For Screening. Notes requested 24/11/2020 Email sent to Mr McElvanna sec for notes. 24/11/20 - Refer to R Haffey for M&M - Joint Surgical and Anaesthetic and await outcome. 27/11/2020 Meeting with SAI, review team to be nominated. 02/12/20 - Governance view that panel should include an external surgeon and an anaesthetist. Clinical team highlig process is M&M which is scheduled for 15 December. This is the accepted process nationally and jumping ahead wit undermine that process. Issue remains communication with family and who will meet with them. Damian to discuss and/or Dr Diamond. and/or Dr Diamond. 09/12/2020 Meeting with family, Melanie McClements and Dr Diamond. For M&M presentation 15/12/2020. 7/12/2020 Discussed at screening, this case was presented at M&M, consensus from 60 clinicians this is not an SAI and do not feel SAI should be completed simply because family are demanding one, this is not appropriate process. Damian advised information family have requested is currently being collated 65 protocols. Patricia advised family are quite dismissive of M&M process and will push for an SAI and Coroners case. Discuss next week.	09509 TRU-09804
December 2020	Email correspondence between Ms Kingsnorth and Hugh Gilbert	Re: Patient 112 Ms Kingsnorth: *"I have been asked if you could assist me some independent view regarding screening for this case. He will not be part of the SAI group but may need to have an SAI separately if required.* *..* *This gentleman has a renal carcinoma. He was also attending haematology with lymphoma and preparing for chemotherapy when a CT scan showed a renal lesion which required biopsy. MDM made a recommendation to biopsy the kidney. This did not happen as the consultant (in his letter dated 16 August 2019) explained why this didn't happen in view of the patient currently undergoing chemotherapy and with his factor V111 condition. This was not fed back to MDM.* *The question is given what appears to be a reasonable reason for the delay to action MDM outcome and not feedback to the MDM does that make this an SAI? However I will point out the letter was not written until October 2019.* *There does not appear to be a proper process for feeding back to MDM and this will be one of the learning from SAI. Can you advise if this was a reasonable approach for this gentleman particularly if it had been with any other practitioner?"* Mr Gilbert: *"This case does not raise any alarms in my head.* *The patient presented to the haematologists in March 2019 with LN enlargement and a biopsy (April 2019) confirmed a follicular lymphoma. As part of his assessment a CT had shown a renal lesion, which was further characterized by a PET CT and pointed to a coincidental kidney cancer. This was discussed at the urology MDT and a biopsy was recommended.*	TRU-09828 – TRU-09833

		Significantly, the patient had low factor V111 (haemophilla) and was about to start 6 cycles of chemotherapy for the lymphoma. He also had a cardiomyopathy and a past history of papillary thyroid cancer. *He was seen by AOB with the written plan to reassess after restaging. It is reasonable to assume he meant post chemo staging. The biopsy was, in my opinion, reasonably deferred; the potential complications, infection, haematoma spread during immunosuppression, or even loss of the kidney outweighed any benefit in knowing the histology.* *A letter describing this plan was not generated until October 2019. This caused unnecessary concern and work for AOB's colleagues.* *Nephrectomy proceeded after the chemotherapy (successful) was completed.* *There is a nodule in the lung fields, which may represent a metastasis. This must be discussed at a specialist MDT (Belfast) to consider the timing of adjuvant treatment.* *My only observation is that the reasonable change of plan should have been discussed in the MDT in a timely fashion. I don't think the patient suffered any harm as a consequence of this omission. I don't think this amount to a SAI.* *As an aside, I would be very interested in the histology of the kidney tumour. The combination of papillary thyroid cancer, renal neoplasia and follicular lymphoma points towards a genetic cause."*	
December 2020	Screening Report	Re: Personal Information redacted by the USI Probable hospital acquired COVID-19 infection. Admission from 18th-22nd December' 20 under urology in 4 south. Transferred to Lurgan, in ward 3 from 22nd Dec to 13th Jan'21. Discharged home, tested COVID positive in community 17th Jan'21 and readmitted to CAH 20th Jan'21 with COVID pneumonia. Sadly passed away Personal n 4 south 08/02/21 - For screening. Datix noted. Not for SAI. CLOSE	TRU-11057
January – March 2021	CSCG Report to Governance Committee	Notes: A high number of second, third and fourth problems indicate that the complaints are reporting more complex and systemic issues. In the January – March 2021 data 49.6 % of problems are systemic.	TRU-21741
January 2021	Screening Report	Re: Personal Information redacted by the USI (?Urology) Background: Patient transferred from male medical for renal biopsy in x-ray on Tuesday 26 January 2021. Patient bled post procedure and was transferred to theatre. Continued to deteriorate and transferred to RVH ICU. Patient suffered arrest and is now ventilated. Screening update: 26/01/21 - Imran advised there was regional guidance for such instances and that radiology team followed this. Stabilise patient, resuscitate if necessary and transfer to Belfast. Appreciates that there were other circumstances around this incident e.g., transfer from DHH to CAH and communication which can be learned from. 04/02/21 - Discussed at MUSC screening on 01/02/21. Team felt that issue should be led by radiology. Imran advises from a radiology point of view the procedure was planned, requested and conducted in an appropriate manner. 10/02/21 - Level 1 SAI. John Harty nominated as chair. Radiology to be asked for a representative.	TRU-10943
January 2021	Interface Incidents	Re: Personal Information redacted by the USI	TRU-10944

	Notification Form	Description: Patient A ([redacted]) was transferred from Daisy Hill to CAH for a renal biopsy which was performed in CAH at 16.30hrs on 27/01/21. Patient A bled post procedurally into the renal tract requiring extensive resuscitation. The Interventional Radiologist on call in RVH was contacted about the case at approx. 17.30 and recommended transfer to BHSCT for embolization under the care of urology. Further communication ensued over the next few hours. It is BHSCT's understanding that it was agreed that a critical care transfer was initially planned for the patient and this was handed over to the Consultant Urologist in BHSCT who had accepted the patient. However the patient subsequently improved and the plan changed resulting in the patient being transferred without an agreed speciality bed to go to. On arrival in RVH significant confusion arose as to where the patient was to be managed and under the circumstances, the IR team agreed to facilitate the clerk in within the IR department and to proceed with the intervention, balancing the risk of waiting for a bed to be confirmed and made available. Intervention was carried out in the form of angiogram only. Patient A was transferred to the urology way post procedurally and experienced acute deterioration approximately one hour after his arrival there. Matters were appropriately escalated and Patient A was taken to theatre and then onto HDU were he is currently intubated and ventilated. BHSCT staff have undertaken a hot debrief and local SEA in respect of events involving our imaging/urology and Anaesthetic teams and would be keen to share this with CAH colleagues once it is finally approved.	
Undated	Screening Report	RE: [redacted]	TRU-15988 – TRU-15991

13:50	Transferred to x-ray for biopsy.	
15:00	Returned to ward post biopsy. NEWS 4. Sats 90% on room air. Commenced on 3L oxygen via nasal cannula. HR 70, BP 124/68, RR 20, T 35.9. SRC insitu and haematuria noted. No complaints of pain at time. Wound site clean and dry. Plan – to remain on bedrest for 6 hourly observations with close observation. Patient to remain in CAH and Dr Harty spoken to by Dr McConville because of haematuria.	Nursing
15:30	Increasing frank haematuria noted with increasing pain and discomfort. Large clots noted in catheter tubing and bag. Dr contact and updated. Dr Fiona (urology reg) seen patient within minutes of being informed. SRC catheter changed to size 22 fr catheter and irrigated ++. Large clots passed ++. Bladder irrigation commenced. Dr Khan informed and seen patient. NEWS 2 – 5 with oxygen continuing throughout 3-10L. Plan for CT scan. Scan carried out. 4 units of blood required with 2 units of FFP. 3 litres of IV fluids. Blood gases obtained. Family contacted and updated – spoken to by Dr Khan.	Nursing
17:45	Urology Team Review – Written in retrospect. ATSP haematuria following left renal biopsy. Frank haematuria – large volume. BP at time was 150 systolic and patient alert, orientated but in pain. Multiple bladder washouts as catheter blocked repeatedly and caused spasms/pain – bypassing. IV access. Bloods. Coag. Cross Match etc sent. Discussed with Dr McConville. No concerns at time of biopsy. CT Angio organised – active bleed into calyx. 2 units (pre CT) PRC. Results discussed with Dr Worthington IR in BCH (BP – 100 systolic, pH on ABG 7.35). happy to accept for attempted embolization. 2 units of PRC post CT. 2 units of FFP.	Mr N Khan Mr J Atkinson Ms Gribben
18:10	Patient deteriorated. NEWS 8. BP reduced to 69/36. Sats 100% on 10L. Patient became agitated. Crash team called.	
18:10	Fast bleeped to transition ward at 18:10 – attended immediately. 53 year old male in-patient DHH since 15/1/21 with increasing shortness of breath and oedema, CCF and AKI, +/- liver failure. Distressed. USG renal biopsy in CAH today. Large volume frank haematuria. CT. Reduced BP. 60 systolic. 4 units PRC, 2 units FFP. CT angio aorta: acute haemorrhage left lower pole. Calyx secondary biopsy. Obstructing haematoma left proximal ureter and hydro ureter. Acute blood left paracolic gutter and pelvis. 1g TXA given.	Dr L Parkes Consultant Anaesthetist Dr S Maughan ST7 Anaesthetics

HCN: Personal Information

	Transferred to theatre 1 for resuscitation and stabilisation. Accepted for embolism by IR BHSCT.	
18:10	Resus call to Mr Graham. Peri-arrest. Patient brought to theatre 1 for resuscitation. Patient had a renal biopsy earlier in the day and ? bleeding. 4 units of blood and 2 FFP given on ward. Arterial line inserted in theatre. Catheter blocked. Urology Registrar re-catherised patient at 19:10 hours with size 24 3 way catheter. Irrigation recommenced. Bloods taken and sent to lab at 19:25 hours. Further 2 units of blood given. Catheter continues to block. Irrigated by Urology Consultant. To be transferred to RVH once stable.	SN D Austin
18:20	Concerns re BP 90-95 systolic and loss of consciousness. Peri-arrest. Bleep called. Discussed with ICU (Dr Clarke) bed available when bleeding controlled. Plan stabilise. Transfer to RVH for embolization. ICU input welcomed. If patient does not improve or if not safe to transfer will require nephrectomy.	Mr J Atkinson
18:45	Daughter contacted and updated. Distressed as expected when spoken to and reassured. Oromorph 5mg given at 16:20 Morphine 5mg IV given at 18:00 Tranexamic acid 1g IV at 18:10 2 units of FFP checked by Dr Jay (urology reg) and not signed for. FFP labels for 2 units of blood missing too – add to emergency massive blood loss for blood component prescription.	Nursing
19:00	On 4th unit PRC and 2 X FFP. Awaiting platelets. Discussed with Consultant Haematologist. Advice – repeat coagulation screen, platelets, calcium. If abnormal then discuss with haematology. NOVO-7 is an option but carries high risk of MI/PE/DT.	Dr N Khan
No time	Discussed with on call anaesthetic SPR in RVH – informed about patient and incident today. Patient will be attending IR in RVH without anaesthetic accompaniment. Patient discussed with A Boyle (RICU) – aware but will need re-referred if required once in RVH – not accepted.	Anaesthetics
21:00	Discussed with Dr Worthington IR Consultant on call at RVH. He has kindly agreed to embolise. Discussed with urology team on call and made aware of this patient. Anaesthetic team here will contact anaesthetic team in RVH re HDU/ICU management +/- transfer.	Dr N Khan
21:20	Spoke to his daughter Personal Informatio Informed of plan and his condition.	Dr N Khan
22:35	Patient has been accepted by interventional radiology in RVH as per Dr Khan. Also has been discussed with anaesthetics team – see anaesthetics note. Decision made by Dr Lowry and Dr Khan/Dr Omer	Sr Charlene Latimer Theatres

	that will accompany patient to RVH in blue light ambulance. Organised by Dr Khan. History of patient given by Dr L Gray and Dr Khan awaiting ambulance. Patient remains stable. Clinical observations recorded.	
22:39	Transfer to RVH.	
27/01/21 No Time	Emergency Procedure – bleeding post left renal biopsy. Right common femoral access. Left renal angio. Selective – no bleeding point. Heparin and GTN challenge. 1500IU and 200mcg IA to renal bed. Anterior no bleed, 5 min delay. Angio no bleed. Angioseal – Haemostasis at right groin. Plan – regular observations, repeat angio if bleeding vie catheter or reduced BP.	Dr Worthington Consultant Radiologist BHSCT
27/01/21 01:00	Patient Accepted For Transfer From CAH. Personal Old Male Frank Haematuria Following Left Renal Biopsy. Profuse Bleeding. Peri-Arrest. 6 Units PRC. 2 Units FFP. CT Acute Haemorrhage Left Lower Pole. Stabilised For Transfer. On Arrival: A – Own And Facemask (4L) B – RR 18, Spo2 100% C – BP 134/79. HR 92 D – T 36.7 E – 24 Fr 3 Way Catheter In Situ. Light Rose With Irrigation. Ur 14.4 K 5.1 Cr 403 Na 14.5 Egfr 14 Hb 84 WCC 13.1 Plan – Embolise. G&H. Cross Match 2 Units. IV Antibiotics. Irrigation To Continue. Chest X-Ray. Pmhx – Sob On Admission To DHH. AKI On CKD. Pulmonary Oedema And CCF. Ascites secondary To Alcoholic Liver Disease. *No Bleeding Point Identified At Interventional Radiology*	Dr A McAdam Urology BHSCT
02:30	Patient brought straight to interventional radiology from Craigavon Theatres. No nursing handover received. No documentation for transfer from medical staff. Contacted Craigavon Theatres – they report patient had a biopsy of left kidney following some frank haematuria, bleeding ++ and per-arrest. Patient received 6 units PRC and 2 units FFP. 1.5l sodium	Sr S Topping BHSCT

		HCN: Personal Information chloride0.9% and 2 litres of Hartmann's. BP systolic 80, pulse over 100. On 25/1/21 fasting from 18:30. Urology reg contacted when patient arrived into department. Explained it is not protocol for patients to come to IR from ambulance. HDU contacted – not aware of patient and reported he is not for their care. Urology reg stayed with patient during procedure and contacted anaesthetics for input if required. Full bloods sent including a group and hold. Observations remained stable during procedure. No bleeding points found. Angiogram only.	
Undated	Screening Report	Re: Personal Information redacted by the USI **Background**: Kardex written during the night of Fri 29th May - Sat 30th May: 1. Apixaban prescribed once daily instead of twice daily. 2. Prednisolone 5mg once daily (long term) not prescribed on the Kardex. 3. Buprenorphine patch prescribed at 5microgram/hr dose instead of 15microgram/hr. 4. Levothyroxine prescribed at 175microgram/day (and received this dose) instead of 100microgram/day from Mon-Fri inclusive and 75microgram/day on Sat&Sun. 5.Memantine prescribed at 5mg/day instead of 20mg/day. 6. Atorvastatin not held in spite of co-prescription of clarithromycin. 7. No signature for prescription of Spironolactone. 8. Cetirizine - missing from Kardex. 9. Lactulose - missing from Kardex. 10. Cetraben - missing from Kardex. **Screening update**: For screening, notes requested. Discussed at screening, patient had multiple co-morbidities and dete normal, to be dealt with through datix system. Not SAI CLOSE.	TRU-06066
Undated	Patient records	Re: Personal Information redacted by the USI	TRU-06069 – TRU-06087
Undated	Screening Report SEC	Re: Patient 4 For screening- to be screened- To forward details to Ronan. Timeline to be completed. Datix needs submitted in order that notification can be made to HSCB. 27/10/2020 Datix to be submitted before notification can be forwarded to HSCB. 02/11/2020 Review team meeting. Next review team meeting 29/11/2020 Meeting to be aranged to meet with patient/ family meeting. Next review team meeting 29/11/2020 Meeting to be aranged to meet with patient/ family. Meeting planned for 16.11.20. 17/11/2020 Meeting with family. Next review team meeting 30/11/2020. Next review meeting 07/12/2020 14/12/2020 next review team meeting 04/12/2020. 29/12/20 - Next meeting 04/01/21. 05/01/21 - Next meeting 18/01/21. 02.03.2021 Draft report and overarching report shared with HSCB. 16/03/2021 Report shared with patjent/ family. 19/04/2021 Final report to HSCB/ Family 20/04/2021	TRU-08702 TRU-09087 TRU-15255
Undated	Timeline	Re: Patient 4	TRU-08710 –

		Jan 2019 – Attended nurse led urology appointment for trial removal of catheter. Removed and by 2.30pm he had not yet voided and had no desire to. A bladder scan was taken which identified a volume of roughly 300mls in his bladder. Patient explained he had ongoing LUTS and urinary symptoms in preceding months prior to this and that they were increasing in severity. PSA was in normal range. A decision was made that patient should undergo a TURP. June 2019 – Patient admitted for TURP. For repeat bloods with GP in 1 week and follow up with Mr O'Brien with results of histology TURP pathology report – Prostate TURP adenocarcinoma. Geeson score 5+5=10probable lympovascular invasion seen though no perneural invasion identified. July 2019 – Discussed at MDM. To be reviewed on 20 August 2019. Plan – patient has a high grade prostate cancer on his TURP pathology. There is no evidence of metastases on a CT abdomen/pelvis. Patient to be reviewed in outpatients, commence on LHRHa, arrange a CT chest and bone scan and for subsequent MDM review. August 2019 – Outpatient review. When patient was reviewed he reported moderately severe urinary symptoms of a storage nature. Mr O'Brien requested a CT scan of chest and bone scan. Also requested an ultrasound scan of his urinary tract. No evidence of any metastatic disease on CT scanning postop. PSA normal. Testosterone was low. Patient advised to stop taking Tamsulosin. Initiated a minimum degree of androgen blockade by prescribing Bicalutamide 50mg once daily in order to assess its tolerability. Since had telephone call and reported he is suffering poor appetite in addition to nausea and vomiting. No longer has urge incontinence. Reported was experiencing difficulty in achieving satisfactory bladder voiding and has resorted to self-catheterization. Arranged for flexible cystoscopy and urodynamic studies for 1 November 2019. October 2019 – Urgent CT chest and US kidney tract ordered. US Urinary tract – right kidney moderate hydronephrosis echogenic urine in urinary bladder. November 2019 – Outpatient review. Attended for flexible cystoscopy and urodynamic studies on 1 November as planned. Symptoms remained unchanged. Dominant finding was that of chronic urinary retention without any evidence of bladder outlet obstructions. Radioisotope bone scanning on 15 November 2019 and MRI of spine was advised. CT chest took	TRU-08715

		place 27 November with no evidence of metastatic. Plan to review in December 2019 and arrange spinal MRI. Jan 2020 – ED attendance. Admitted to urology ward. Transurethral resection & insertion of left ureteric stent. Was found to have high grade prostate cancer. February 2020 – Discharged but returned to ED. Patient was reviewed in outpatient clinic. Most significant finding was PSA level increase. Had right nephrostomy drain capped and administered 1st maintenance dose of 80mg Degarelix. Patient's wife contacted consultant to advise that patient unwell since having right nephrostomy drain capped. Arranged to attend inpatient and free drainage of urine from right nephrostomy drain was restored. March 2020 – Patient more comfortable. Requested palliative care nurse specialist to arrange an assessment of needs. Follow up with Mr O'Brien in 2 months. May 2020 – Attended for Nephrostomy change. Personal Information – Deceased	
Undated	Screening report	References an "urology incident" regarding delayed prostate cancer treatment. Will bring to screening next week. This was highlighted by Ronan Carroll	TRU-06796
February 2021	Screening Report	Re: Patient 100 Urology - Diagnosed with prostate cancer 2010. Multiple outpatient attendances with no correspondence. commenced on palliative androgen deprivation therapy, unclear if alternative curative treatment options or watchful waiting discussed. Unclear if MDM discussion occurred but MDM processes may not have been fully running at the time of diagnosis. 10/02/21 - For screening - notes requested. Will these be structured reviews or SAI in light of communication from Brid Farrell HSCB. There is a lot of systemic learning coming out of the current SAI Reviews. Under normal circumstances these would be Level 1 SAI. Further discussions required at urology meeting in relation to what tool should be used for investigation. Ronan to ask Martina if patients have been notified of incidents and obtain an update on status.	TRU-11285
Undated	Screening Report	Re: Patient 100 Urology – diagnosed with prostate cancer 2010. Multiple outpatient attendances with no correspondence. Commenced on palliative androgen deprivation therapy, unclear if alternative curative treatment options or watchful waiting discussed. Unclear if MDM discussion occurred but MDM processes may not have been fully running at the time of diagnosis. 2010 – Diagnosed with benign prostate hypoplasia	TRU – 11588

		June 2010 – Diagnosed with Gleason 3+4=7 No referred to MDM April 2016 – GP referral for haematuria. Commenced on bicalutamide and tamoxifen October 2020 – GP request to review in view of haematuria – seen by consultant	
11.02.2021	CSCG Report to Governance Committee	Notes *"A high number of complaints with multiple problems indicates that the complaints reported are more complex and systemic issues are prevalent. In October – December 2020 data 81.1.% of problems were systemic which given current waiting times and access to services being limited is to be expected in the current circumstances…"*	TRU-21677
February 2021	Screening Report	Re: Patient 58 Urology - Initial prostate cancer treatment with bicalutamide 50mg daily - not licensed dose and outside of guidance. Does not appear to have been offered alternative treatments to palliative Androgen deprivation therapy. | 10/02/21 - For screening - notes requested. Will these be structured reviews or SAI in light of communication from Brid Farrell HSCB. There is a lot of systemic learning coming out of the current SAI Reviews. Under normal circumstances these would be Level 1 SAI. Further discussions required at urology meeting in relation to what tool should be used for investigation. Ronan to ask Martina if patients have been notified of incidents and obtain an update on status.	TRU-11285
Undated	Screening Report	Re: Patient 58	TRU – 11589 – TRU-11592

Initial prostate cancer treatment with bicalutamide 50mg daily - not licensed dose and outside of guidance.Does not appear to have been offered alternative treatments to palliative Androgen deprivation therapy.
Seen Sept 2015 and not reviewed in Dec 2015. Next seen March 2017. Delay from December 2017 to Jan 2019 for TURP. Regrowth of resected prostate gland but no malignancy in histopathology. Active surveillance for prostate CA from 2012.Discussed MDM in 2017

Date/ Time	Summary Of Events	Staff
9/5/08	US kidneys full bladder – kidneys normal, no obstructive uropathy.slight trabeculation bladder wall.prostate 64ccs ICATS clinic – plan for TRUS biopsies and r/v after.	
20/5/08	Trus Biopsy clinic. Prostatic biopsy pathology report Both cores 25% geason 3+4 =7 adenocarcinoma.	
3/6/08	OPD urology clinic. CA prostate – book MRI and bone scan	
13/6/08	NM bone static – no evidence of bony mets	
30/7/08	Carcinoma prostate PSA 5.2 MRI prostate. Appearances consistent T2a disease.	
20/10/08	MRI –ve, Bone scan –ve. For AM. PSA in 3/12.	
12/1/09	PSA 5.9.stable LUTS.PSA in 3/12 + 6/12. See in 6/12 OPD.	
4/1/10	PSA increased ? 12 1. Re TRUS Bx 2. PSA 3. Start Rx. PSA 7.92	
17/2/10	PSA 7.5. PSA in 3/12. Prostate clinic.	
6/8/10	ICATS urology clinic. PSA on 29/7/10 7.41r/v 3/12.	
22/10/11	r/v OPD. PSA 8.41on 13/10/10.r/v 3/12	
14/1/11	PSA 5/1/11 7.51 arrange biopsies Feb 2011.	
1/2/11	Bx 1/2/11. Prostatic biopsy pathology report Prostatic adenocarcinoma gleason score 3+3 =6. Tumour present in total 3/10 of the cores.	
13/4/11	MRI pelvis prostate. appearances suggest T2 disease.	
16/5/11	PSA 11.4 urology clinic. r/v aug 2011	
10/6/11	PSA 7.93	
13/08/11	urology clinic r/v – no notes made	
7/2/12	urology r/v clinic- no notes made	
8/6/12	TURP – large occlusive prostate.trabeculated bladder.resection.	
23/7/12	Histology clinic – plan urine culture, ciproxin, urgent US testes.6/12 PSA check.	
10/8/12	PSA 7.90	
29/2/12	PSA 7.65. Patient 58 seen 25/2/12. On W/L TURP	

		9/6/12	C reactive protein 10.79 U&E Normal range FBC			
		18/7/12	Letter to GP histology confirms benign nodular hyperplasia.on active surveillance for prostate cancer. Voiding since operation but pain in groin/scrotal area. Dipstick urine – small amount blood and leucocytes.differential diagnosis epididymitis or small inguinal hernia.urine for culture . c/o ciproxin.PSA in 6/12.			
		10/8/12	PSA 7.90			
		28/9/12	6 week post TURP US Testes normal in size,shape and echo texture. small ® hydrocele			
		7/3/13	PSA 7.2			
		12/3/13	r/v clinic. PSA 7.2 stable over 2 years. See in 1 year with PSA.			
		16/9/13	PSA 6.91			
		12/9/14	IFCC HbA1c 50mmol PSA 8.4 please book OPA oct/nov. letter to GP			
		14/10/14	r/v clinic Turp 2012, G6 Tic. LUTS flow ok,nocte 2-3,freq 2-3.PSA stable. PSA check in March. See on request.			
		16/3/15	PSA 7.84 PSA in 6/12			
		14/8/15	Urgent referral from GP to Urology. Patient 58 eported 3 episodes of painless haematuria over the last year. Hx CA prostrate. Last PSA 8 in sept 2014.			
		25/8/15	r/v at clinic– nocturia >3, variable flow, haematuria. Plan – MRI. Rx finasteride 5mg. PSA 7.87 Flexible cystoscopy US urinary tract . ® kidney 10.5cm, L Kidney 10.2 cm.no focal renal parenchymal lesion, calculi or hydronephrosis. residual vol 54ml, prostate vol 115ml Review Dec 15.			
			PSA 13/3/14 8.46 12/9/14 8.40 Total PSA 16/3/15 7.84			

	25/8/15 7.87 7/6/16 3.03	
10/3/17	r/v at clinic LUTS nocturia 1-3. On finasteride. loss of libido, important. PSA 3.03 June 2016 Hb 112,MCV 79.7, MCH 25.0. Ferritin less than 11. DRE – firm prostate. MRI feb 2016 – tumour L apex. Plan FBC, serum iron &ferritin, PSA, TRUS bx and MDM discussion. Letter to GP. MRI in Feb 2016 reported probable focus of adenocarcinoma within the apex of Left lateral lobe of prostrate and PSA had decreased to 3.03 by June 2016.	
4/4/17	Nurse led clinic - prostate Bx taken. Plan – MDM and r/v with Dr 5. Pathology report prostatic biopsy – adenocarcinoma gleason 4+3=7tumour volume 8%. No lymphovascular invasion Letter to GP	
20/3/17	MDM –Gleason 4+3 intermediate risk prostate cancer. review in clinic, bone scan and MDT discussion	MDM
28/4/17	Urology OPD Plan – PSA, bone scan, MRI scan. RX Bicalutamide 50,ferrous fumarate 305, review with reports/MDM. Letter to GP	
8/6/17	Discussed at urology MDM- prostate biopsies suggest grade progression of prostate cancer localised on imaging. Dr to review at OPD and discuss further management options	MDM
17/7/17	r/v urology. LUTS, nocturia x 0-3.Plan FBC, U&E, Iron, PSA. remain on bicalutamide. Rx tamoxifen. r/v Nov 2017 letter to GP	
27/10/17	LUTS: urgency, minimal urge incontinence, reduced flow, terminal dribbling, nocturia x 3-6. GFR >60. PSA 0.24 sept 2017.less gynaecomastia – much improved. Plan- MSSU, F/C & UDS 17/11/17.	
17/11/17	Urology OPD .Plan – FBC, U&E, LFT, serum ferritin, PSA. Increase dose of bicalutamide to 150mg. TURP in Jan 18. Plan Ferritin 22.5 Total PSA(T) 0.17 Letter to GP plan to admit in early new year 2018.	
19/12/17	Preop assessment TURP	
23/1/19	Letter to [Patient 58] om Dr 5 confirming telephone conversation to be admitted on 31/1/19 for endoscopic resection of prostate gland. Letter to GP	
31/1/19	TURP- bilobar regrowth of previously resected prostate. Prostate resected. For MDM discussion. Discharged 2/2/19.R/v in 2/12.	
1/2/19	D1 post TURP.W/R -Stop finasteride.	

		<table><tr><td>7/3/19</td><td>MDM urology discussion-histology benign on recent resection.for review with Dr to continue present management.</td><td>MDM</td></tr><tr><td>8/3/19</td><td>Letter to GP regarding plan in Nov 2017 to admit Patient 58 as an inpatient for flexible cystoscopy and urodynamic studies. Unable to admit until 31/1/2019 and regrowth of previously resected prostate gland. No evidence of malignancy on histopathological exam. PSA 0.05ng/ml. severe urinary symptoms. On telephone review on 6/4/19 his symptoms had improved significantly.</td><td></td></tr><tr><td>28/3/19</td><td>r/v urology LUTS urgency, urge incontinence. fair flow, increased frequency. nocturia x 3-6.Plan – PSA, MSSU. Rx oxybutynin 5mg daily .review may 19.</td><td></td></tr><tr><td>17/5/19</td><td>Review urology– LUTS- urgency, nocturia x 0-4. Plan- PSA 0.07.Increase oxybutynin MR to 5mg BD. r/v Aug 2019 Letter to GP.</td><td></td></tr><tr><td></td><td></td><td></td></tr></table>	
February 2021	Screening Report	RE: Patient 96 <table><tr><td>Urology - awaiting datix.</td><td>10/02/21 - For screening - notes requested. Will these be structured reviews or SAI in light of communication from Brid Farrell HSCB. There is a lot of systemic learning coming out of the current SAI Reviews. Under normal circumstances these would be Level 1 SAI. Further discussions required at urology meeting in relation to what tool should be used for investigation. Ronan to ask Martina if patients have been notified of incidents and obtain an update on status.</td></tr></table>	TRU-11285
Undated	Screening Report	Re: Patient 96	TRU-11593 – TRU-11594

		<table><tr><td>21/10/2011</td><td>Biopsy prostate No evidence of cancer Discussed at MDM Plan To remain on Xatral and **he will be reviewed by Mr O'Brien during January 2012.** I have contacted Perso by telephone to inform him of all of that good news. He remains well since having biopsies</td><td>CNS</td></tr><tr><td>May 2015</td><td>GP referral re: increase in PSA</td><td></td></tr><tr><td>13/6/2016</td><td>Seen by consultant urologist On examination – benign enlarged prostate PSA - 13.85ng/ml. Plan for MRI and USS urinary tract</td><td></td></tr><tr><td>29/11/2016</td><td>Attended for USS urinary tract Finding – incomplete bladder emptying due to enlarged prostate</td><td></td></tr><tr><td>16/1/2017</td><td>Attended for MRI scan Findings - Conclusion: No definite focus of disease is identified/organ confined disease.</td><td></td></tr><tr><td>July 2019</td><td>Reviewed at urology clinic following GP letter to expedite review. Noted urinary symptoms improved but raising PSA plan to proceed to biopsy of prostate.</td><td></td></tr><tr><td>3/12/2019</td><td>MRI scan - Prostatomegaly secondary to benign prostatic hyperplasia. No definite radiological evidence of a significant prostate tumour.</td><td></td></tr><tr><td>7 Oct 2020</td><td>Reviewed by another urology consultant Found elevated PSA Plan repeat MRI and PSA and perform biopsy of prostate.</td><td></td></tr><tr><td>12/10/2020</td><td>PSA result elevated 21.4ng/ml</td><td></td></tr><tr><td>7/12/2020</td><td>Attended for biopsy of prostate gland Results clear MRI did not detect any significant abnormality. Patient advised and plan for PSA in 6 months.</td><td></td></tr><tr><td>17/12/2020</td><td>Discussed at MDM</td><td></td></tr></table> <table><tr><td></td><td>Noted prostate biopsies are benign. For review with Mr Haynes to recommend PSA monitoring.</td><td></td></tr><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr></table>	
February 2021	Screening Report	Re: Personal Information redacted by the USI <table><tr><td>Urology - On surveillance for prostate cancer. planned follow-up was for a repeat PSA in May and an outpatient clinic in June 2020. However with well recognized review backlogs the review OP did not occur, indeed backlogs for the particular clinic ran to 2 years overdue. No robust process in place for review of PSA result in absence of outpatient capacity. Risk of patients disease progressing while awaiting overdue review.</td><td>10/02/21 - For screening - notes requested. Will these be structured reviews or SAI in light of communication from Brid Farrell HSCB. There is a lot of systemic learning coming out of the current SAI Reviews. Under normal circumstances these would be Level 1 SAI. Further discussions required at urology meeting in relation to what tool should be used for investigation. Ronan to ask Martina if patients have been notified of incidents and obtain an update on status.</td></tr></table>	TRU-11285

Undated	Screening Report	Re: Personal Information redacted by the USI Urology – Personal Information old man on surveillance for prostate cancer. Planned follow-up was for a repeat PSA in May and an outpatient clinic in June 2020. However with well recognized review backlogs the review OP did not occur, indeed backlogs for the particular clinic ran to 2 years overdue. No robust process in place for review of PSA result in absence of outpatient capacity. Risk of patients' disease progressing while awaiting overdue review.	TRU-11595-TRU-11597

20/3/2017	Red flag referral from GP Rising PSA and "knobbly prostate" pmhx adenocarcinoma of bowel requiring left hemicolectomy in June 2016. Previous attendance at LUS clinic in 2012 total PSA 2.85ng/ml, had been on finasteride since June 2011 with noted improvement in urinary symptoms.	
21/3/2017	Red flag letter reviewed and agreed red flag	JOD
13/4/20217	Reviewed at clinic noted fluctuating PSA levels between 15.62 and 17.56 in view of PSA less than 25 following discussion with patient and his wife – decision for watchful waiting. Should there be an increase in PSA – MRI scan would be needed or my need to start empirical treatment. Stopped Alfuzosin and commenced trial of combodart once at night for a period of 3 months, if effective to repeat thereafter. Plan review in 6 months and GP advised to arrange PSA 2-3 weeks before his planned review.	TJ (locum)
31/1/19	Letter to patient from urology nurse specialist. Noted previous PSA tests were 14ng/ml plan for review at LUS clinic in March 2019.	
19/3/2019	Personal Information old man attend LUS clinic Noted pmhx and attendance in April 2017 when DRE showed 60-80cc benign feeling prostate. Noted PSA higher than 25 and referred to consultant for review.	
16/4/2019	Seen at consultant clinic. Noted PSA 14.41 but corrected for finasteride 28.84. DRE vague T2a right apex ?? 100g prostate. Discussed with patient the likelihood of	

	adenocarcinoma of prostate. Plan re: diet advise and MRI scan to help patient with decision re: treatment.	
16/5/2019	MRI performed- findings- *"this is a limited examination given the non diagnostic diffusion weighted imaging. A rounded lesion at the gland apex is therefore nonspecific but may represent tumour. If radical treatment is being considered for this patient, you may wish to consider targeted biopsies."*	
24/5/2019	Letter to patient advising that MRI scan did not show any definite cancer but identified an area worth biopsying. Listed for TRUS biopsy.	MT locum consultant
14/6/2019	Attended for TRUS biopsy Patient noted to have been taking herbal medication which can contribute to additional bleeding following procedure. Therefore deferred biopsies for a period of 2 weeks.	CNSM
	MRI pelvis	
18/6/2019	Attended prostate biopsy clinic. Consent obtained for TRUS biopsy of prostate. 15 core biopsies taken and commenced 3 days of prophylactic antibiotics. Plan for results to be discussed at urology MDM.	
25 June 2019	Biopsy result showed overall gleason sum score 3+3=6 present in 3 of 15 samples. Tumour occupies less than 1% of total tissue volume.	
27/6/2019	Case presented at MDM- presented by Mr OB- plan for active surveillance.	
16 August 2019	Attended for outpatient appointment. Noted urge incontinence. plan for TURP due to bladder outlet obstruction.	
3/10/2019	GP letter regarding review in August clinic detailing the need for TURP as may be harbouring higher grade cancer than previously identified on biopsy.	
January 2020	Letter to GP requesting PSA to be checked.	
22 January 2020	Admitted for TURP	

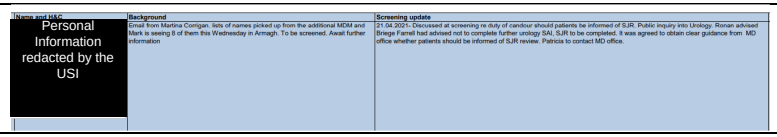
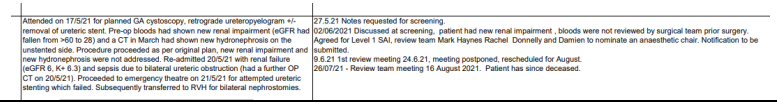
		<table><tr><td>30/1/2020</td><td>Re-discussed at MDM – findings at TURP benign – plan continue with PSA surveillance.</td><td></td></tr><tr><td>7/2/2020</td><td>Attended clinic appointment Letter dictated and typed April 2020. Detailing patient had attended for TURP biopsy no evidence of adenocarcinoma on samples obtained but noted increase in urinary symptoms. .</td><td></td></tr><tr><td>Sunday 29 March 2020</td><td>Phone call to patient – noted to be keeping well. Patient asked to arrange with practice nurse for PSA to be taken in May 2020 Plan for review in June 2020 – pending covid restrictions. No record in chart re: consultation.</td><td></td></tr><tr><td>May 2020</td><td>PSA performed by GP -22.09 ng/ml</td><td></td></tr><tr><td>December 2020</td><td>PSA performed by GP – noted 50ng/ml</td><td></td></tr><tr><td>13/1/ 2021</td><td>Reviewed at clinic Noted rise in PSA 50ng/ml Plan for MRI and repeat PSA in Feb 2021 Review planned.</td><td></td></tr><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr></table>	
February 2021	Screening Report	Re: Patient 98 <table><tr><td>New diagnosis of Gleason 6 prostate cancer under the care of Urology Consultant in 2015. Not listed for MDT.</td><td>10/02/21 - For screening - notes requested. Will these be structured reviews or SAI in light of communication from Brid Farrell HSCB. There is a lot of systemic learning coming out of the current SAI Reviews. Under normal circumstances these would be Level 1 SAI. Further discussions required at urology meeting in relation to what tool should be used for investigation. Ronan to ask Martina if patients have been notified of incidents and obtain an update on status.</td></tr></table>	TRU-11285
Undated	Screening Report	Re: Patient 98	TRU-11598 – TRU-11600

Date/ Time	Summary Of Events	Staff
17/9/13	Routine GP referral to Urology H/O BPH. Intermittent symptoms from 2008.Nocturia x3-4.Bouts of urgency. Intermittent bilateral groin discomfort with post micturition burning but no dysuria. Urine normal. MSU no growth.no blood/pus. Avoids fluids after 6pm. Combodart from 3.5.13 help with flow but no other symptoms. PSA Nov 2012 was 4.8 now 3.7(actual 7.4). Rectal exam shows moderate firm smooth prostate. eGFR reduced to 43 may be due to hypertensive. Medication : Lisinopril,dutasteride,tamsulosin.	
27/1/14	Seen by Urology consultant – deteriorating renal function. PSA 4.8 nov 2012 PSA 3.7 sept 2013 on combodart. LUTS, loss of erectile function 3-6 mths. ® testicular pain,DRE:benign prostate,moderately enlarged,not tender. Abd:suprapubic tenderness, genitalia ® epididymal tenderness.Plan – PSA 3.9, MSSU normal, U/S urinary tract. Rx ciproxin,oxybutin,tadalafil. Review April 2014.	
11//3/14	US urinary tract – kidneys normal size, normal parenchyma and collecting systems.bladder normal appearance.bladder vol 402mls, post mict residual vol 111mls.prostate vol 25mls.	
25/9/14	GP referral letter requesting private appointment after last review in Jan 14.nocturiax3-4,® groin and suprapubic pain with poor stream.PSA 3.9 July 13.	
4/10/14	Review with urology consultant Dr 2.LUTS, increase frequency,nocturia x 3-6, pain referred to suprapubic region and rectum.still has ® epididymal tenderness less than previously,.Plan – remain on alfuzosin, ciprofloxacin until urodynamic studies 17/10/14	
17/10/14	Review with urology consultant - flexible cystoscopy.urodynamic studies – detrusor over activity. Plan – PSA, remain on alfuzosin, ciprofloxacin. Rx solifenacin nocte, intradural injection of 250 units botulinum toxin. PSA - 4.84	
25/2/15	Rigid cystoscopy and botox injection	
11/5/15	Review with urology consultant - LUTS, urgency less marked,hesitancy,slow flow,nocturia x 3-4, dysuria. PSA 4.84 Oct 2014 GFR 38 Feb 2015 PSA 5.8 March 2015. Qmax 7mls/sec, Qmean 3mls/sec. residual 265mls.Plan - TURP 9 June 15.	
9/6/15	TURP- fibrotic hypertrophy of bladder outlet.modest prostatic enlargement. Prostate and bladder neck resected 20F catheter. Pathology report – prostate adenocarcinoma with gleason	

			score 6(3+3)			
			21/8/15	MRI- No definite site of residual neoplastic disease is seen in prostate gland. No evidence of extracapsular neoplasm or lymph node metastases.		
			6/7/15	Review with Urology Consultant – well, LUTS minimal urgency,nocturia x 3-4.Plan PSA, MSSU, U/S lower tract. MRI prostate Sept . R/v Oct 15. 14/9/15 MRI pelvis prostate – no definite site of residual neoplastic disease seen in prostate gland.no evidence of extracapsular neoplasm or lymph node metastases.		
			5/6/17	Review Urology Consultant - LUTS urgency, nocturia x 3,suprapubic pain. PSA 2.1 in NOV 16. GFR 31ml/min Nov 16. Plan – U&E,PSA,MSSU,U/S Urinary tract, MRI prostate, UDS Rx ciprofloxacin x 6 weeks. US abdominal aorta -The kidneys are normal in size with normal parenchyma and collecting systems. The bladder is normal in appearance. Pre mict volume = 320ml Post mict volume = 40ml Prostate volume = 48cm3 The aorta is normal in calibre throughout.		
			9/6/17	MRI -No definite evidence of residual prostate malignancy. No major change when compared to previous scan from 14/09/2015.		
			18/7/17	U/S of urinary tract MRI prostate gland 9/6/17 – no definite evidence of residual prostatic malignancy.small hepatic cyst and sigmoid colonic diverticular disease.prostatic carcinoma remains under active surveillance Review with urology consultant PSA unchanged.flow good enough, nocte x 2-3. MRI nil. 4/12 PSA r/v 1 year.		
			20/8/18	Review with urology consultant – LUTS nocturia x 3. Elevated bladder base by prostatic enlargement, trabeculated bladder.UDS –bladder outlet obst –N,detrusor hypocont – Y. Plan- furosemide 20@noon, PSA & GFR Dec.R/v Jan 19.		
			29/6/18	US abdominal aorta – Normal US urinary tract- The kidneys are normal in size with normal appearing parenchyma. No obstructive uropathy.		

		June 2017. The bladder is sub optimally filled, but as far as could be determined it appears normal. Prostate dimensions 4.3cm x 3.5cm x 2.7cm (21mls). The aorta is normal in calibre throughout. CONCLUSION: Normal examination 23/9/19 r/v urology consultant. Furosemide discontinued July due to deterioration in renal function. LUTS terminal dribbling,urgency,nocturia x 4-5.Plan – Rx oxybutynin,tadalafil.r/v nov 19. ? IC aldrostadil mean GFR 31.4 2018, 27.9 2019. PSA down 2.72 sept 19 Plan –if no symptomatic improvement at review, repeat F/C & UDS Letter to GP PSA level: July 19 - 3.02 Sept 19 - 2.72 Dec 19- 2.95 June 20- 3.30 Nov 20- 3.61	
February 2021	Screening Report	Re: Patient 97 Letter sent to Urology Department in May 2020, requesting that patient P was added to waiting list for RF Flexible Cystoscope. When checked on 30 October 2020, Mr P had not been added to any waiting list. Delay in arranging patient for RF Cystoscopy 10/02/21 - For screening - notes requested. Will these be structured reviews or SAI in light of communication from Brid Farrell HSCB. There is a lot of systemic learning coming out of the current SAI Reviews. Under normal circumstances these would be Level 1 SAI. Further discussions required at urology meeting in relation to what tool should be used for investigation. Ronan to ask Martina if patients have been notified of incidents and obtain an update on status.	TRU-11285
Undated	Screening Report	Re: Patient 97 Letter sent to Urology Department in May 2020, requesting that patient Per was added to waiting list for RF Flexible Cystoscope. When checked on 30 October 2020, Mr Per had not been added to any waiting list. Delay in arranging patient for RF Cystoscopy Sept 2010: Diagnosed with Gleason 3+4 clinical T2 adenocarcinoma of the prostate. *He was initially managed by active surveillance until his serum total PSA level had increased to 9.19ng/ml, prior to further biopsies being performed in 2012 when he was still found to have adenocarcinoma of Gleason score 7 still present in 3 of 11 cores. He then progressed to have radical radiotherapy completed in 2014.* Mar 2017: Reviewed urology clinic Oncology: Reviewed by oncology from January 2018-January 2020. Commenced on bicalutamide and tamoxifen by oncology team. Oncology May 2020: Letter to AOB requesting urgent red flag cystoscopy in view of haematuria. 30 October 2020: Noted patient not added to waiting list for red flag cystoscopy.	TRU-11601

24.02.2021	Email correspondence between Mr Carroll& Ms Kingsnorth	Notes that Professor Sethia has returned his comments on the urology screening. He doesn't think that any of the cases meet the critieria for SAI. However, he acknowledges the delay and uncoventional treatments provided to the patients. He looked at 6 cases for us. Cases looked at: There are two cases of delays in management ([redacted], [redacted]), two of failure to discuss at the MDM ([redacted] - these all represent substandard care. There are three cases (including [redacted] of the unconventional use of bicalutamide. The three cases where Mr O'Brien prescribed bicalutamide ([redacted], [redacted] and [redacted] do raise the question of whether he should have offered earlier radiotherapy. This would certainly have been better practice so the patients were denied the chance of discussing the options properly .My thoughts are 1. [redacted] Prognosis remains good so although perhaps a candidate for radiotherapy in 2017 no harm done. [redacted] Might have been candidate for radiotherapy in 2013. This might have conferred a small survival advantage at 10 years but he is doing well. 2. [redacted] should have started radiotherapy in Feb 2020 - therefore 6 month delay. Probably no harm. [redacted]	TRU-11903 – TRU-11905
March 2021	Trust Governance Committee Meeting – Quarterly Report	RE: Litigation Claims Notes that the nature of claims are: 1. Birth Defects 2. Failure to diagnose/delay in treatment 3. Failure to provide appropriate advice on medication 4. Failure to provide treatment 5. Failure to supervise/leading to fall 6. Inappropriate treatment 7. Mesh claim	TRU-20945

21.04.2021	Screening Report		TRU-13553
15.05.2021	SCCR List	List of patients included in structured clinical record review [unsure whether these all relate only to Urology]	TRU-14392
17.05.2021	Screening Report	Re: Personal Information redacted by the USI 	TRU-16713
April – June 2021	CSCG Report Governance Committee	Notes that the top 10 complaints in this period were: 1. Communication/Information 2. Quality of Treatment & Care 3. Staff attitude/Behaviour 4. Professional Assessment of Need 5. Clinical Diagnosis 6. Property/expenses/finance 7. Waiting times, outpatient Departments (First time since Dec 2018 that waiting times in Outpatients has occurred in the top 10. The majority of these complaints were received into IMWH, Surgery and Elective care and 1 for children's health) 8. Waiting times, A&E departments 9. X3 subjects = 6 (Three subjects appeared on 6 occasions within the time period April – June 2021 sharing 9th place. These subjects were waiting lists, delay/cancellation outpatient appointments, quantity of treatment and care and policy/commercial decisions 10. Confidentiality	TRU-21784
June 2021	Trust Governance Committee Meeting – Quarterly Report	Re: Litigation Claim Notes that the nature of claims are: 1. Birth defects 2. Failure to diagnose/delay in treatment 3. Failure to provide appropriate advice on medication 4. Inappropriate treatment 5. Mesh Claim	TRU-20963
09.06.2021	Screening Report	Re: Personal Information redacted by the USI	TRU-14629

		Attended on 17/5/21 for planned GA cystoscopy, retrograde ureteropyelogram +/- removal of ureteric stent. Pre-op bloods had shown new renal impairment (eGFR had fallen from >60 to 28) and a CT in March had shown new hydronephrosis on the unstented side. Procedure proceeded as per original plan, new renal impairment and new hydronephrosis were not addressed. Re-admitted 20/5/21 with renal failure (eGFR 6, K+ 6.3) and sepsis due to bilateral ureteric obstruction (had a further OP CT on 20/5/21). Proceeded to emergency theatre on 21/5/21 for attempted ureteric stenting which failed. Subsequently transferred to RVH for bilateral nephrostomies. 27.5.21 Notes requested for screening. 02/06/2021 Discussed at screening, patient had new renal impairment , bloods were not reviewed by surgical team prior surgery. Agreed for Level 1 SAI, review team Mark Haynes Rachel Donnelly and Damien to nominate an anaesthetic chair. Notification to be submitted. 9.6.21 1st review meeting 24.6.21, meeting postponed, rescheduled for August. 26/07/21 - Review team meeting 16 August 2021. Patient has since deceased.	
Undated	Mortuary Report & Death Certificate and notes and records from admission	Re: Personal Information redacted by the USI Situation: Personal Information redacted by the USI old gentleman who was admitted with haematuria. Felt to have an advanced prostate cancer. Background: Admitted following recent treatment with acute care at home. Was found to be haematuric. He was recently referred to urology by his GP due to a significantly elevated PSA as a suspected prostate cancer.	TRU-14986 – TRU-15046
June 2021	Screening Report	Re: Personal Information redacted by the USI Background: Patient attended for flexible sigmoidoscopy. On review of his records on NIECR, he had a CT CAP for an apparent proximal transverse cancer booked by consultant surgeon. No details of when or where this cancer was detected, no histology reports, no MDM reports. CT scan was normal. Patient had not attended private sector for any investigations. Patient unaware of details on CT referral. Screening update: 24/06/21 - for discussion. Person [illegible] 10/06/21 - await outcome of discussions with patient and for screening 15.7.21 Patient referred wrongly. Referrer has reflected on incident. Referred to RQIA. Right patient has been scanned. CLOSE	TRU-14959 TRU-15821
June 2021	Screening Report	Re: Personal Information redacted by the USI Background: Referral made for patient from ED department red flag lumbar spine MRI for ?prostate cancer metastasis, but also in the details have mention CES. This is an emergency indication yet was not communicated to the MRI department and therefore potentially could have been missed. Screening update: 16.6.21 - For screening 16.6.21 To be presented at M&M. CLOSE.	TRU-14692
June 2021	Screening Report	Re: Personal Information redacted by the USI Letter from solicitor to litigation. Claiming damages arising from personal injury occuring at CAH in or aroind October 2020. Admitted to CAH around 11.10.20 due to ongoing pain with renal stone. Received regular anti-sickness injections 3-4 times daily, on 19.10.21 received injectionto left buttock resulting on paralysis to left hand side of body. Letter attached. 24.6.21 Notes requested from Litigation.	TRU-15252
June 2021	Litigation Documentation	RE: Personal Information redacted by the USI *"Our client instructs that they were admitted to the Hospital in and around 11th October 2020 due to ongoing pain with renal stones. He was receiving regular anti-sickness injections 3-4 times daily, however on the evening of the 19th October, an injection to our clients left buttock was administered which resulted in paralysis to his left hand side of his body. Our client has not fully recovered from the paralysis which was an agent of the Trust disclosed before discharge had "probably clipped a nerve"*	TRU-15259 – TRU-15260
June 2021	Grievance Appeal Review	Terms of Ref:	Grievance Appeal

		1. We are concerned that no account has been taken of the failures of Senior Managers within the Trust in respect of discharging their responsibilities 2. Disagree with panel and do not find that there was appropriate action taken to affirm the seriousness of this situation .. the approach which Mr O'Brien had to his work was known for years 3. Matter not referenced again until oversight committee in September 2016 – was not discussed with Mr O'Brien. No action taken after October 2016 as Mr O'Brien was off for Personal information redacted by 4. Mr O'Brien had not been told about Oversight Committee discussions, some 5 months since they were held… The senior managers who did not bring these matters to Mr O'Brien's attention had a responsibility to do so and are accountable for their failures to act in accordance with their own professional codes 5. Conclude that the failures to follow up from the March meeting, the reporting and development of the action plan in September and lack of action on this and agreed deferral at the October meeting suggest that if the SAI had not arisen that the question of an MHPS investigation may not have been delayed even furtehr or not have arisen at all	Review page 13-14 AOB-50031 – AOB-50032
June 2021	Grievance Appeal Review	Terms of Reference 1. In looking at the decision of the Stage one panel there are elements of this that we feel are not justifiable 2. Note particularly the summary of conclusions by the panel the following (a) *Overall we do not find Mr O'Brien's greivance upheld:* It is noteable that the panel use the term overall which suggets that they have essentially weighed the issues identified against the evidence available but in the consideration of these tehre is more weight given to what is "against" that "in favour" of Mr O'Brien 3. Accept there are several findings of the issues of grievance where we accept the findings that the Trust's actions may have been reasonable and justified, we find that the conclusions reached have not addressed the failures on the part of the Trust Managers in addressing their concerns and responsibilities in a prompt and thorough manner.. we hold the view that this is a weakness in the outcome and is fundamentally unfair 4. Meeting of March, no follow up – the inaction in relation to follow up while not excusing Mr O'Brien's interpretation in this regard does in our view suggest that the seriousness of this was not as was later argued and gives more weight to his inaction .. 5. Chance of resolution was avoided – we do not agree that this is a fair assessment. It relies on the March 2016 meeting with him and the subsequent letter as the evidence to support this and ignores the decussions that were held subsequently at which dialogue and discussion were held by other senior colleagues and which were not shared with him. The panel	Grievance Appeal Review Page 15 – 18 AOB-50033 – AOB-50036

		concluded that the events which unfolded may have had some opportunity for resolution is quite disturbing. To lay the responsibiliy for this completely at the door of Mr O'Brien is disproprortionate .. absence of concise and proper management of the concerns held about Mr O'Brien by Trust Management which was not just an issue at the time but appears to have been known for years 6. … There is an absence of thorough and proper management of the concerns raised in respect of Mr O'Brien of the concerns raised in respect of Mr O'Brien and of the management of Mr O'Brien himself.. conclude that the stage one grievance has not judged the grievance fairly. We hold the opinion that there are several of Mr O'Brien's complaints that should have been upheld or partcualrly upheld.	
June 2021	Grievance Appeal Review	Terms of Reference: 1. … While we accept that Mr O'Brien's approach to this being raised was to initially ignore it, the absence of timely follow up did not affirm the seirousness with which the Trust was viewing this but supported his casual approach to it. 2. The most troubling concern that we have in relation to this matter is that throughout this time there is little mention of patients and the degree to which the failure to triage and report and then subsequent ongoing delays in processes all servced to compromise patient care….	Grievance Appeal Review Page 19 – 20 AOB-50037 – AOB-50038
July 2021	Screening Report	RE: Personal Information redacted by the USI Patient appears to have contracted Covid-19 as an in-patient,Covid neg 21/1/21, positive 24/1/31 (in Urology CAH, having been transferred from SAHospiceand sadly died Person although had advanced malignancy and sepsis. Transferred to DHH for palliative care and passed away uner my care 05/07/21 - for screening. 5.7.21 COVID and M&M. CLOSE	TRU-15626
30.09.2021	Emerging Issues : Trust Board	1. Draft Report on Covid-19 clusters and subsequent deaths in Daisy Hill and Craigavon Area Hospitals (a) Draft copy of Level 3 SAI report has been received (b) 15 Patient deaths within the Trust between August and October 2020 2. Urology Services Inquiry 3. Trust Management Structures (a) Changes to senior team due to retirements (b) Succession planning to develop rewarding Director portfolios to attract high calibre candidates (c) Maximising collective leadership opportunity (d) Learning from post Covid-19 4. Strategy Developments to develop a new three-pronged approach to our strategy direction	TRU-01818 – TRU-01823

<table>
<tr>
<td>November 2021</td>
<td>Screening Criteria for SAI</td>
<td>
<table>
<tr><th colspan="2">SCREENING CRITERIA FOR SAI</th></tr>
<tr><th>Operational Directorate</th><th>Any adverse incident which meets one or more of the following criteria should be reported as a SAI</th></tr>
<tr><td rowspan="7">Mental Health & Learning Disability Services

Acute Services

CYPS

OPPC</td><td>1. Serious injury to or the unexpected/unexplained death of:
- A service user (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)
- A staff member in the course of their work
- A member of the public whilst visiting a HSC facility;</td></tr>
<tr><td>2. Unexpected serious risk to a service user and/or staff member and/or member of the public;</td></tr>
<tr><td>3. Unexpected or significant threat to provide service and/or maintain business continuity;</td></tr>
<tr><td>4. Serious self-harm or serious assault (including attempted suicide, homicide and sexual assaults) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;</td></tr>
<tr><td>5. Serious self-harm or serious assault (including homicide and sexual assaults)
- on other service users
- on staff, or
- on members of the public
by a service user in the community who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and/or known to/referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services in the 12 months prior to the incident;</td></tr>
<tr><td>6. Suspected suicide of a service user who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and/or known to/referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services in the 12 months prior to the incident;</td></tr>
<tr><td>7. Serious incidents of public interest or concern relating to:
- any of the criteria above
- theft, fraud, information breaches or data losses
- a member of HSC staff or independent practitioner</td></tr>
<tr><td colspan="2">Note: The HSC Regional Risk Matrix may assist in determining the level of 'seriousness'</td></tr>
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<td>TRU-02867</td>
</tr>
<tr>
<td>Undated</td>
<td>Screening Report SEC</td>
<td>
Re: [redacted] Patient 2
<table>
<tr><th>Background</th><th>Screening update</th></tr>
<tr><td>Urology - Delay in referral to oncology</td><td>datix to be submitted, noted requested. Screened on 1.10.2020 by Mark Haynes, Ronan Carroll, Martina Co Kingsnorth.</td></tr>
</table>

datix to be submitted, noted requested. Screened on 1.10.2020 by Mark Haynes, Ronan Carroll, Martina Corrigan and Patricia Kingsnorth. 12/10/2020 Review team meeting.
21/10/20 - Next review team meeting 02/11/20. Datix to be completed.27/10/2020 Datix to be submitted before notification can be forwarded to HSCB

forwarded to HSCB.
10/11/20 - Meeting took place on 09/11/20. 09/11/2020 meeting with family, Next review team meeting 30/11/2020 30/11/2020. Next review meeting 07/12/2020 next review team meeting 04/12/2020
29/12/20 - Next meeting 04/01/21.
05/01/21 - Next meeting 18/01/21. 02.03.2021 Draft report and overarching report shared with HSCB.16/03/2021 Report shared with patjent/ family. Final report to HSCB/ Family 20/04/2021 Final report to HSCB/ Family 20/04/2021
</td>
<td>TRU-07931

TRU-09087

TRU-15255</td>
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CHRONOLOGYCONCERNS/COMPLAINTS RE AOB

MR AIDAN O'BRIEN

Personal Information redacted by the USI

MPS REF: AP1/LEA/646528/N

Date	Document Name	Comments	Document No.
09 June 2004	Letter to Mr Stirling to Mr Humphrey	Re consent to treatment & Trust's definitive guidance on these issues **ELECTIVE PROCEDURES**	TL1 Page 41 - 42

		It is recommended that patients be allowed time to reflect upon the information provided at outpatient clinics and consent should therefore not be obtained at that time…. Some patients may be consented up to three years before admission and the consent is reaffirmed on the day of admission. **OPEN ACCESS / DAY CASE PATIENTS** It is now unacceptable to obtain written consent on the day of a procedure. There are several ways around this such as preassessment clinics, training a nurse to obtain consent for several procedures etc…. the alternative is that day case/open access lists from Monday onwards are cancelled, the patients recalled to obtain consent and an alternative date is arranged. This is the least preferred option as it would have a major impact on lists which are already arranged. I would emphasise that the Surgical Directorate is willing to comply with implementation of the new consent process but is concerned that neither individuals nor the Trust are exposed due to the lack of clarification on the above issues and given that all your staff have not attended the out-of-hours training sessions….	
2007	2010 Appraisal	In 2010 Appraisal we have an extract from the 2007 Appraisal (Form 4) which comments on relations with patients "No problems because of Aidan's non-time management."	2010 Appraisal page 190 AOB - 22191
11.02. 2009	Workshop to Launch the Southern Trust Review of Urology Services		TL1 Page 182
01.06. 2009	Letter from Ms Youart to Mr O'Brien	Re Urology Services and Surgical Reconfiguration Many thanks for your letter dated 29 May 2009 regarding the recent response to the consultation on the surgical reconfiguration of beds and making the time to come and see me directly on Friday ..	TL1 Page 190
02.06. 2009	Email correspondence from Mr Mackle, Mr Gibson and Ors dated 02 June 2009 enclosing slip from Mr Mackle	Email by Mr Mackle in relation to AOB's request to cancel clinical work during July. Notes there was a similar exercise two years previously as a "*one off*". Alleges AOB already had 3.87 PAs of admin time in his Job Plan in excess of others. Notes "*If, as you state, Aidan feels there is now a clinical risk because he has allowed the backlog to develop, then there is a serious governance issue regarding his practice. I am copying this email to him so as to get an urgent response to the clinical risk issues he has raised and I may need to consult with the Medical Director regarding the performance issues raised."*	Doc File 1 Page 131 AOB-00131
12.06. 2009	Letter to Mr Mackle from Mr O'Brien	Letter from Mr Mackle to Mr O'Brien that he did not submit any request to be allowed to cancel all clinical work during July to allow him to clear a backlog of paperwork. Notes considerable stress over the previous few months for all in urology due to the loss of the ward and fragmentation of	Doc File 1 Page 133 AOB-00133

		inpatient urological services posing a potential existential threat. Requests a response in writing from Mr Mackle	
24.05. 2010	Email correspondence between Ms Murphy and Consultants	Re setting up meeting to discuss backlog review Meeting was scheduled for 17 June 2010	TL1 Page 414
04.06. 2010	Email from Ms Trouton to Mr O'Brien	Re: Personal Information redacted by the USI Complaint Complaint was forwarded for investigation on 30 March with the internal response due on 14 April 2010. Internal response is still outstanding from Mr O'Brien. Reminders were sent 14 April, 22 April, 11 May, 17 May and 25 May.	TL1 Page 432
27.09. 2010	Letter to Mr O'Brien from Dr Rankin	Dr Rankin notes he is in receipt of correspondence "*in relation to 3 patients. In each case you have written to the patient, the General Practitioner and Mr Hagan".* *"Each of these patients have been transferred to the City Hospital for further management by Mr Hagan. I understand that you expected and wished to carry out this surgery yourself in Craigavon Area Hospital, but following contact from our Commissioner the Trust was obliged to refer the patients to Belfast.* *It is of great concern that you have indicated to a patient (in advance of a care pathway being agreed) your preferred management of the case. I believe this puts inappropriate pressure on the receiving team and is regrettable. I understand that the transfer of these patients, with whom you may already have formed a good therapeutic relationship, was somewhat unexpected.* *There is another difficult area which we are currently examining – the intravenous therapy (IVT) cohort. Since we have internal agreement that the future care pathway of these patients will be subject to a multi-disciplinary decision I do not want you to write to any of these patients individually. Any outcome of the multi-disciplinary team should be 'signed off' by that team and only an agreed communication sent/provided to each patient."*	Doc File 1 Page 191 AOB-00191
2010	2010 Appraisal	In the 2010 Appraisal, signed off by Mr Young on 15.07.2011, Form 4 includes the following in relation with patients:- Two complaints are recorded, one relating to a delay in outpatient review (a known Trust issue) and a second from a relative. Both complaints are resolved."	2010 Appraisal Pages 195-203 AOB-22196 – AOB - 22204
2010	Letter dated 28.06.2010 from AOB to Dr Gillian Rankin	In the 2010 Appraisal in relation to the complaints:- 1. Personal Information redacted by the USI –Mr O'Brien notes how he considers the centre of Mr Personal Information redacted by the USI's frustration has been an assumption that his continued pain	2010 Appraisal Pages 163 – 166

	Letter dated 24.06.2010 to Dr Gillian Rankin	remained caused by his stone disease however Mr O'Brien did not believe that to be the case. Mr O'Brien notes the pain is unlikely to be related to the obstructive stone disease and probably musculoskeletal in nature. 2. Mrs [Personal Information redacted by the USI] concerning her sister, [Patient 130]. He summarises the complaint as relating to the recurrence of urinary sepsis following surgical intervention on 19 January 2011. That intervention followed a complex range of conditions/procedures following admission to hospital on 31 October 2010 with UTI, gram negative septicaemia, diabetic keratosis and acute renal failure. The complaint refers to surgical intervention on 19 January 2011 from which it is suggested the patient should not have developed urinary sepsis on the basis that surgical intervention was not a major surgical procedure. Mr O'Brien notes that any surgical procedure in an infected tract, can be complicated by significant and severe urinary sepsis. The patient was predisposed having a chronically dilated right upper urinary tract presumably hypocontractile bladder and insulin dependent diabetes. Mr O'Brien accepted that the patient should have continued to have intravenous fluids post-operatively "It had been our mistake not to have left an indwelling urethral catheter insitu post-operatively." If both had occurred the urinary tract would have been optimally irrigated and continuously drained. However Mr O'Brien noted that there was still every possibility urinary septicaemia may have occurred. Antibiotic prophylaxis had been provided and IV Gentamicin intra-operatively. He does not believe a post-operative antibiotic one or two hours earlier would have altered significantly the subsequent clinical course. Noted the patient had to be transferred to ICU to a bed in Craigavon due to non-availability at Erne and the need for consideration of a further procedure which could not be performed at Erne and indeed consideration had been given to transferring her to Altnagelvin but Craigavon was decided to be the best venue clinically. Mr O'Brien commented on nursing issues noting at the time they had a number of highly dependent patients and there was simply not enough nurses to provide adequate care for such high dependent patients.	AOB – 22164 – AOB – 22167 2010 Appraisal Page 168 AOB – 22169
2011	2011 Appraisal	In Form 4 under heading "*Relations with patients"* it notes plenty of cards and letters of support have been received from patients. No complaints are disclosed. In relation to Probity it comments as follows:- *"An issue relating to the inappropriate disposal of patient*	2011 Appraisal pages 24-25 AOB-22245 - AOB-

		related information had resulted in an informal warning. The discussions relating to this issue have been accepted, resolved and the warning is now time expired. *Otherwise there are no issues."*	22246
11.01.2011	Email from Ms Trouton to Mr O'Brien	Re: Waiting Times *Mr O'Brien* *I appreciate that there are important clinical considerations to be made when deciding who to schedule to your inpatient list on a weekly basis. However I have to stress that you currently have 34 patients who will be waiting greater than 36 weeks by the end of March who currently have no date for surgery. The longest waiter at the minutes with no date is currently waiting 54 weeks.* *Your list for tomorrow has 3 patients waiting 2 weeks, one waiting 14 weeks , one waiting 17 weeks and 1 waiting 19 weeks.* *Can I please ask if you would look at these 34 patients and either list them or if they do not require surgery take them off the waiting list particularly as some of these patients are actually categorised as urgent.* *Urology has got special dispensation to go out from 13 weeks to 36 weeks as there is a recognition that we do have a capacity gap, however we cannot justify some patients being treated within 2 weeks while others wait 54 weeks.* *I appreciate that you have offered to do additional Saturday lists which is great, however as you know this is proving difficult to secure with theatre nursing staff and we really do need to use the core lists we have to treat these long waiters at least until we see what additionality, if any, we can secure.* *Can I ask that this gets your urgent attention and Sharon and Martina will be very happy to work with you to identify the patients needing listed before the end of March "*	TL3 page 9 AOB-05687
06.04.2011	Meeting re Patient 130 held in DUP Office Personal Information redacted by the USI	Re: Issues 1. Nursing care issues a) Sitting out of bed with a "paper apron" and feet on cold floor. No drink available b) Mrs Personal Information came to visit Patient 130 with her cousin and found Patient 130 hanging out of bed 2. General Nursing issues 3. Medical Care issues a) Transferred to ICU post-operatively b) Mrs Personal Information was not aware surgery was a major surgery	TL3 Page 67 – 74 AOB-05745 – AOB-05752
11.04.2011	Email patient complaint	Re: Personal Information redacted by the USI *"The above named constituent has been waiting for a*	TL3 page 36 AOB-05714

		prostate operation at Craigavon Hospital and now informed a 6 month waiting list. He is in considerable pain and discomfort at present and grateful if this operation could be treated as a priority due to the discomfort he is experiencing. He is currently under Personal Information redacted by the USI *"*	
06.05. 2011	Email correspondence between Ms Corrigan and Mr O'Brien	Email correspondence between Ms Corrigan and Mr O'Brien. Notes *"two red flags escalated to me that are with you for triage."* Also notes "… *got the data through this afternoon from booking centre and it has been highlighted that they are waiting on you to triage some more letters so that they can fill May clinics."*	Doc File 1 Page 252 AOB-00252
23.05. 2011	Letter to Mr Poots	Re: Patient complaint – Personal Information redacted by the USI	TL3 page 105 – 106 AOB-05781 – AOB-05782
01.06. 2011	Email from Ms Corrigan to Mr O'brien	Re: Patient complaint – Patient 71 Formal complaint re her treatment and care in A&E and the delay in her admission for Urology/Gynae Surgery. Martina from PAS I see she was added to Aidan's waiting list for surgery on 7/2/11 and was prioritise as urgent … to check with Aidan when he plans to admit this lady.	TL3 page 61 – 62 AOB-05739 – AOB-05740
03.06. 2011	Letter from Ms Christine Smith to Ms McAlinden	RE: Patient Complaint – Personal Information redacted by the USI	TL3 page 102 AOB-05780
08.06. 2011	Email to Mr O'Brien from Ms Stinson	Re: Meeting with Dr Rankin regarding urology issues Arranging time for 09 June at 2pm	TL3 page 87 AOB-05765
15.06. 2011	Email correspondence between Mr Mackle, Mr O'Brien and Ors	Email from Eamon Mackle to Aidan O'Brien and others	Doc File 1 Page 253 AOB-00253

		From: Mackle, Eamon <Personal Information redacted by the USI> To: O'Brien, Aidan <Personal Information redacted by the USI>; aidanpobrien <Personal Information redacted by the USI>; Rankin, Gillian <Personal Information redacted by the USI>; Walker, Helen <Personal Information redacted by the USI>; Trouton, Heather <Personal Information redacted by the USI> Subject: Antibiotics and Urology Patients Date: Wed, 15 Jun 2011 16:33 Dear Aidan I am seriously concerned that you don't seem to recall our conversation at the meeting last thursday. At that meeting I informed you that if you wanted to admit a patient for pre-op antibiotics or for IV fluids and antibiotics that a meeting had to be held with Sam Sloan and a microbiologist and that this prerequisite was non negotible. You have also been given this in writing following a previous meeting with Dr Rankin and myself. I now find that you initially planned to admit a patient this week without having discussion with anyone and then when challenged you only spoke to Dr Rajesh Rajendran. Would you please provide me with an explanation by return. Eamon Mackle MD The Information and the Material transmitted is intended only for the person or entity to which it is addressed and may be Confidential/Privileged Information and/or copyright material. Any review, transmission, dissemination or other use of, or taking of any action in reliance upon this information by persons or entities other than the intended recipient is prohibited. If you receive this in error, please contact the sender and delete the material from any computer. Southern Health & Social Care Trust archive all Email (sent & received) for the purpose of ensuring compliance with the Trust 'IT Security Policy', Corporate Governance and to facilitate FOI requests. Southern Health & Social Care Trust IT Department Irrelevant redacted by the	
01.07.2011	Memo from Ms Trouton to Mr O'Brien	Re: Issues from meeting held on 9th June 2011 … 1. Job plan 2. Review Backlog: To discuss a way forward in managing review backlog in a timely manner. Also to ensure responsibility taken to manage all outpatient appointments in such a way as to only review backlog unnecessarily. 3. Patient admission for surgery – not to be brought in the days prior to surgery for IV fluids and IV antibiotics without discussion and agreement 4. Urodynamics- was agreed that Mr O'Brien would require 20 minutes per patient to review the results of their urodynamics studies and agree/provide a management plan for each patient. This would be factored into workload but does require a full dedicated urodynamics session. 5. Pooled lists – agreement on the need to manage all day case patients in a chornological manner. To support Mr O'Brien in managing the chronological booking process. 6. Cancer pathway – agreed 30 minutes slot would be required	TL3 page 109 – 111 AOB-05788 – AOB-05789
01.07.2011	Memorandum between Mr O'Brien and Ms Trouton	Discussion regarding the leadership requirement of all senior staff (inclusive of consultants) *"to give confidence to all ward/department nursing staff regarding patient care and to take action to improve patient management rather than protecting a negative and critical attitude within the team".*	Doc File 1 Pages 255 – 256 AOB-00255 - AOB-00256
15.07.2011	2010 Appraisal	2010 Appraisal completed with Mr Young on 15 July 2011. Includes the following comments:-	2010 Appraisal page

		"*No formal complaints nor critical incidents are logged by the Trust. The Trust however has had discussions with reference to patients being treated with IV fluids and antibiotics. This has been satisfactorily concluded."* *"Two complaints are recorded, one relating to a delay in outpatient review (a known Trust issue) and the second was from a relative. Both complaints are resolved."* ***Any other points:*** *"IV fluids/Antibiotic issue has been improved by a new care pathway defined by the Trust."*	195 – 199 AOB-22196 – AOB-22200
21.07.2011	Letter from Trust to Arlene Foster re patient complaint	Re Mrs [redacted] *"Dear Mrs Foster* *I refer to our meeting which took place on Wednesday 6 April 2011 in connection with the treatment and care provided to* [redacted] *A full investigation has now been completed regarding the care and treatment issues raised at the above meeting as follows:* *Medical Care issues* *Mr O'Brien Consultant Urologist has provided me with the following report in response to the medical care issues raised.* *Mr O'Brien appreciates Mrs* [redacted] *'s concerns for her sister's condition and her belief that if Mrs* [redacted] *has been seen by a doctor immediately her admission to ICU may have been avoided. However Mr O'Brien has confirmed that with all invasive procedures there is a risk of infection and bleeding, the potential of this complication was explained to Mrs* [redacted] *prior to her surgery.* *In Mr O'Brien's response he has stated that unfortunately any surgical procedure involving the urinary tract, particularly one which is infected at the time of the procedure can be complicated by clinically significant and severe urinary sepsis. However within the context of Mrs* [redacted] *case this is fundamentally more important due to Mrs* [redacted] *past history of urinary sepsis which is predisposed by her medical history.* *Mr O'Brien confirms that he spoke to Mrs* [redacted] *on the 01/02/11 regarding Mrs* [redacted] *condition. During this discussion Mr O'Brien explained to Mrs* [redacted] *that a decision had been taken to remove Mrs* [redacted] *urinary catheter and discontinue her IV fluids following her surgery. However Mr O'Brien emphasised that in view of Mrs* [redacted] *past medical history there was every possibility that urinary septicaemia would have occurred even if the IV fluid and urinary catheter had remained in place. Mr O'Brien has concluded his report by stating that all*	TL3 page 131 – 134 AOB-05809 – AOB-05812

		interventions by medical staff were carried out effectively and in a timely manner. *Our investigation indicates that Mr O'Brien gave Mrs* Personal Information *his assurance that clinicians would collectively endeavour to care for her sister to the best of their ability but he is certain that he gave no assurance of Mrs* Patient 130 *receiving one to once nursing on her return to ward 3 south.* *Nursing Care Issues* *The Head of Urology and ENT and the ward manager of ward 3 south have provided me with the following response to nursing care issues raised at the above meeting.* *Regarding Mrs* Personal Information *concerns relating to finding Mrs* Patient 130 *s sitting at her bedside with a paper apron on and feet on a cold floor, with no drink available. Our investigation confirms that on this visit Mrs* Personal Information *did find Mrs* Personal Information *dressed in a theatre gown as she had no alternative clothing available at this time. Mrs* Patient 130 *water was replenished by the ward assistant as per normal ward procedure prior to Mrs* Personal Information *visit.* *In response to Mrs* Personal Information *concerns relating to her sisters transfers and manual handling our investigation indicates that Mrs* Patient 130 *was assessed at the time as being able to transfer with assistance of nursing staff, therefore it would have inappropriate to use a hoist. This method of transfer also provided an opportunity for Mrs* Patient 130 *to improve her independence and mobility. The nursing staff who participated in this transfer have been trained in the correct manual handling techniques by the Trust. Staff have reported that Mrs* Patient 130 *ileostomy bag did not leak during this transfer.* *In response to Mrs* Personal Information *further concern at finding Mrs* Personal Information *handing out of bed. Nursing staff confirm that they were alerted by Mrs* Personal Information *of this occurrence, but stress that Mrs* Personal Information *often "dangled" her legs over the edge of the bed, but was in no apparent danger.* *AT our meeting of the 3rd April 2011 Mrs* Personal Information *had expressed that she was generally unhappy with the nursing care her sister had received in 3 South. Unfortunately the ward manager did not have the opportunity to meet Mrs* Personal Information *until the morning of her sister's transfer to ICU. At this time Mrs* Personal Information *had articulated to the ward manager that she had some issues which she wished to discuss. Mrs* Personal Information *and the ward manager both agreed that it was not an appropriate time to continue with this discussion as it was Mrs* Personal Information *priority to visit her sister in ICU. However the ward manager had asked Mrs* Personal Information *to make contact with her when she felt up to it.* *Our investigation indicates that Mrs* Personal Information *did not make contact with the ward manager following this discussing. This further meeting may have provided an earlier opportunity to resolve Mrs* Personal Information *issues regarding her*	

		sister's care. *I trust that this letter addresses the issues you have raised and I apologise that the response had been significantly delayed due to the leave of key people involved in the care provided. …."*	
25.07. 2011	Email from Ms Glenny to Mr O'Brien	Re: Waiting lists and scheduling *Dear Aidan* *I hope you are keeping well. Heather had spoken to me before the holidays about the above as she had met with you regarding setting up a process for dealing with waiting lists and scheduling. She has asked that Andrea and I take this forward and I was hoping that we could come to discuss this with you.."*	TL3 page 116 AOB-05794
27.07. 2011	Email correspondence between Ms Trouton, Ms Corrigan & Consultants	Re: Results *"Dear all,* *I know I have addressed this verbally with you a few months ago, but just to be sure can you please check with your consultants that investigations which are requested, that the results are reviewed as soon as the result is available and the one does not wait until the review appointment to look at them"*	TL3 page 130 AOB-05808
19.08. 2011	Letter to Mr O'Brien from Mr R Brown, Surgical Clinical Director	Copy only HSC Southern Health and Social Care Trust 19 August 2011 **STRICTLY PRIVATE AND CONFIDENTIAL** Mr A O'Brien Personal Information redacted by the USI Dear Mr O'Brien **RE: ISSUE OF INFORMAL WARNING** I refer to our meeting on 23 June 2011 with regard to the following concern: 1. You disposed of a large section of patient filing in a bin, which was later found and retrieved by an auxiliary on the ward. The filing consisted of fluid balance charts, mews charts, TPN prescription forms, Aminoglycosides prescription forms and prescription Kardex for an inpatient on the Ward. I now write to confirm to you that as part of the Trust's Disciplinary Procedure, you will be issued with an informal warning in respect of this concern. This warning will remain valid for a period of six months. It is noted that during our meeting, you confirmed that you accepted your action was wrong and that it would not occur again. You have the right to appeal this decision. Should you wish to appeal you must write to Mr E Mackle, Associate Medical Director within seven working days of receipt of this letter, stating the grounds of your appeal. Yours sincerely Personal information redacted by USI pp Mr R Brown **Surgical Clinical Director** **Copy to: Mr E Mackle Associate Medical Director** 29 SEP 2011 AA Heus verbal warning	Doc File 1 Page 277 AOB-00277
30.08. 2011	2011 Appraisal	In the 2011 Appraisal is a letter from Mr O'Brien to Martina Corrigan in relation to a complaint made by an MLA in	2011 Appraisal

		relation to Personal Information redacted by the USI. It related to a patient who had an angiomyolipoma which underwent selective embolization in December 2001. It increased in size by 2007 and a further selective embolization occurred, which did not result in reduction in size of the lesion. Patient was symptom free. She continued under Mr O'Brien's care in 2009. At that stage she was pregnant and a review appointment was to occur in January 2010 after her pregnancy. The patient did not have an appointment in January 2010 and suffered a haemorrhage from the renal lesion in April 2011.	Pages 69-70 AOB-22290 - AOB-22291
08.09. 2011	Email correspondence between Ms Rankin and Mr Mackle	Chain of email correspondence in relation to a request that results requested by Consultants are reviewed as soon as available and to not await until the review appointment. AOB raises certain queries in relation to the procedure. Mr Mackle states on 26 August 2011 …… "*I have been forwarded this email by Martina* [the queries raised by AOB] *and I think it raised a Governance issue as to what happens to the results of tests performed on Aidan's patients. It appears that at present he does not review the results until the patient appears back in OPD."* Ms Rankin responds indicating "*I am concerned that we have not been able to sort this one out yet despite trying to have a conversation with Mr O'Brien."* Asks Heather Trouton to discuss this with the three Consultants.	Doc File 1 Pages 303 – 306 AOB-00303 – AOB-306
19.09. 2011	Mr O'Brien's comments and concerns regarding proposed Job Plan	AOB addresses the issue of reports and results in his Job Plan facilitation document. He notes "*It has recently been proposed that all laboratory results and radiological and pathological reports, pertaining to outpatients, be read when available, in order to ensure that appropriate action is taken, when indicated and in a timely manner, in order to avoid unsafe delay whilst waiting for patients to be reviewed. This is clearly a major issue of clinical governance. I believe this is currently conducted on an ad hoc basis only, and it will require significant consumption of administrative time if it is to be done completely."*	Doc File 1 Pages 308 – 313 AOB-00308 – AOB-313
01.10. 2011 – 30.09. 2012	Complaints Consultant Appraisal 1 October 2011 – 30 September 2012 Mr Aidan O'Brien	Complaints Consultant Appraisal 1 October 2011 – 30 September 2012 Mr Aidan O'Brien Complaints: *1. 21 May 2012 –* Patient 131 *Description:* *Complainant unhappy with treatment given for kidney stones whilst he was a patient on ward. Also unhappy with the delays experience in getting an appointment for follow up care.* *Outcome:* *Apology given for delay in responding to complaint.* *Apology given for conflicting information in the ED and for any misunderstanding which has arisen. Doctor give patient information to keep him updated. Patient has been treated and will be reviewed In 1 year."*	2012/13 Appraisal pages 195 - 198 AOB-22515 - AOB-22518

		2. *24 September 2012 –* Personal Information redacted by the USI *Description:* *Complainant unhappy with length of time he is having to wait for review appointments.* *Outcome:* *The 3 issues raised by complainant of treatment for carpel Tunnel Syndrome, treatment at pain clinic and urology. Complainant has been advised further correspondence will be read and filed. Complainant advised of the complaints guidelines April 2009.* *3. 31 January 2012 –* Personal Information redacted by the USI *Description:* *Complainant unhappy with delay in provision of an appointment for her father. Also unhappy that his hopes were raised for successful treatment by given false expectations.* *Outcome:* *Thanked the complainant for her positive experience of the Haematology Dept. Apology given for delay in patient's treatment and the breakdown in communication. Acknowledged that the consultant is in direct contact with patient.* *4. 13 May 2013 –* Personal Information redacted by the USI *Description:* *Complainant wishes to have his constituents operation brought forward and is not happy that there could be a delay in provision of same.* *Outcome:* *MLA advised it was explained to patient and family his prognosis and treatment.* There is also an incident undated. Incident relating to a nursing issue. It is alleged that "*The surgeon asked the second nurse for a blade in order to insert a drain. The blade was already on the BP handle at the time of handover and seemed secure.* *The blade was given in the correct manner: However the blade dislodged into the patient and was retrieved. On inspection the BP handle was noted to be worn.* *No harm came to the patient and the incident was reported to senior staff and CSSD"*	
04.10.2011	Email from Mr O'Brien to Ms Farrell	Re: Complaint re Ms Personal Information redacted by the USI *"Dear Roisin,* *I had not appreciated that this letter of complaint was directed to me for response, and I remain unsure that it is intended to*	TL3 page 174 – 175 AOB-05852 – AOB-05853

		be. It would appear that the complaint pertains to the attitude of nursing staff on Ward 3 South. It seems rather inappropriate that I should have to investigate this matter. Would it not be more appropriate that the Ward Manager do so? Let me know"	
13.10.2011	Email from Ms Farrell to Mr O'Brien	Re: Trust response to Complaint (Ms Personal Information) *"Dear Cllr O'Neil* *I refer to your letter to the Minister of Health in relation to the treatment and care provided to Mrs* Personal Information redacted by the USI *of* Personal Information redacted by the USI *. Thank you for taking the time to highlight your concerns and for providing me with the opportunity to address them.* *Mrs* Personal Information *was under the care of Mr O'Brien for the treatment of Angiomyolopoma. Mrs* Personal Information *attended Mr O'Brien in January 2009 and it was planned to review her in January 2010, to undertake an MRI scan following completion of her pregnancy. This review apparently did not take place.* *We have investigated this issue and it is clear that the booking of this review did not take place due to an administrative oversight. However, since this time we have introduced new failsafe mechanisms to ensure that the outcomes form all outpatients' appointments are clearly identified and patients are reviewed in the appropriate time scale. I wish to apologise most sincerely for the delay in investigation this error has caused.* *…."*	TL3 page 186 – 188 AOB-05864 – AOB-05866
26.10.2011	Email from Ms Davidson to Mr O'Brien	Re: RIQA "*Dear Mr O'Brien* *I have filled in an IR1 Form and have informed the Radiation Protection advisor for the trust about the gentleman that had a CT scan and Bone scan done by mistakes. He has informed me that we will have tor eport this incident to RQIA so I need you to investigate the incident from your end. RQIA will be asking the questions about who referred and where and how the mistake happened and is there any adverse effect on the patient. I need to know how you were informed etc of the mistake. The patient eventually will need to be spoken to but that will be for the AMD or AD I think. I presuming that a full RCA and SAI will be conducted by the Trust"*	TL3 page 199 AOB-05877
17.11.2011	Memorandum re complaint	Re: Complaint re inappropriate discharge	TL3 page 256 AOB-05934
28.11.2011	Letter from Dr Rankin to Patient (Ms Personal Information redacted by the USI	*"Dear Ms* Personal Information redacted by the USI *I refer to your complaint in respect of your disappointment with the care given to you whilst you were a patient in Ward 3 South in June 2011.*	TL3 page 236 – 237 AOB-05914 – AOB-05915

		At the outset please accept my apology for the delay in responding to you. *Thank you for sharing your experience with us. We are continually trying to ensure that our patients are treated with the utmost respect and care and we are sorry that this was not your experience during this admission. Please be assured that we have addressed your concerns with all staff involved to ensure this experience is not repeated.* *I trust that this letter addresses the issues you have raised.* *If however you remain unhappy please do not hesitate to contact a member of the Clinical and Social Care Governance Team on* Personal Information redacted by the USI *who will discuss the options available to you"*	
05.12.2011	Email correspondence between Mr Mackle, Mr O'Brien and Ms McCorry	""*Dear Aidan* *As you are aware in the letter post your job plan facilitation it was stated 'This will undoubtedly require you to change your current working practices and administration methods. The Trust will provide any advice and support it can to assist you with this.'* *I as a result, organised a meeting to discuss same. I note however, that you cancelled said meeting. I am therefore concerned that we haven't met to agree any support that you may need. I would appreciate if you would contact me directly this week to organise a meeting. If however you are happy that you can change your working practice without the need for Trust support then you obviously do not need to contact me to organise a meeting."*	Doc File 1 Page 337 AOB-00337
12.12.2011	Email from Ms Corrigan to Mr O'Brien	Re: Outcome delay due to charts at home Personal Information redacted by the USI *attended Mr O'Brien's clinic on 18/11/11 but Vicki has been unable to get an outcome from this appointment as she cannot locate the chart. Can you please see if you could get us an outcome?* *Vicki has advised that she has problems getting outcomes for patients who attend a day 4 clinic with Mr O'Brien as he takes the charts away with him and no one knows where he takes them to. Can you please raise this issue with Martina and Mr O'Brien"*	TL3 Page 238 -239 AOB-05916 – AOB-05917
19.12.2011	Letter from Patient re complaint	*"Dear Sir/Madam* *I am writing to express my extreme disappointment at how I have been treated by whoever makes the appointment for Mr O'Brien's at the Urology Department in Craigavon Area Hospital.* *I was last seen on 6/5/2011 and was told I would be put on the next surgical list. After a couple of months I phoned his secretary since I had not received an appointment and was told I would be put on the next month's list, I phoned again and was told the same story and the next month and the next. The last time I phoned the lady said she would check*	TL3 page 246 AOB-05924

		and phone me back – I have still not heard from her. *I also work for the* Personal information redacted by USI *so I understand how busy staff must be but I really need this surgery as the condition is having a very negative impact on my quality of like and I keep having my expectations raised that it won't be for much longer only to be disappointed month after month.* *I would like you to review my notes and please contact me as soon as possible to let me know when I can expect to be seen"*	
23.12.2011	Email from Ms Corrigan to Mr O'Brien	Re: Complaint Query whether Mr O'Brien could provide the patient with an appointment. Letter of complaint dated 19 December 2011	TL3 page 241 – 245 AOB-05919 – AOB-05924
23.12.2011	Email correspondence between Ms Corrigan and Mr O'Brien	Email from Martina Corrigan to AOB headed "*New complaint for investigation –* Personal Informati*."*	Doc File 1 Page 340 AOB-00340
28.12.2011	Email from Ms Corrigan to Mr O'Brien	Re: Patient complaint Complaint in relation to inappropriate discharge by SHO. Ms Corrigan requested Mr O'Brien to provide a response to this. Memo of this complaint was generated on 17 November 2011 but Mr O'Brien was not made aware of this at this time (included in chronology above)	TL3 Page 252 – 259 AOB-05930 – AOB-05937
2012	Policy For the Safeguarding, Movement & Transportation of Patient/Client/Staff/Trust records, files and other media between facilities	**Policy loosely allows for records to be stored at home.**	SUP 399 – 431 AOB-03890 – AOB-03927
15.01.2012	Letter from Patient to Mr O'Brien	*Re:* Personal Information	TL3 page 267 – 270 AOB-05945 – AOB-05948

My father was not provided with support for the ongoing management of his cathet
service but was told to see his GP with any concerns. They however have not appe
helping with all his queries about the catheter and explained that he needed to disc
service! This is very confusing!

Fortunately my father's sister is a retired nurse who discussed with the GP about u
catheter instead of him carrying around the bag. For my dad this little thing was lif
meant he had his confidence and activity levels back again which I'm sure you will
difference to a person's quality of life! Why was this option not discussed with him

When he attended his appointment with the Urologist in October 2011 he was told
further investigations and surgical intervention would be unlikely to happen before
Later in October 2011, feeling very fed up of the catheter he wondered if he could
normally and so he attended the practice nurse clinic at the GP surgery and asked
be removed. The nurse did this and dad reported that he was able to urinate norm
days. After this, micturition stopped and he was in such severe pain he attended t
the catheter to be reinserted. Almost 3 months have now passed since he was las
personally called your secretary on a number of occasions in the last few months t
at on your waiting list and she has told me repeatedly that she would pass on my r
ultimately you would decide on the order of patients seen according to priority, whi
would expect. When I last called on 28th December 2011 I asked your secretary w
target waiting time is for a patient like dad to have the surgical procedure is, I was
is a very long time to leave someone with no ongoing support or communication w

In conclusion I think that my father's treatment overall is ***VERY*** unacceptable for th
reasons:

1. His hopes and expectations of receiving further investigations and surgica
raised early on by telling him this would occur in September, then change
since then **no** further information has been given! Why has no-one conta
explain the situation or ask him how he is managing? It is very unfair to h
hopes and then not explain what has happened to change the situation.

2. Other than his outpatient review in October 2011 suppo
has been non –existent since his discharge from A&E i
helpline number or specialist nurse service number giv
follow up arranged to check that all was going well – ev
discharge from A&E?

3. Why is there no further outpatient appointments arrange
investigation/ surgery?

4. Why was the cap option on the catheter not discussed
this is not a suitable option?

As you will note from the above address I no longer live in North
home to attend the urology outpatient clinic in October 2011 wit
admitted to hospital so I have not been able to talk to any of the
would greatly appreciate if you could respond to this letter as so
concerns.

		My father was not provided with support for the ongoing management of his cathet service but was told to see his GP with any concerns. They however have not appe helping with all his queries about the catheter and explained that he needed to disc service! This is very confusing! Fortunately my father's sister is a retired nurse who discussed with the GP about u catheter instead of him carrying around the bag. For my dad this little thing was life meant he had his confidence and activity levels back again which I'm sure you will difference to a person's quality of life! Why was this option not discussed with him When he attended his appointment with the Urologist in October 2011 he was told further investigations and surgical intervention would be unlikely to happen before Later in October 2011, feeling very fed up of the catheter he wondered if he could normally and so he attended the practice nurse clinic at the GP surgery and asked be removed. The nurse did this and dad reported that he was able to urinate norm days. After this, micturition stopped and he was in such severe pain he attended t the catheter to be reinserted. Almost 3 months have now passed since he was las personally called your secretary on a number of occasions in the last few months t at on your waiting list and she has told me repeatedly that she would pass on my r ultimately you would decide on the order of patients seen according to priority, whi would expect. When I last called on 28th December 2011 I asked your secretary w target waiting time is for a patient like dad to have the surgical procedure is, I was is a very long time to leave someone with no ongoing support or communication w In conclusion I think that my father's treatment overall is ***VERY*** unacceptable for th reasons: 1. His hopes and expectations of receiving further investigations and surgica raised early on by telling him this would occur in September, then change since then **no** further information has been given! Why has no-one conta explain the situation or ask him how he is managing? It is very unfair to h hopes and then not explain what has happened to change the situation. 2. Other than his outpatient review in October 2011 support with managing a cath has been non –existent since his discharge from A&E in August 2011. Why is helpline number or specialist nurse service number given? Why was no comm follow up arranged to check that all was going well – even if it was just for one discharge from A&E? 3. Why is there no further outpatient appointments arranged as dad awaits a date investigation/ surgery? 4. Why was the cap option on the catheter not discussed with my father? Is there this is not a suitable option? As you will note from the above address I no longer live in Northern Ireland, and so hav home to attend the urology outpatient clinic in October 2011 with dad or to be present w admitted to hospital so I have not been able to talk to any of the medical staff personall would greatly appreciate if you could respond to this letter as soon as possible to answe concerns.	
30.01.2012	Email to Mr Hall from Mr Mackle	Re: Antibiotics *"Dear Sam,* *I have been advised that a patient* Personal Information redacted by the USI *may have been admitted to Urology by Mr O'Brien and under his instruction was given IV antibiotics the latter necessitating a central line to be inserted.* *I have checked with Dr Rajendran and he advises me that no discussion took place prior to the administration to the antibiotics.* *I would be grateful if you could investigate this and advise me of your findings"*	TL3 page 284 AOB-05962
04.02.	Email from Mr O'Brien to	Re: Patient complaint requiring urgent response - Personal Information	TL3 page

2012	Ms Corrigan	Mr O'Brien requested that defer response until after patient's surgery. He confirmed that he had spoken to the patient recently.	312 - 313 AOB-05990 – AOB-05991
06.02.2012	Email from Ms Corrigan to Mr O'Brien	RE: Missing medical notes *"Vicki is unable to find the below 2 patients medical notes following a day 4 appointment with Mr O'Brien and can therefore not get a clear outcome. Can you please speak to Mr O'Brien to see where these charts may be as they are still tracked to Thorndale Unit?"*	SUPAUG
06.02.2012	Email correspondence between Ms Corrigan, Mr O'Brien and Ms Montgomery	Email entitled "*Day 4 outcome escalation".* Email from Martina Corrigan on earlier email in relation to below 2 patients whose medical notes following a day 4 appointment with Mr O'Brien. Cannot get a clear outcome to speak to Mr O'Brien where these charts may be.	Doc File 1 Page 344 AOB-00344
07.02.2012	Email correspondence between Mr O'Brien and Ms Corrigan	Complaint not attached, it seems to relate to position on waiting list. AOB notes how patient's catheter had been removed and therefore he is removed from the waiting list and had been arranged to be seen at the LUTS Clinic. Notes he would respond as soon as possible to the complaint.	Doc File 1 Page 345 AOB-00345
09.02.2012	Email from Mr O'Brien to Ms Troughton	Re Lists *…."Lastly, having spent considerable time arranging above admissions which are certain, I want to take this opportunity to clarify for you (and Leanne acting for KJ) is that I will not accept any other surgeons taking patients off my list weeks in advance to preadmit etc. It only places entirely unnecessary pressure on me to do things out of order. I had other plans for my time yesterday evening. So, I will select all patients of mine for surgery by Mehmood and KJ during March. I will not compromise on that, and I will do it in my own good time"*	SUPAUG

15.02.2012	Complaint report structured reflective template	Southern Health and Social Care Trust *Quality Care - for you, with you* **Complaint report structured reflective template** Requirement: one for each complaint you have received. Name of doctor: Aidan O'Brien GMC No: 1394911 Date of complaint: 15 January 2012 Nature of complaint: The complaint was made by the daughter of a man who had developed a urinary retention, requiring catheterisation, in August 2011. The patient fo it very difficult to accept indwelling catheterisation for any period of time, certainly until review as an outpatient in October 2011, when I advised th patient that I hoped to have been able to have him admitted for surgery in November 2011, an aspiration which was not realised. In discomfort and frustration, he had the catheter removed by a practice nurse, only to requ be recatheterised 5 days later. However, as a consequence of the progre effects of pharmacological management, he was eventually able to pass satisfactorily without recourse to surgery. When last review, he was entire asymptomatic. Apart from the inherent length of time required for medicat to take effect, the complaint listed the lack of appreciation of the trauma associated with indwelling catheterisation, the lack of counselling and sup and her father having to wear a leg bag rather than having a valved spigo Status of complaint: On-going / resolved Resolved Involvement of other bodies: Responsible organisation / GMC / Other None If resolved, what were the findings? Expression of regret How will my practice change? My practice has changed in several respects as a consequence. Unfortunately, it is still the case that the reflex reaction to catheterisation is arrange a trial removal of catheter without an adequate assessment of the likelihood of success. Even success can be short lived as in this case. Sh lived success or initial failure adds to the patient's frustration.	2012/13 Appraisal pages 199-200 AOB-22519 - AOB-22520
		When receiving a request for trial removal of catheter, I make an assessr of the probability of success, based upon previous history of symptoms, circumstances in which retention occurred, comorbidity and performance status, and prostatic volume. I arrange trial removal if success is probabl and an urgent outpatient appointment if not, in order to arrange trial remo with the capacity to arrange prostatic resection if unsuccessful. In most cases, a bladder does not require continuous drainage by cathet more than does a bladder without an indwelling catheter. In comorbid pat with compromised performance status, continuous drainage may be pref by patient and carers. However, in the active patient, a continuous draina bag may be more inconvenient and traumatic for the patient, as was the here. If preferred, we now fit a valved spigot in the outpatient department arrange to have patient supplied. Lastly, this case brought home to me the extent to which we underestima the negative impact that indwelling catheterisation can have upon a patie We are fortunate to have an excellent community continence service who have the capacity and enthusiasm to provide domiciliary counsel and sup and who can be immediately notified at c[Irrelevant redacted by the USI] Final outcome after discussion at appraisal: (Complete at appraisal considering how your outcome will improve patient care) In addition to the above improvements in the management of those who develop acute urinary retention requiring catheterisation, it is our departm collective intent, with the appointment of additional consultant staff, to be to expedite the care of these patients, including surgery if required or considered likely to be required	

17.02. 2012	Email from Ms Corrigan to Consultants	Re: PTL Total Daycases with no dates are 24 patients AOB = 1 MY = 17 MA = 6 Total Inpatients with no dates are 67 patients AOB = 34 MR = 33 MA = 0 I know you are all working at scheduling for March so I expect to see a change on Monday's PTL but wanted to let you see the overall picture.	TL3 page 320 AOB-05998
17.02. 2012	Email from Ms Corrigan to Mr O'Brien	Re: PTLs **Mr O'Brien Inpatients without date** Approx. 35 patients longest waiting 49 weeks **Mr O'Brien Daycase without date** Approx 7 patients longest waiting 37 weeks	TL3 page 321 - 323 AOB-00599 – AOB-06001
20.02. 2012	Email from Mr O'Brien to Mr Jong	Re: January clinics **Mr Jong –** "*Hi , I understand there may be an issue with the trust regularly booking 15 patients to clinics. I just want to clarify this before I raise the issue as all my clinics (am and pm) have 15 booked (it had been 12 last month). According to Andrea this is a direct instruction from Martina. Obviously if this is what we collectively have agreed to do then I will drop the issue."* **Mr O'Brien –** *"I just realised that I had not commented to you on the issue of numbers of patients appointed to clinics. It has indeed been the case that the Trust has aggressively insisted that there should be 15 patients appointed to be seen by a consultant at a 4 hour clinic. I have sincerely and genuinely tried to see increasing numbers of patients within the four hours of a clinic, and have been unable to accommodate more than 12 patients. As a consequence, I still do have a maximum of 12 patients appointed per doctor for a clinic lasting four hours. I understand that it is the same for Michael to date."*	TL3 Page 324 – 325 AOB-06002 – AOB-06003
23.02. 2012	Email from Ms Corrigan to Consultants	Re: Urology Saturday additionality lists	TL3 page 326 AOB-06004
25.02. 2012	Trust letter to Patient in response to complaint	Re: Personal Information redacted by the USI *"I refer to your complaint in respect of the quality of care and lack of communication with the family of* Personal Information redacted by the USI*. Thank you for taking the time to highlight your concerns and for providing me with the opportunity to address them.* *At the outset I am delighted to learn of your positive experiences of the Haematology Department of Craigavon Area Hospital and I have taken the opportunity to share these with the staff who provided your father's care.* *In relation to your complaint about the Urology Depatrment, as part of our investigation I have spoken directly to Mr O'Brien, Consultant Urologist who I understand has contacted your father by telephone to discuss the issues raised in your letter. Mr O'Brien has agreed with your father at this stage, he did not need a procedure and he gave him*	SUPAUG

		advice on the management of his catheter. I also believe he has agreed that the next stage of treatment would be that your father would come to the Lower Urinary Tract Clinic (LUTS) in the Thorndale Unit on 5 March to discuss further and agree how best to manage the catheter and to answer any other concerns with a view to decide the best way forward for your father. *I appreciate there is a recognised gap between the hospital and the community regarding catheters and the Trust is in the process of addressing this by appointment additional continence nurses in community services.* *On behalf of the Trust I would like to apologise to your father for the delay in his treatment and the breakdown in communication. I do hope that by Mr O'Brien having contacted him directly and arranging a follow-up appointment that this has gone some way to addressing his concerns.* *I trust this letter addresses the issues you have raised and I wish your father well for his forthcoming consultation.* *…"*	
15.03.2012	Email from Mr O'Brien to Ms Corrigan	RE: Urodynamics *"Just to give you update on inpatient PTL.* *All patients have been contacted by me to be offered dates by end of March. Some patients were unable for admission for several reasons, such as current illness, other surgeries pending, abroad on holidays etc. All patients available and fit for admission by 31 March have had their admission arranged.* *Regarding urodynamic studies, I do not understand how some patients can suddenly appear on a PTL list. For example,* Personal Information redacted by the USI *I have been unaware of this patient being on my waiting list until I received your email. She certainly was not on my urodynamic waiting list as of 31/01/2012, and which I have in front of me. Your list indicates that she was placed on list on 04/07/11. It would appear that she attended my clinic in Banbridge, and I presume that she was placed on waiting list then. It just is all the more difficult to meet target times when patients can disappear from a waiting list for months, and only to reappear just when you think that all targets have been met"*	TL3 page 367 AOB-06045
20.03.2012	Patient complaint	Re: Personal Information redacted by the USI	[New Bundle]
30.04.2012	Email from Mr McKeown to Ms Carson	Re: Review patients and clinic outcome sheet Few complaints. It was noted that the doctors should not fill in extra paper work. Doctors role to see patients and that administrative duties should be carried out by admin staff or a health care assistant. This is what happens at other hospitals	TL3 page 400 – 403 AOB-06078 – AOB-06081
11.05.2012	Email correspondence between Ms Corrigan and Ms O'Brien	Re Patient complaint – Personal Information Personal Information redacted by the USI wife was seen in DHH on 11 October 2011 with regards to kidney problems and also had catheter bag inserted. She was discharged and told would be referred to Mr Akhtar in CAH.	TL3 page 423 – 427 AOB-06101 – AOB-06105

		Seen by Mr Akhtar on 25 Jan 2012 and was told she should require a further procedure to have bag inserted into stomach Mr Akhtar no longer working and every time rings secretary, gets answering machine. Patient wants to know who has taken over wife's care and wants procedure done as soon as possible Issues: 1. Unhappy with waiting times 2. Would like to be transferred to RVH or BCH 3. Suffering infections 4. Ring secretary – get answering machine	
11.05.2012	Email from Ms Marshall to Mr O'Brien	Re: Attendance at Surgical M&M Mr O'Brien's 67% attendance	TL3 page 406 AOB-06084
12.05.2012	Significant event audit (SEA) structured reflective template	Southern Health and Social Care Trust *Quality Care - for you, with you* Significant event audit (SEA) structured reflective templat Requirement: one annually **Name of doctor:** Aidan O'Brien **GMC No:** 1394911 SEA Title: Dislodgement of scalpel blade from handle Date of incident: 12 May 2012 Description of events: It was only on requesting that a blade be mounted on a scalpel handle fo purpose of making an incision for the purpose of insertion of an intraperit drain at the end of an operation, was it appreciated that the blade was mi as a consequence of having become dislodged from the handle on withdr through a similar, earlier incision. The blade was located within the abdor cavity and removed. It had not caused any visceral injury. What went well? The vigilance of the scrub nurse alerted the operating team to the fact tha blade was missing, leading to its early, intraoperative location. What could have been done better? The dislodgement was due to the fact that the handle was relatively old, resulting in the blade mounting slot to have become worn, rendering the mounted blade less secure. It would have been better if that risk relating t the condition of the handle had recognised by all personnel, from CSSD t surgeon. What changes have been agreed? Personally: To check on the security of the mounted blade prior to use, and after, use For the team: Having had the incident reported to CSSD, staff there have endeavoured to do likewise, in addition to the operating team Final outcome after discussion at appraisal: (Complete at appraisal considering how your outcome will improve patient care) I was unaware of the risk of dislodgement associated with lack of confluence between new blade and worn handle. I have been since this incident. I check it on each occasion since, to ensure that no harm comes to any patient as a consequence.	2012/13 Appraisal pages 201-202 AOB-22521 - AOB-22522

17.05.2012	Patient complaint letter	Re: Patient 131 *"I wish to make a formal complaint in regard to my treatment over the last few months.* *Consultant Name: Mr O'Brien but Mr Young looked after me.* *On 6th January I was diagnosed as having kidney stones and was admitted to the urology ward Craigavon Area Hospital.* *On the 9th January I had a stent inserted.* *I was discharged from the ward on the 10th January to attend the stone treatment centre for ESWL and was given an appointment for the 6th February.* *This appointment was subsequently cancelled.* *As I was in so much pain/distress I had to attend the G.P and was then given an appointment to attend on the 8th February.* *I was reviewed by Mr Young on the 12th March and was told the stone had got bigger, but advised they would try a further treatment of ESWL;this was performed on 30th April.* *The report of the USS showed the stent had moved and an urgent appointment was required with Mr O'Brien, to date (17th May) no appointment has been received.* *During the interim period my GP sent me for an ultrasound which showed the stent had moved, and I was referred to a&e.* *They did an x-ray and I as told the stent hadn't moved, I am frustrated and dissatisfied with the conflicting information I am receiving.* *The A&E doctor's attitude toward me was hardly professional as he stated "you can stay if you want, but you probably won't be treated until Tuesday".* *As this was over a weekend period I felt it was unreasonable and unjustified to take up a hospital bed, especially when news reports day and daily state the number of trolley wait patients to be seen.* *I am in constant distress because of the continuing back pain, stomach pain, weight loss, urinary incontinence and pain on passing urine.* *All of these symptoms have affected my sleeping pattern and impact on my daily work/home activities.* *My home life has suffered because of the psychological affect this is having on me.* *I am worried that there might be long term damage to my kidneys, and really all I want is to have the necessary*	TL3 page 412 – 414 AOB-06090-AOB-06092

		treatment in a timely manner. *I appreciate the demands on the health service are ever increasing, but I do feel January to mid May is a long time to be in constant pain. "*	
23.05. 2012	Consultant attendance at Surgical M&M 2011		TL3 page 410 – 411 AOB-06088 – AOB-06089
24.06. 2012	Email correspondence between Ms Corrigan and Mr O'Brien	Reference to a response due to the complaint from Patient 131 Patient 131. Reminder to AOB re same.	Doc File 1 Page 374 AOB-00374
2012	Record of Attendance Morbidity and Mortality Meetings 2012	Record of Attendance Morbidity and Mortality Meetings 2012 for AOB – 4 out of 12 = 33% meetings attended	2012/13 Appraisal Page 86 AOB-22406
06.09. 2012	Letter from Trust to Patient re complaint	Re: Patient 131 *"I refer to your complaint in respect of the treatment and care provided to you firstly at the Emergency Department of Craigavon Area Hospital and in general the service provided to you by Urologists.* *At the outset I would like to apologise that you feel your treatment in the Emergency Department did not meet your expectations and I fully appreciate your concerns over the conflicting information given. I also regret the length of time it has taken to respond to your complaint.* *In relation to your comment that "they did an x-ray and told me the stent hadn't moved", I sincerely regret that you were given conflicting information whilst in the Emergency Department. I have asked Dr Feenan to make a comparison of the two most recent x-rays available to him and sincerely regret any misunderstanding which has arisen. At the stage Dr Feenan provided you with information I understand he had already spoken to the Urology on-call team who had accepted your care. I believe the only reason he told you this piece of information was to keep you up to speed with your progress through the Emergency Department and to ensure you did not feel forgotten about. I apologise that this has led to distress for you.* *With regard to your comments that "the A&E doctor's attitude towards you was hardly professional as he stated "you can stay if you want, but you probably wont be treated until Tuesday". Our investigation has confirmed that this was not Dr Feenan. Nonetheless it was unacceptable for the doctor who said this to do so and I sincerely apologise for how it made you feel.* *Moving on to your complaint in respect to the waiting time for your procedure in Urology. I have asked Mrs Corrigan, Head of Urology to investigate this delay. I can confirm that you were admitted under Mr O'Brien, Consultant Urologist on 8 January 2012 and that you were discharged with an*	TL3 page 448 – 450 AOB-06126 – AOB-06128

		appointment arrange for you to attend the Stone Treatment Centre on 8 February 2012 under Mr Young's care. You attended this and a further appointment in the Stone Treatment Centre on 30 April 2012. As you state in your correspondence you were advised that you had been placed on the waiting list for further treatment. Mrs Corrigan advises that you have since been admitted under Mr O'Brien's care on 13 June and that you have had your procedure completed and that you are scheduled to be reviewed again in one year. *I apologise that you have had to wait longer than you had expected for your procedure and for the pain and discomfort you experienced during this wait. There has been an increase in the demand for urology within the Southern Health and Social Care Trust. The Commissioners are working with the Trust and Consultant Urologists to address this increase.* *…."*	
08.10.2012	Email from Ms McQuaid to Ms Montgomery	Re: Red flag triage *"I had left referrals for Mr O'Brien to triage in Thorndale unit on Friday 28/09/12, I phoned on the Monday to see if they had been done. I was advised that Mr O'Brien had taken these referrals with him. On Tuesday I emailed Monica and she advised me that he was in theatre Tues and Wed and could not be disturbed. I again chased these on Friday. I phoned Thorndale unit and left a message re referrals and that I needed to know urgently what had been done with them. I received a phone call from the Thorndale unit on Friday PM to say that Mr O'Brien had forgotten about them. On Sat I received an email from Monica to say that Mr O'Brien would be giving the names of these patients to her early this week to be booked onto his extra oncology clinic on Sat 13th.* *This means they will miss their 10 day target and leave them D15 – D17*	TL3 Page 503 – 506 AOB-06181 – AOB-06184
23.11.2012	Email from Ms Magennis to Ms Addis	Re: Personal Information redacted by the USI *"Mr* Personal Information *explained that his father is awaiting an urgent procedure under the care of Mr O'Brien and as yet has received no contact regards an appointment or estimated timeframe.* Personal Information redacted by the USI *explained that his father has attended pre-op on three occasions and is no suffering great discomfort.* Personal Information redacted by the USI *said that he contacted Mr O'Brien's secretary who was unable to give him a date or estimated timeframe.* Personal Information redacted by the USI *and his son are quite anxious to receive contact with this information and have explained that they will go to their local representative or media if need be…"*	TRU-01497 – TRU-01498
25.11.2012	Communication re Use of Health Records Charts		TL3 page 583- 585 AOB-06261 – AOB-06263

27.11.2012	Email from Ms Corrigan to Mr O'Brien	Re patient complaint – Personal Information redacted by the USI **Complaint:** *"Personal Information redacted by the USI explained that his father is awaiting an urgent procedure under the care of Mr O'Brien and as yet has received no contact regards an appointment or estimated timeframe. Personal Information redacted by the USI explained that his father has attended pre-op on three occasions and is no suffering great discomfort. Personal Information redacted by the USI said that he contacted Mr O'Brien's secretary who was unable to give him a date or estimated timeframe. Personal Information redacted by the USI and his son are quite anxious to receive contact with this information and have explained that they will go to their local representative or media if need be.* *I explained the complaints process to Personal Information redacted by the USI and Mr Personal Information agreed for this to be treated informally in the first instance. I have explained to Personal Information redacted by the USI that he may not receive contact today with this information and that it could be the start of next week."*	TL3 page 587 – 588 AOB-06265 – AOB-06266
30.11.2012	Antibiotic Ward Round	• O'Brien: 13 patients. CURB score n/a. ○ **Indication not recorded and choice and dose inappropriate in 1 patient** ▪ 1pt given IV meropenem 500mg TID (1g TID recommended), switched form IV tazocin after 2 doses, no indication documented. ○ **Choice inappropriate in 3 patients** ▪ 1pt given IV gentamicin 480mg OD + PO ofloxacin for epididymo-orchitis, PO ciprofloxacin recommended. ▪ 1pt given IV co-amoxiclav 1.2g TID on elective admission for catheter removal, no evidence of infection. If prophylaxis for catheter change, 1 dose IV gentamicin recommended. ▪ 1pt given PO trimethoprim 200mg BD for UTI, no clinical evidence of infection (patient had catheter in situ-may lead to resistance).	SUPAUG page xxx
31.12.2012	Antibiotic Ward Round	• Dr O'Brien: 32 patients, CURB score appropriate for 4 patients, **recorded in 3**. ○ **Choice** inappropriate in 6 patients.	SUPAUG Page xxx
October 2012 – December 2012	List for surgical M&M		SUPAUG
2013	Record of Attendance Morbidity and Mortality Meetings 2013	Record of Attendance Morbidity and Mortality Meetings 2013 for AOB – 6 meetings attended	2012/13 Appraisal Page 87 AOB-22407
01.02.2013	Antibiotic Ward Round	▪ 1 pt on PO co-amoxiclav 625mg TID post op, no documented evidence of infection. • O'Brien: 2 patients. CURB score n/a. ○ **Choice inappropriate in 1 patient:** ▪ 1 pt on IV benzylpenicillin 1.8g BD for post op infection, IV gentamicin recommended.	SUPAUG Page xxx
04.02.2013	Email from Ms Kerr to Mr O'Brien, Mr Hall and Mr Davidson	Re: SAI – Mr Personal Information Requesting for consultants to meet with Margaret Marshall to take the SAI forward. SAI was enclosed.	TL3 Page 736 – 746 AOB-06414 – AOB-06424
08.02.2013	Letter to Patient from Trust	Re: SAI Mr Personal Information – incorrectly underwent scan when did not have symptoms to do so.	TL3 page 760 – 761 AOB-06438 – AOB-06439
15.02.2013	Letter from Mr Mackle to Mr O'brien	Re: M&M Attendances Attendances for 2012 calendar year is 33%	TL3 page 793 AOB-06471
19.02.2013	Email correspondence between Ms Corrigan and	20 patients raised in emails between Ms Trouton and Ms Corrigan in relation to outstanding triage between 5th and 14th	Doc File 1 Pages

	Ms Trouton	February 2013	402 - 404 AOB-00402 - AOB-00404
12.03.2013	Email from Mr O'Brien to Ms Corrigan	Re: Urology patients in Knightsbridge "*From a governance perspective I , and am sure the other consultants, would appreciate to have a list of our patients who were transferred to the independent sector and knowledge of their outcome and letters of correspondence on their therapy. Although this was a Trust decision and their responsibility, I would appreciate to know what has happened to patients who were previously under my wing"*	TL3 page 848 AOB-06526
28.02.2013	Antibiotic Ward Round	• O'Brien: 4 patients. CURB score n/a. ○ **Dose inappropriate in 1 patient:** ▪ 1 pt on PO fluconazole 50mg OD for treatment of fungal UTI, treatment dose of 400mg OD recommended if patient symptomatic and requiring treatment.	SUPAUG Page xxx
01.05.2013	Email correspondence between Ms Corrigan, Mr O'Brien and Ms Coleman	Email indicating "*Anita just to let you know that another IR1 has been put in today for 2 charts that Mr O'Brien has at home and that are needed for Monday."*	Doc File 1 Pages 457 – 458 AOB-00457 - AOB-00458
03.05.2013	Antibiotic Ward Round	• O'Brien: 1 patient. CURB score n/a.	SUPAUG Page xxx
13.05.2013	Email correspondence between Ms Burns and Ms Corrigan	Reference is made to an IR1 being completed in an email of 9 May in relation to notes for a patient who was admitted to MAU but the charts were at AOB's house. 12 May email Martina Corrigan to Deborah Burns "*Debbie, This has been an ongoing problem years. The last time that Helen spoke to me about this I spoke to Aidan and advised him of the issues which he did say he would stop it and did stop it for a while but I had asked Helen if it had happened again to raise it with me and also raise an IR1. Unfortunately there are three charts now in Aidan's house and I am unsure if anyone has spoken to him about it direct (I will check with Helen tomorrow).* *I am happy to talk to Aidan again but think we need to involve Robin as CD as well?*	Doc File 1 Pages 459 – 460 AOB-00459 - AOB-00460
13.05.2013	Email correspondence from Ms Corrigan to Mr O'Brien	Re: IR1 being completed due to patient lack of consent *"after checking in a patient on the urology list I discovered she had no consent. Her procedure was discussed and patient confirmed the procedure she was having was the same procedure noted on the theatre list. Mr O'Brien was to consent the patient in the anaesthetic room but as we walked down the corridor someone opened the main theatre doors said we were ready suggesting bringing the patient into theatre and I forgot the patient at that stage hadn't formally consented. I was not the anaesthetic nurse that day but one patient had to go to recovery as this patient arrived at theatre so I checked the patient in. Lack of consent highlighted just*	SUPAUG

		as patient was having her anaesthetic"	
16.05. 2013	Email correspondence from Ms Corrigan to Mr O'Brien	Re: New complaint – Personal Information redacted by the USI *"I write regarding the concerns raised with me by Mr Personal Information redacted by the USI Hospital Number Personal Information redacted by the USI.* *Mr Personal Information redacted by the USI is suffering from an aggressive bladder cancer as diagnosed at a consultation with Dr O'Brien on Good Friday this year.* *Given the seriousness of his condition the Consultant was keen that the operation take place as soon as possible and had hoped that this would be before the end of April. In light of the fact that we are now well into the months of May, both Mr Personal Information redacted by the USI and his family are concerned that he has not as yet got a date for his surgery to remove the bladder.* *I am aware that Mr Personal Information redacted by the USI has another appointment with Mr O'Brien on 17th May and I am led to believe that as the bladder operation has to be carried out in Belfast, the family were informed that due to the fact two different Trusts are managing the case this can lead to delay, I would hope this would not be the case.* *I would be grateful in light of the real concerns of Mr Personal Information redacted by the USI and his family if an operation date could be secured in the shortest possible time frame.* *Your assistance in this matter would be most appreciated and I look forward to your response."*	TL3 page 985 – 986 AOB-06663 – AOB-06664
28.05. 2013	Letter from Trust to Cllr William Irwin	Response to Mr Personal Information redacted by the USI complaint	TL5 Page 198
04.06. 2013	Antibiotic Ward Round	• O'Brien: 4 patients. CURB score n/a. ○ **Indication not recorded and compliance not assessable in 3pts:** ▪ 1pt on IV benzylpenicillin 1.2g BD, no documentation of antibiotics in notes, no documented evidence of infection. ▪ 1pt on PO amoxicillin 500mg TID, no documentation of antibiotics in notes, no documented evidence of infection. ▪ 1pt on IV tazocin 4.5g BD, no documentation of antibiotics in notes, no documented evidence of infection. ○ **Choice non-compliant in 1 patient:** ▪ 1pt on IV gentamicin, admitted for IV fluids & antibiotics, no documented evidence of infection (note: most recent MSSU resistant to gentamicin).	SUPAUG Page xxx
13.06. 2013	Email correspondence between Ms McAloran, Ms Corrigan and Ms Trouton	Re: Personal Information redacted by the USI Notes that getting regular contact from both patients chasing a response from Mr O'Brien. Mr Personal Information redacted by the USI was added to waiting list as urgent in March 2013 and Mr Personal Information redacted by the USI was added to the waiting list as urgent in March 2013, has attended pre-ops and passed medically fit in May 2013. Mr O'Brien at this time had advised Mr Personal Information redacted by the USI that he would have his surgery carried out within 2 weeks of appointment date.	TRU-01503 – TRU-01504
18.06. 2013	Email correspondence between Ms Burns, Ms Brown, Ms Trouton and Ms Corrigan	Debbie Burns (Interim Director of Acute Services) to Robin Brown, Heather Trouton and Martina Corrigan. "*Could you give me a wee update on discussions with clinician re charts and triage for the above. Happy to discuss tonight Robin but if no success we will need to escalate as really affecting our ability to see patients in the correct timeframe."*	Doc File 1 Page 461 AOB-00461
02.07. 2013	Email correspondence between Ms Corrigan, Ms McAloran, Ms Cowan and Mr O'Brien	Email exchange in relation to delay in admission of two patients for surgery, one of whom had bladder cancer and according to his family had been told that he would have surgery within two weeks (advised that in March 2013	Doc File 1 Pages 465 – 466

			AOB-00465 - AOB-00466
03.07.2013	Letter of complaint from patient	Re: Personal Information redacted by the USI Discusses issue about delay in dye testing (referred from Mr O'Brien's private practice) and issues with difficulty in communicating with Mr O'Brien and the Trust in general	TL3 Page 1026 – 1031 AOB-06704 – AOB-06709
05.07.2013	Antibiotic Ward Round	• O'Brien: 2 patients. CURB score n/a. ○ **Indication not recorded and compliance not assessable in 1pt:** ▪ 1pt on IV gentamicin 240mg OD, no documentation of antibiotics in notes, no documented evidence of infection.	SUPAUG Page xxx
25.07.2013	Letter of complaint from patient	Re: Personal Information redacted by the USI	TL3 page 1090 – 1092 AOB-06768 – AOB-06770

06.08.2013	Response to Patient complaint – Mr Personal Information redacted by the USI	Dear Ms Personal Informati I refer to your complaint in respect of your brother, Mr Personal Information redacted by the USI. Thank you for taking the time to highlight your concerns and for providing me with the opportunity to address them. I would like to apologise for the delay in returning this response to you. I had asked Mrs Martina Corrigan, Head of Urology to investigate your complaint. In doing so she talked with your brother's consultant Mr O'Brien. Mr O'Brien has advised her that he has met with you about your brother's care and his treatment and Mr O'Brien feels that this meeting was beneficial and that it answers any issues or queries from his perspective and I hope that you have found this to be the case? Mr O'Brien also advised Martina that your brother has since been admitted on 16 September 2013 and had his procedure performed and I hope that this has been a success and that your brother has been keeping well since then. Martina also spoke with the Ward Manager, Sister Emma McCann who also investigated the issues surrounding your brother's stay in 3 South. Firstly Sr McCann would like to take the opportunity to apologise for any distress caused to your brother while an in-patient in 3 South. She has went through your brothers notes from the evening of 18th March 2012 and advises that it is documented that your brother was for discharge on the 18th March 2012 following his day	TL3 page 1291 – 1295 AOB-06969 – AOB-06973

		procedure, it is also documented that you had rang to say that you were unable to take your brother Mr Personal Informati home that evening as he was having work carried out to his house. Sr McCann would like to apologise if the nurse did not communicate with you in a manner that you deserved and at their Measure Board meetings she has reiterated to all staff the importance of being courteous and mannerly whilst dealing with patient and carer's queries. Sr McCann also advises that she has also spoken to all the Nursing staff on duty in January 2013 when your brother was a patient on the ward and there appears to be have been a mis-communication with his discharge, although it is documented that you were contacted mid-morning to arrange a collection time for Mr Personal Informati this would appear not to have happened so Sr McCann apologises as this was not a seamless discharge. I hope that you will find this response has addressed the issues that you raised. However if you would like to discuss any aspect of this response further so that we may help in resolving any outstanding issues, please do not hesitate to contact a member of the Clinical and Social Care Governance Team on Personal Information redacted by the USI, or by e-mailing AcutePatient.ClientLiaison@southerntrust.hscni.net within 3 months of the date on this letter. Alternatively, if you remain unhappy with the Trust's response and feel that further contact with the Trust will not resolve your complaint, you can refer your complaint to the NI Commissioner for Complaints (the Ombudsman) at the following address: Freepost BEL 1478, Belfast, BT1 6BR or Freephone: 0800343424 or email ombudsman@ni-ombudsman.org.uk Further information on the role of the NI Ombudsman can be found at www.ni-ombudsman.org.uk	
19.08.2013	Email correspondence between Ms Corrigan, Mr O'Brien and Ms Truesdale	Complaint provided to AOB in relation to Personal Information redacted by the USI.	Doc File 1 Page 472 AOB-00472
29.08.2013	Email from Ms Corrigan to Mr O'Brien	RE: Patient complaint – Mr Personal Information **Complaint:** Patient has had prostate problems and been in and out of hospital as a result. In February 2013 he had catheter fitted hoping this would resolve his problems but it was unsuccessful and no benefit to him. From February the catheter has been blocking and causing discomfort. He has been seen to Mr O'Brien's deputy to explain his problems. After this he was informed that he was on a list to have a minor operation to rectify the prostate. His GP has been proactive and requested that urgent attention is given. Patient recovering from hernia operation but really needs the operation to resolve his distress but most regrettably to date he has not been called for . Waiting from February for a minor operation is too long to wait. **Response from Ms McAlinden:** Thank you for contacting me with Mr Personal Information's concerns. Unfortunately the Urology service in Craigavon, in common with the other Urology services provided in other parts of NI, is experiencing	TL3 page 1104 – 1106 AOB-06782 – AOB-06784

		increased demands. However our consultants do their best to treat patients with clinical priorities.	
03.09.2013	Email from Ms Magill to Mr O'Brien	Personal Information redacted by the USI Patient 109 Suffers Personal Information redacted by the USI. Presented with pain and swelling in the right testicle which had commenced the previous day Personal Information redacted by the USI although there was a history of a similar episode of pain in May 2008. Client admitted to hospital and was examined and an ultrasound scan was carried out the next day. He was advised that he had torsion of the right testicle and an operation was carried out by Mr O'Brien and it was noted that the right testicle was necrotic due to torsion. A right orchidectomy was carried out and our client was discharged home on 8 July 2008 with fixation of the left testicle arranged for September 2008. The healing process was not straight forward and our client presented with an infection at the wound site at CAH A&E dept on 16 July 2018 and was prescribed Ciproxin for 2 weeks. Swab taken reported that this was Ciproxin resistant bacteria on 18 July 2008 but he was not treated with any different form of antibiotic. Presented at Causeway hospital on 25 August 2008. Pain in left testicle which had developed that morning. Surgical Registrar made diagnosis of left torsion and an operation carried out by him on 25 August and the testicle was found to be dead. Allegations CAH 1. Failure to carry out immediate surgical exploration on 6 July 2008 in face of history and physical signs 2. Failure to fix the contralateral left testicle on 7th July 2008 3. Failure to adequately treat the stephyloccus B infection on 16 July 2008 in the face of swab showing resistance to Ciproxin which delayed wound healing 4. Delay in arranging left testicular fixation which out to have been possible in early Auust 2-08	
05.09.2013	Email correspondence between Ms Corrigan, Ms Burns, Mr Mackle and Ms Brown	Email chain starting with a email from Pamela Lawson to Helen Ford on 27 August 2013 "*Charts to consultants home".* Notes that "*I have been submitting IR1 forms regarding this but the problem is getting worse instead of better."* Matter escalated to Robin Brown who indicated he would have a word with Aidan (see email of 4 September 2013). Martina Corrigan on 5 September 2013 emails Deborah Burns and Eamon Mackle as follows: "*I will speak with him today and then let Robin follow this up on this? One of the things that was said to me before is that he is not the only consultant who brings a chart home, but I suppose with Aidan it is more the amount he brings home and the length of time he keeps them. I will let you both know how I get on."*	Doc File 1 Pages 474 – 476 AOB-00474 - AOB-00476
08.10.2013	Email correspondence between Ms Corrigan, Ms Trouton, Ms Carroll and	Email from Helen Forde to Anita Carroll (4 October 2013) noting an "*example of the extra work that associated Mr O'Brien having charts at home."*	Doc File 1 Page 482

	Ms Forde	Email from Heather Trouton to Martina Corrigan dated 8 October 2013 indicating *"I need to talk to Aidan re this, when would be the best time."*	AOB-00482
26.10. 2013	Email from Mr O'Brien to Ms Corrigan	Re: SWAH clinic *"I wish to emphasise that I personally have no problem seeing a patient at 6pm, except that the outpatient department is closed and the patient has already been waiting for 2 hours, because of inappropriate appointment time templates. It has only been by declining to attend the SWAH clinic on Monday 28 October 2013 that, hopefully, the correct and agreed numbers of patients will be attending, even if they will still not be attending at the agreed intervals set out below. Lastly I take this opportunity to emphasise that I will not return to SWAH in November unless and until the agreed numbers of patients are appointed at the agreed times set out below, and that I will check on Friday 22 November 2013 to ensure that is so, prior to the clinic on Monday 25 November 2013*	TL3 page 1357 – 1358 AOB-07035 – AOB-07036
12.11. 2013	Email correspondence between Ms Burns, Ms Carroll, Ms Trouton and Ms Corrigan	Email exchange in relation to a chart which was not available for consultation by Dr Convery. Discussion in relation to potentially escalating it to Dr John Simpson.	Doc File 1 Pages 483 – 484 AOB-00483 - AOB-00484
04.12. 2013	Email correspondence between Ms Trouton, Mr Young and Ms Brown	Reference by Heather Trouton in email of 26 November 2013 to Michael Young and Robin Brown:- "*I also spoke to him not more than 4 weeks ago about timely triage and having charts at home and he promised me he would deal with both."* In email of 3 December 2013 from Heather Trouton to Michael Young and Robin Brown notes how "R*e charts at home, I think we all agree this is just not acceptable".*	Doc File 1 Pages 487 – 490 AOB-00487 - AOB-00490
04.12. 2013	Email correspondence between Ms Trouton, Mr Young and Ms Brown	Exchange of emails in which AOB accepts (26 November 2013) that he had fallen "*so behind in triaging".* Noted how he had fallen behind "*particularly badly (except for red flag referrals which are up to date)."* Heather Trouton in an email to Michael Young and Robin Brown of 26 November 2013 notes how she had spoken to AOB "*this practice on several occasions and Martina has also much more often."* However, without further intervention by his senior colleagues it will happen again. She refers to previous promises how it would be dealt with "*however we find today that patients are still with him not triaged from August."* Also notes how "*a further IR1 Form has been lodged by health records and 6 charts cannot be found*." Robin Brown writes to Michael Young and Heather Trouton on 30 November 2013 as follows:-	Doc File 1 Pages 487 – 490 AOB-00487 - AOB-00490

		"…… *I had a lengthy one-off meeting with AOB in July on this subject and I talked to him again on the phone about it week before last.* *I agree that we are not making a lot of headway but at the same time I do recognise that he devotes every wakeful hour to his work – and is still way behind.* *Perhaps some of us – maybe Michael, Aidan and I could meet and agree a way forward.* *Aidan is an excellent surgeon and I'd be more than happy to be his patient (that can be sooner than I hope!) so I would prefer the approach to be 'how can we help'"* 3 December 2013 Michael Young notes how he does not agree that it is "*unlikely that Aidan will change."* He notes however that he does not agree with the "*chart issue*". He notes that he has offered to help out to get the backlog sorted. There was some discussion as to whether or not triage should be taken over by other consultants in this email chain however it was decided that was not acceptable.	
2014	2014 Appraisal	***COMPLAINTS*** ***APPRAISALS 1 October 2013 .31 December 2014*** ***Mr Aidan O'Brien*** *1. 13/02/2014* Personal Information redacted by the USI *Description:* *Unacceptable wait for appropriate treatment* *Outcome:* *Complainant advised patient has received appropriate treatment and care. Apology given for patient feeling he was not given adequate information on his treatment. Apology given for time patient had to wait at his appointment.* *2. 30/04/2014* Personal Information redacted by the USI *Description:* *Complainant unhappy with the delay in a referral being sent from Craigavon Area Hospital to Belfast City Hospital leading to a further delay in receiving treatment for Prostrate Cancer.* *Outcome:* *Apology for delay in referral which was due to increased clinical commitments.* *3. 02/12/2014* Personal Information redacted by the USI *Description:* *Pallant diagnosed with a swollen lymph gland on outside of bladder in July 2014. Advised that a procedure would be performed in November 2014 however in the meantime patient was admitted to hospital and placed in palliative care.*	2014 Appraisal page 49 AOB-22594

		Patient now advised that he will be receiving radiotherapy because cancer was spread to his bone. *Outcome:* *Red flag referral received from GP on 11.7.14. Patient attended appointment on 23.7.14 with consultant who admitted him to 2 south to have biopsy. On 30.7.14 patient had another procedure done. Results discussed with patient. After meeting with Belfast trust it was agreed patient treatment and care to be transferred to Belfast trust. Therefore unable to comment on the last points of complaint.* *4. 21/05/2014* Personal Information redacted by the USI *Description:* *Complainant concerned about how long his constituent has had to wait for an outpatient appointment.* *Outcome:* *Complainant advised his constituent has been given an appointment for 21 July 2014* *5. 10/07/2014* Personal Information redacted by the USI *Description:* *Complainant unhappy to have to wait so long for a review appointment.* *Outcome:* *Complainant given a date for 6 August 2014. Apology given for delay.* *6. 23/04/2014* Personal Information redacted by the USI *Description* *Complainant unhappy at length of time he has had to wait for an appointment, he is constant pain.* *Outcome:* *Complainant advised the consultant is aware of his need for an appointment and is endeavouring to get him scheduled. Consultant contacted patient directly to reassure him.*	
14.01.2014	Email from Ms Corrigan to Mr O'Brien	RE: Patient late for scheduling Patient was advised by Mr O'Brien that he would be brought back in in October but has not yet been called for. Ms Corrigan noted that she was aware that this was one of the patients she was aware Mr O'Brien has previously discussed	TL5 page 21 AOB-70183
14.01.2014	Email from Ms Corrigan to Mr O'Brien	Re: Patient late scheduling Patient went to Craigavon on 15th October 2013 to have a stent put in and was to go back 2 weeks later to have it removed but they haven't sent for him.	TL5 page 22-23 AOB-70184 – AOB-70185
17.01.2014	Email from Ms McMahon to Ms Brown	Re complaint from patient re delay on consultation. Was assured that a follow up with Mr O'Brien would be organised asap but its been over a month and nothing has happened.	TL5 page 101

			AOB-70263
21.01.2014	Letter from Cllr William Irwin to Trust	Re: Personal Information redacted by the USI Suffered aggressive bladder cancer and has since passed away. Raised concerns re time waiting on surgical intervention. Family wished to correct a point - original procedure not carried out until 6th February 2013 but was not informed that he bladder cancer until 29th March. The family wanted to know why the patient waited this period of time before being told of cancer	TL5 page 195 – 198 AOB-70357 – AOB-70360
05.02.2014	Email correspondence between Ms Kerr and Mr Carroll	Re SAI Personal Enclosing SAI Personal dated July 2011	TL5 page 180 – 192 AOB-70342 – AOB-70354
06.02.2014	Email from Mr O'Brien to Ms McCorry	Re: Ms McCorry booking patients without Mr O'Brien approval. Concerns that patients with advanced malignancy will not be seen for weeks	TL5 page 194 AOB-70356
Until December 2013	Multi-source feedback structured reflective template	2014 Appraisal includes GMC and Colleague Feedback Form. In that Mr O'Brien makes the following comments: *"Main outcomes of feedback* *Hints: Look at your positive outcomes, as well as learning needs:* *The Colleague Feedback was on the whole very satisfactory. The only domain in which some colleagues considered that I was less than satisfactory was that of effective time management.* *What learning might I undertake?* *Hint It may help to separate learning from changing your behaviour. So, rather than "I will show more respect to nursing colleagues", it might be more productive to undertake learning which develops your understanding of the benefits of the diversity of teams. Your ideas in this section can be discussed further with your appraiser.* *It may help if I could learn how to delegate administrative duties rather than tending to micromanage, even though I believe that there is an inverse relationship between clinical care and effective time management.*	2014 Appraisal page 77 AOB-22622
07.03.2014	Email from Ms McCorry to Mr O'Brien	Re: missing triage X5 patients outstanding triage	TL5 page 229 – 232 AOB-70391 – AOB-70394
07.03.2014	Email from Ms Graham to Mr O'Brien	No outcome for patient who was reviewed by AOB on 23 December 2013	TL5 page 233 AOB-70395
12.03.	Email from Mr O'Brien to	Re: Urology department meeting	TL5 page

2014	Urology	Mr O'Brien raised issue that implementation of the ground until appoint clinical nurse specialist to do the job and administrative support to make it work. If have both, no excuse to fail to proceed.	316 AOB-70478
31.03.2014	Email from Ms Hanvey to Ms McCrory	Re: Patient complaint Patient rang querying why not referred to Belfast. Very distressed and unhappy.	TL5 page 449 AOB-70611
14.04.2014	Letter from MLA to Trust	Complaint re Mr Personal Information redacted by *"Diagnosed with prostate cancer around 5/6 years ago. He had complained of having to fight to get an appointment in August with a Consultant, a Dr O'Brien, at Craigavon area hospital in relation to pain he had been experiencing.* *Following the initial appointment he was told by the consultant that he would need to see him again in a months time. Having heard nothing since he recently phone to enquire as to why this was the case, only to be told that he was supposed to have an appointment in September of which he reports that he was not notified*	TL5 page 610 – 619 AOB-70772 – AOB-70781
18.04.2014	Email from Ms Corrigan to Mr O'Brien	Re: Missing triage which is going to be escalated Approx x93 Patients for triage letter	TL5 page 539 – 542 AOB-70701 – AOB-70704
18.04.2014	Email from Ms Corrigan to Mr O'Brien	RE: Complaint from Mr Personal Informatio n redacted Phoned to complain about the length of time he is having to wait to see Dr O'Brien. Was given injection in bladder on 2 January 2013 and he was advised by Mr O'Brien on 14 May 2013 that this had not worked.	TL5 page 545 – 547 AOB-70707 – AOB-70709
18.04.2014	Email from Ms Corrigan to Ms Farrell	Re: Complaint from Mr Personal Informatio n redacted Noted that Mr O'Brien is aware of this patient but the urology department are experiencing an increase in waiting times for non-cancer patients as currently concentrating on treating cancer patients	TL5 page 548 -549 AOB-70710 – AOB-70711
29.04.2014	Email from Ms McCorry to Ms McAloran	Re: Personal Information redacted by the USI complaint Patient's mother called to make a complaint on behalf of her son who has a brain injury. Put Person al Inform on trial of medication for his kidneys in July 2013 and informed that he would	TL5 page 561 – 562 AOB-70723 – AOB-70724

		review in 6 weeks time. Personal Information still awaiting review	
01.05.2014	Email from Ms Farrell to Mr O'Brien	Re: Complaint from Mr Personal Information redacted by Complaint re length of time taken to get referred to City Hospital Belfast for further management for prostate cancer.	TL5 page 566 – 568 AOB-70728 – AOB-70730
28.05.2014	Email from Ms Corrigan to Mr O'Brien	Re Patient enquiry Mr Personal Informatio Noted that he was seen on Jan 2014 and discovered recurrence of bladder TCC. Plan was to red flag waiting list for TURBT. To date no date for surgery has been received	TL5 page 671 – 672 AOB-70833 – AOB-70834
09.06.2014	Letter from Trust to patient	Re: Complaint – Mr Personal Informatio Notes that Mr O'Brien is aware of the patient but at present patients in urology who are not categorized as very urgent patients are regrettably having to wait longer for their procedures.	TL5 page 1192 AOB-71354
10.06.2014	Email from MLA to Ms Wright	Re: Personal Information redacted by the USI *"was admitted to Craigavon Area Hospital on 3 October 2013 for a hysterectomy which was performed by Dr Bogues but 10 days later had to be re-admitted with damage to uterus and a stint was inserted and told by Dr O'Brien that this would be removed within 4-6 weeks. The young mother continues to suffer unsustainable pain & discomfort and continues to attend her local GP at* Personal Information redacted by the USI *in* Personal Information redacted by the USI *and despite the second operation which was in October 2013 which was over 7 months ago no plans for removal of stint and has been informed by Craigavon Hospital that she is not even on a waiting list for the hospital and as yet no definite arrangements for an operation…"*	TRU-01486 – TRU-01488
12.06.2014	Email correspondence between Ms Corrigan, Ms McVey, Ms Burns, Ms Trouton, Ms Stinston, Mr Caldwell and Ms Corrigan	Email received from an MLA in relation to a patient who had a stent fitted in October 2013 and there were no plans to remove the stent. Martina Corrigan notes she spoke to AOB and he agreed to the procedure on 25 June 2014.	Doc File 1 Pages 722 – 724 AOB-00722 - AOB-00724
12.06.2014	Email correspondence between Ms Corrigan, Ms Burns and Mr O'Brien	Re Patients awaiting cancer-related procedures Ms Corrigan noted that she had a long conversation with Mr O'Brien and he is supportive of the direction she is trying to achieve. Mr O'Brien put the following into writing which Ms Corrigan noted was "not like him"	TRU-01545 – TRU-01546

		Botulinum Toxin I believe there are 30 cases on this list, and their procedures may easily require 30 hours of theatre time. I do not know what the situation is regarding cancer related procedures on Michael's waiting list. I am also cognisant that Ram and Tony will have considerable quantities of cancer related work to be done, and that Mark will be similarly building a list as I have transferred a number of cases to him recently at MDM. I think we should discuss tomorrow our priorities for operative work as we move forward. It is my view that we should have as our first objective that we will be within the 62 day timeframe, or as near as possible, by 31 July 2014. I believe that would be an impressive achievement to relate back to the Board. I believe that it would demonstrate that we have seriously addressed one priority cohort, and it should be of reassurance for the Board. I say this fully aware that there are other priorities as well and which will similarly have to be addressed thereafter. The problem which I can foresee is that the longest waiters may not be a clinical priority to have been eliminated by 30 September. These are just my thoughts! Aidan	
23.06. 2014	Email correspondence between Ms Corrigan and Ms Trouton	This contains a chain of emails from 5 February 2014 through until 23 June 2014. In summary it relates to a complaint by a family on behalf of a deceased patient. There are no details of the actual complaint therein other than "*If the patient had been seen sooner would this have made a difference to his outcome?"* There are a number of emails aimed at obtaining AOB's comments in relation to same, commenting in the email of 23 June 2014 from Martina Corrigan to Heather Trouton as follows:- "*This is one of Aidan's and I need him to answer this as it is a clinical response. In particular if the patient had been seen sooner would this have made a difference to the outcome? I have explained this to Roisin and I have copied her into all of the escalation. I have spoken to Aidan about the same and explained the urgency of this to him and he did say he would try to respond to same. Perhaps he may respond to you if you forward this on."*	Doc File 1 Pages 763 – 769 AOB-00763 - AOB-00769
27.06. 2014	Letter from Ombudsman to Trust	Re Complaint on behalf of Mr [redacted] e mesh which was used during the hernia repair surgery has left him in severe pain and with severe bladder issues Akhtar made him promises which were never fulfilled Brown (who conducted the hernia surgery) made him promises which were never carried out was misdiagnosed for years when doctors insisted that he	TL5 page 961 – 965 AOB-71123 – AOB-71127

		had a bladder problem ggestions that there was a problem with his prudenal nerve were never followed up by Mr Brown 1. Dr Sobicinski at the Pain Clinic reduced Mr Personal Information redacted by the USI's pain medication by half and advised him to take twice as many. Mr Personal Information redacted by the USI believes that this was pointless Sobicinski informed Mr Personal Information redacted by the USI that he would review him in three months time yet this did not happen McMullan suggested various treatments for Mr Personal Information redacted by the USI, yet informed him at his last appointment that he would do nothing and discharged him O'Brien's waiting times are too long Mr Personal Information redacted by the USi says that he has been left in severe pain, with severe bladder issues, he can no longer work, he cannot drive, he cannot leave the house unless it is necessary, he cannot have any more children, his marriage is therefore under stress, and his mental health is rapidly declining	
15.07.2014	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient ringing re referral to Oncologist (seen AOB in June 2014) but nothing is recorded on system	TL5 page 997 AOB-71159
15.07.2014	Email from Ms Elliot to Mr O'Brien	Re: Patient query Patient's wife on phone re date for surgery, he is supposed to have procedure done annually but last had it done in May 2013. He is not on waiting list	TL5 page 998 AOB-71160
21.07.2014	Letter from Trust to Patient	Re Response to complaint about waiting list	TL5 page 1412 AOB-71574
21.07.2014	Letter from Patient	Re: Complaint. Attended in investigative appointment in Feb 2014 and was advised that he would be contacted again by April. To date has no follow up. Contacted urology Department on many occasions but no one got back to him.	TL5 page 1035 – 1037 AOB-71197 – AOB-71199
30.07.2014	Email from Mr O'Brien to Ms Corrigan	Re: Possible complaint Mr O'Brien noted that he recalls Ms Corrigan having communicated with him re a complaint from patient Mr Personal Information redacted by. Mr O'Brien cannot find the correspondence and highlighted that eh receives so many emails about complaints, queries etc and finds it difficult to remember	TL5 page 1123 AOB-71285

		exactly who they are from. Mr O'Brien had settled the patient in question	
01.08. 2014	Email from Ms Dignam to Mr O'Brien	Re patient query Patient was referred to Mr O'Brien in April 2014 but the referral has not yet been triaged. There was a further query from a patient who last attended in April 2014 and is awaiting a date for surgery and thought she was to be seen in July 2014. However, there is no discharge letter on patient centre and she was on waiting list for review in July 14	TL5 page 1158 AOB-71320
05.08. 2014	Email from Ms Dignam to Mr O'Brien	Re Patient query Patient wondering whether referral has been received. It is recorded on system as being received but has not been triaged. Referral was sent in April 2014	TL5 page 1194 AOB-71356
06.08. 2014	Email from Ms Trouton to Mr O'Brien	Re: Patient Complaint *" This patient's son,* Personal Information redacted by the USI *, has been on the phone with me. He is very distressed. He told me that he is very disappointed with the way his father's care has been handled and the family are becoming increasingly frustrated. He told me he had contacted the ward earlier today to get answers and he said "the attitude of the nurse he spoke to stank". He wanted to speak with you to discuss his father's care. I advised him you were in theatre all day but I would pass on his concerns.* *Last Sat his father had a procedure to drain his kidney. They were told the consultant that ca do the right side is on leave until next week and are waiting for his father to be transferred to BCH for this procedure. This hasn't happened and they have been given no indication of when this is likely to be…."*	TL5 page 1200 AOB-71362
20.08. 2014	Email from Ms Elliot to Mr O'Brien	Re: Outcome from SWAH clinic Patient's GP calling but secretary notes that there is no follow up plan on PAS from the erne hospital outpatient appointment in March 2014	TL5 page 1335 AOB-71497
04.09. 2014	Email from Ms Elliot to Mr O'Brien	Patient attended clinic in April 2014 and Mr O'Brien advised that would list for surgery. Secretary checked PAS and nothing there for an outcome.	TL5 page 1387 AOB-71549
24.09. 2014	Letter of Complaint from Patient	Re: Mr Personal Informatio n redacted	TL5 page 1516 -

		Complaining about length of time Mr O'Brien has kept patient waiting to get stent removed. Patient was meant to have catheter removed after 4-6 weeks and it has now been 9 months.	1519 AOB-71678 – AOB-71681
25.09.2014	Letter of Complaint	Re Ms Personal Information redacted by the Complaint about the waiting times and management of cancer patients in Urology speciality in CAH.	TL5 Page 439 – 443
03.10.2014	Letter of Complaint	Re: Ms Personal Information redacted by Patient has CA of bladder. Originally had it in 2011 but it returned this year. On 2 May 2014 was advised by the locum of Mr O'Brien that the CA was still there and that more malignancy needed dealt with and taken away. This greatly distressed the patient who was shocked to learn the cancer had returned. Patient made informal enquires in to the waiting times after 02 May 2014 but to no avail. Mr O'Brien spoke to patient on 18 August 2014 and spoke with her for some time on the phone advising that there were 267 patients on urology waiting list. This statement actually left the patient in worse position as she could not shake the feeling that there may be 266 people in front of her. Patient did not find information relayed very helpful to content her. Mr O'Brien told her she would be lucky to be seen before November. Patient has had no word since and her clinical need has increased due to recurring UTIs and bleeding. Patient feels CA not taken seriously and that she is not a priority.	TL5 page 1495 – 1498 AOB-71657 – AOB-71660
16.10.2014	Letter of Complaint	Re Mr Patient 110 1. No baseline analysis done on his cognitive abilities as per NICE guidelines 2. Nursing staff were patronising when we tried to explain that this was out of character for him 3. Requested meeting with Mr O'Brien which took place on 25 10 2013 4. Despite assurances made at the meeting, little changed 5. Complaints about nursing staff and general treatment on ward 6. Mr O'Brien carried out surgery even though missing piece of equipment. 7. Patient died 8 weeks after admission with problem still not treated	TL5 page 241 - 245

<table>
<tr><td>28.10.2014</td><td>Email from Ms Corrigan to Ms McAloran</td><td>Re complaint Mr [redacted]

Ms Corrigan notes that there is no date for patient as currently concentrating on cancer cases but that Mr O’Brien is aware of this</td><td>TL5 page 1700 – 1702

AOB-71862 – AOB-71864</td></tr>
<tr><td>28.10.2014</td><td>Email from Ms Elliot to Mr O’Brien</td><td>Referring to The list of patients who are long waiters but have not been booked for a date No attendances and outcomes for the following

EUROAOB on 08 Sept 2104 – 17 patients booked EUROAOB on 22 Sept 2014 – 15 patients booked EUROAOB 13/10.14 – Total 16 patients</td><td>TL5 page 1703 – 1736

AOB-71856 – AOB-71898</td></tr>
<tr><td>22.12.2015</td><td>Letter of complaint</td><td>Re Ms [redacted]

Complaining that catheter should be changed every 12 weeks but has not been seen by trust until 21 weeks. Meant she now has an infection internally. Feels trust has been negligent against her</td><td>TL5 page 2021 – 2024

AOB-72183 – AOB-72186</td></tr>
<tr><td>01.01.2015 to 31.12.2015</td><td>2015 Appraisal</td><td>2015 Appraisal notes:

INCIDENTS
Appraisals 1 January 2015 to 31 December 2015
Mr Aiden O’Brien

<table><tr><th>Record Name</th><th>Incident</th><th>Description</th><th></th></tr><tr><td>[redacted]</td><td>07/10/2015</td><td>Patient booked on emergency list on 7/10/15 at 12:45 for bilateral inguinal exploration. Patient sent for at 17:37 however when porter arrived on the ward to collect patient he was told there was no staff available to take the patient to theatre as they were all on tea break. Porter returned to the theatre department and reported same to theatre sister. I tried to contact the ward however no answer.</td><td>Mr O’Brien informed who then collected the patient from the ward, patient arrived at 18:09, approximately 30 mins after being sent for.</td></tr></table></td><td>2015 Appraisal page 33

AOB-22683</td></tr>
<tr><td>01.01.2015 to 31.12.2015</td><td>2015 Appraisal</td><td>2015 Appraisal notes:

COMPLAINTS
Appraisals 1 January 2015 to 31 December 2015
Mr Aiden O’Brien

<table><tr><th>First Received</th><th>Record Name</th><th>Description</th><th>Outcome</th></tr><tr><td>03/11/2015</td><td>[redacted]</td><td>Complainant</td><td>Complainant</td></tr></table></td><td>2015 Appraisal page 34

AOB-22684</td></tr>
</table>

					unhappy with the length of lime it took for him to be assessed after him presenting with chest pain. Also concerned with the manner in which he was spoken to by a nurse when he queried the treatment that he was receiving.	*advised HOS spoke with consultant, consultant refutes allegations made against him. Consultant advised it was the complainant approached him in a shopping centre and he didn't wish to appear rude and did talk on this occasion but felt uncomfortable speaking in a public area regarding complainants health issues. Complainant advised he was offered two appointments, both were cancelled and in line with the Department of Health guidelines was discharged back to GP. Complainant has now been placed onto another consultant waiting list and has been upgraded to urgent. Complainant should receive an appointment mid March.*		

2015	2015 Appraisal Complaint report structured reflective template	Southern Health and Social Care Trust *Quality Care - for you, with you* **Complaint report structured reflective template** Requirement: one for each complaint you have received. Name of doctor: Aidan O'Brien GMC No: 1394911 Date of complaint: 03 November 2015 Nature of complaint: Complainant alleged that he had had a second appointment for hydrostatic dilatation of his bladder cancelled even though he advised me in a local shopping sister that he had had a MRI scan of his brain requested. Nevertheless, he did not attend even though I advised him that there was no need for him to cancel the appointment because he was awaiting an MRI scan. In his letter of complaint, he also alleged that I had been rude to him and his wife during an earlier outpatient consultation. Status of complaint: On-going / resolved Addressed and resolved by having him placed on another consultant's waiting list. Involvement of other bodies: Responsible organisation / GMC / Other None If resolved, what were the findings? I do not know, as I declined to involve myself in any response to it. How will my practice change? It will not. Final outcome after discussion at appraisal: (Complete at appraisal considering how your outcome will improve patient care) Case discussed. Patient issues Personal Information redacted by USI	2015 Appraisal page 35 AOB-22685
2015	Reflective Template	Reflective template document in AOB's 015 Appraisal includes the following comment in relation to the Peer Review process: *"They also brought the following drawbacks to my main clinical role:* *Such work consumes a significant quantum of time and effort, which did impact negatively upon my main clinical role. No allowance was made by theTrust."*	2015 Appraisal 97 AOB-22747
23.01. 2015	Email from Mr O'Brien to Ms Corrigan	Re Complaint Mr Patient 110 Mr O'Brien notes that he recalls this man but was unaware that a complaint had been received. [No complaint attached]	TL5 page 237 – 245 AOB-72432 – AOB-72440
26.01. 2015	Letter to Mr Tom Elliot MLA in response to Complaint	Re: Personal Information redacted by the USI	TL5 Page 1109 – 1110
06.02. 2015	Patient complaint	Re Ms Personal Information Refers to a serious medication mishap	TL5 page 1443 – 1144 AOB-73638 – AOB-73639

19.02. 2015	Minutes of Meeting with patient	Re Mr Patient 110 complaint Urology **"***Ms Corrigan stated that the care given to Mr Patient 110 could have been better and apologised that she could not turn the clock back; however she assured the family that there was a new manager in place and that both her and Sr Kennedy were working tirelessly to improve the care delivered to patients"* "Mr O'Brien commented that Mr Patient 110 clinical picture improved significantly after stenting, however the family were unhappy that it took 10 days for the stenting to take place and they felt he could have been take to theatre earlier. Mr O'Brien apologised for the delay in getting him to theatre and assured the family that he did not allow his theatres to be cancelled unless there is an extreme emergency. Mr O'Brien stated that he did not feel the urology treatment or delay in the stenting led in any way to Mr Patient 110 's demise"	TL5 page 577 – 581 AOB-72772 – AOB-72776
22.03. 2015	Email from Mr O'Brien to Ms Corrigan	Re SAI in relation to Ms Personal Information redacted by the USI Mr O'Brien notes that she was transferred from SWAH on 19 August 2014 under Mr Suresh and then transferred back to SWAH on 23 August 2014. She was transferred again from SWAH to BCH on 29 August 2014. Following complex interventions including TAH, BSO, Omentectomy and Colostomy, she died in Personal information redacted by USI [No SAI report was provided]	TL5 page 720 – 723 AOB-72915 – AOB-72918
23.03. 2015	Letter of complaint	Re Mr Personal Information *"Mr Personal Information phoned today to complain about the way he was treated in 3 South on Thursday 19th March 2015. He stated that "You wouldn't treat a dog like that!". He went on to say that "the staff had bad manners and are the most ignorant people he has ever met in his whole life".* *He advised me that he had a urine problem and received an operating on Wednesday 18 March under Dr O'Brien. When he woke up at 8.30am back in 3 South he was naked from the waist down and no member of staff had bothered to cover his dignity.* *He was examined by a junior Dr before being discharged. Mr Personal Information was not happy with the advice that the junior Dr was relaying to him so he asked to see Dr O'Brien but the junior Dr informed him that Dr O'Brien was in Personal information on his holidays. Mr Personal Information advised me that he knows Dr O'Brien personally and he also knows that he was not in Portugal. Mr Personal Information wants to know why the Junior Dr was lying to him. I asked Mr Personal Information for the name of the Junior Dr but Mr Personal Information said he did not get it but said, that the junior Dr was on duty in 3 South from 8.30 to 12.30 on Thursday and that he wore a brown shirt and glasses. He said a few other unpleasant things about the junior Dr.* *Mr Personal Information further advised me that his left leg is paralysed and no-one offered him any assistance with getting dressed.*	TL5 page 727 – 730 AOB-72922 – AOB-72925

		Therefore he sat around 3 south for 3 and half hours wrapped in a sheet. *When he was discharged he was told that his medication was not ready. He said that they knew he was being lifted around 12.30 that day. What was the delay? Why was it necessary for his wife had to do a 40 mile return journey to get the medication.* *Mr* Personal Information *sounds enraged and mentioned contacting the Human Rights Organisation because of the way he was treated."*	
13.04. 2015	Email from Ms Corrigan to Mr Glackin and Mr O'Brien	Re Complaint from Mr Personal Informati	TL5 page 1108 - 1110
27.04. 2015	Letter of complaint from GP surgery	Re Mr Personal Information GP had to give results of MRI (possible spread) to a patient	TL5 page 1533 - 1534 AOB-73728 – AOB-73729
08.05. 2015	Further letter of complaint	Re Mr Patient 110 – letter for further clarification following meeting with Trust	TL5 page 1388 – 1392 AOB-73583 – AOB-73587
13.05. 2015	Complaint letter	Re Mr Personal Information Patient was diagnosed with enlarged prostate in April 2015 and when he saw Mr O'Brien in November 2015 he was told that his operation was urgent and would be carried out before Christmas. They understand there is a waiting list but would appreciate clarity to how long he will have to wait. Disappointed that they never received a response to a letter they wrote in Feb 2015 asking for approximate waiting time for operation and that having made a number of phone call to Mr O'Brien's secretary they receive the same standard answer each time.	TL5 page 1441 – 1442 AOB-73636 – AOB-73637
19.05. 2015	Letter of complaint	Re Personal Information redacted by the USI Mrs Personal Information stated that she made a similar complaint 4 months ago and has never had any response. Mrs Personal Information states that her son is waiting from last year for an injection in relation to his kidneys which are now so bad he is constantly incontinent during the day. Mrs Personal Information is very annoyed she had to wait 18 months on the initial appointment with Mr O'Brien and has now waited one year for the required injection – total of 2 ½ years from referral.	TL5 page 1523 – 1525 AOB-73718 – AOB-73720

		Mrs Personal Information requests date for injection to help her son. Will only accept full formal written response.	
08.06.2015	Email from Patient (Ms Personal) to Ms Clarke, Mr O'Brien and Ms Kelly	Expressing concern for extended wait for surgery in CAH. In October 2014 was admitted due to suffering severe pain due to large kidney stone. It is now over 7 months since original surgery and still no indication of when will be called for surgery.	TL5 page 2222 AOB-74417
16.06.2015	Complaint letter from Patient	Re Personal Information redacted by the USI	TL5 2422 – 2428 AOB
07.07.2015	Letter of Complaint	Re Personal Information redacted by the USI Mrs Personal Information redacted by the USI was referred to Mr O'Brien last October (cyst Testicle). He saw Mr O'Brien at end February and states Mr O'Brien promised him to operate on 23rd April – says Mr O'Brien wrote this in his diary. Despite phone calls from himself and letters from his GP –he has not got a date for the operation. Mr Personal Information redacted by the USI states he is in a lot of pain and is unable to work at present and requests an urgent operation. Mr Personal Information redacted by the USI asks if there is a possibility of being referred for his operation to another hospital – he is willing to travel to England	TL5 page 2690 - 2694
09.07.2015	Trust response to complaint letter	Re Personal Information redacted by the USI Notes that Ms Corrigan could not find anything in her investigations	TL5 page 2445 – 2446 AOB-74640 – AOB-74641
October 2014 – March 2015	SAI Learning Report		TL5 page 2560 – 2593 AOB-74755 – AOB-74788
18.08.2015	Trust Response to Complaint	Re Personal Information redacted by the USI I have asked Mrs Corrigan, Head of Urology to investigate your concerns, Mrs Corrigan advises me that your GP had referred you on 16 February 2015 to the Urology Service and you were seen by Mr O'Brien on 10 March 2015 when Mr O'Brien added you to his waiting list for surgery so currently you have been waiting 23 weeks which we do appreciate is very long and we would like to apologise for this. However, the Urology team are giving priority to their cancer patients which there is a high demand for and our current waiting time	TL5 page 2690 – 2694 AOB-74885 – AOB-74889

		for urgent non-cancer patients for which you are one, is regretfully 65 weeks.	
24.08.2015	Letter from Ombudsman re complaint	Re Mr [redacted] Request for further information - Only mention re Mr O'Brien is as below: 1. *"Was Mr [redacted] discharged from the care of the pain clinic following the review meeting of 2 August 2013 or did he continue to attend. If he was discharged please let me know why and was sole responsibility for his care and treatment transferred to Mr O'Brien at this time. Is Mr [redacted] still attending and has a diagnosis and/or treatment plan been agreed for his continuing care*	TL5 page 2827 – 2834 AOB-75022 – AOB-75029
02.09.2015	SAI Report	Ms [redacted] report Notes a capacity and demand issues in regard to follow up review appointments scheduled for the uro-oncology review clinic service in the Southern Trust. The imbalance has resulted in patients being placed on waiting lists for review.	TL5 page 3298 – 3317
15.09.2015	Email from Ms Elliot to Mr O'Brien	Re Patient complaint – [redacted] *"Patient's wife rang in yesterday regarding his care under Mr O'Brien. She came on the phone quite cross and said she was going to sue Mr O'Brien for negligence and holds him fully responsible for her husband's current state and that Mr O'Brien will be hearing from her solicitor & MP. He is currently an inpatient in Daisy Hill Hospital, she rang the ambulance on Sunday and said in the 40 years she has been married to [redacted] she has never seen him in such a state. She would like Mr O'Brien to ring her himself, there are couple of contact numbers on the system for the patient"*	TL5 page 3022 AOB-75217
25.09.2015	Email from Ms Farrell to Mr O'Brien	Re Patient query/complaint (Mr [redacted]) Patient's mother called to complain that patient is now deteriorating. Was supposed to have a simple procedure done 2 years ago. When first met with Mr O'Brien he advised that the procedure would be done in 2 weeks.	TL5 Page 3099 – 3100 AOB-75294 – AOB-75295
27.09.2015	Mr O'Brien's response to Ombudsman complaint	Re Mr [redacted] Having read the letter of 24 August 2015 from Ms. Claire McIlhatton, Director of Investigations, to Ms. Paula Clarke, Interim Chief Executive, I do believe that there are some inadequacies in the section entitled 'Background and History of Complaint' and which I believe to be important. In particular, it is incorrect that Mr. [redacted] was first seen by Mr. Brown following his presentation with abdominal pain and increased urinary frequency. I have detailed Mr. [redacted] history, investigation and management in a letter of 08 April 2015 addressed to his family doctor, [redacted], and which I have attached.	TL5 page 3101 – 3104 AOB-75296 – AOB-75299

		I am happy for a copy of that letter to be sent to the Director of Investigations. It does however contain one typographical error which I am unable to edit. A sentence in the third last paragraph of the letter reads: 'I also do believe that the possibility of inguinal herniorrhaphy particularly with implantation of a mesh, has not also been a contributor to the totality of his pain.' I would be grateful if you would delete the word 'not' highlighted in red before its submission to the Director of Investigations. From my perspective, I believe and hope that the Director of Investigations would find the letter to be of some benefit in the conduct of her investigation. I would subsequently be happy to be of any further assistance. If you wish to discuss before submitting attached letter, please feel free to contact me on Personal Information redacted by the USI. Thank you,	
19.10.2015 – 24.11.2015	Email from Personal Information and email correspondence between Ms Trouton, Ms Corrigan and Ms Stinson	Re Personal Information redacted by the USI Notes that Personal Information had attended with Mr O'Brien in February 2015 when he put the patient on the list for surgery to try to resolve the matter on a longer term basis, this was marked as urgent. To date there has been no communication between Mr O'Brien and patient or her GP although Dr Personal Information (GP) has written to Mr O'Brien urging that he do the surgery. This was chased up with Mr O'Brien but no response was ever received	TRU-01478 – TRU-1483
02.11.2015	Letter of Complaint	Re Mr Personal Information redacted by the USI Mr Personal Informati (who is Personal Information redacted by the USI is very annoyed by the system for Urology out-patient appointments and forthcoming procedure which he is currently unable to have due to other medical problems. Mr Personal Informati informs me that he was under the care of Mr O'Brien and gives a history of having his bladder stretched by insertion of Botox in October 2013 due to spinal stenosis. Mr Personal Informatio has highlighted that at the out-patient appointment prior to this surgery, he felt Mr O'Brien's comments very inappropriate – his wife had accompanied him to the appointment and when she asked when the procedure would take place, Mr O'Brien stated he did not know. Mr Personal Information wife asked if he could be moved up the line to which apparently Mr O'Brien said "Bull-shit" and continued to say the Mrs Personal Informati was only there as her husband "has a problem down there".	TL5 page 3533 – 3535 AOB-75728 – AOB-75730

		Mr Personal Informati also informs me that he was told by Mr O'Brien his heart was not strong enough and he had to get a monitor on prior to the operation. The Procedure took place on 30th October 2013 and after the operation Mr O'Brien apologized as he put too much Botox into the bladder. Mr O'Brien has continued to attend out-patients for regular follow-up appointments and now has a catheter in situ. Mr Personal Informati reports that when he is out in Personal Information redacted by the USI having coffee with his family he often "meets" Mr O'Brien family and on one occasion Mr O'Brien asked him when he was coming back in to which Mr Personal Informati reports he told Mr O'Brien he was not able to have the procedure carried out due to unstable diabetes and also because he was currently attending Musgrave Park Hospital under the care of Dr Murnaghan and is waiting on Surgery from June 2015 on his knee. Mr Personal Informati states he got an appointment for Tuesday 25th March 2014, which he assumed was for the procedure, and he cancelled this appointment as felt unable to have this due to reasons noted above. A further appointment letter was received for Tuesday 1st April and he attended this appointment with Mr O'Brien and decision was made that no action would be taken at present regarding the operation. Mr Personal Informatio cannot understand why he got further appointment letters for Monday 5th January 2015 @ 2.30pm and another for Tuesday 28th January 2015 @8pm when decision was made not to have procedure at present. Mr Personal Informati is adamant these were for the procedure rather than an out-patient appointment and he therefore cancelled both appointments. He is very cross that Mr O'Brien would continue to send for him when he was aware that Mr Personal Information other medical problems made it impossible to attend for the procedure. He cannot see that these were appointment letters were perhaps out-patient appointments routinely generated by the computer system following his previous out-patient appointment with Mr O'Brien and strongly feels that Mr O'Brien has personally asked someone to send these appointments, aware that he could not attend. At a routine GP appointment Mr Personal Informati was informed that the GP has received a letter to say that due to non-attendance with Mr O'Brien, Mr Personal Informati had been discharged from the list but could be re-referred if necessary. The GP re-referred Mr Personal Informati and at Mr Personal Information request, asked for a different Consultant. As Mr Personal Informati had heard nothing in relation to this referral, he states that he contacted the Booking Centre on Friday 30th October to hear that he is now on Dr Glacklin's list but that it will be a further 50 weeks before he receives his first appointment. <u>Summary:</u> Mr Personal Informati is very angry that he would have to wait almost a	

		year for an appointment when he was already on Mr O'Brien's list and could not attend for his procedure due to other health problems. He cannot see that he cancelled two appointments which resulted in his discharge. Mr Personal Informati is very cross that Mr O'Brien inserted too much Botox, when he was aware that he is a diabetic and that he is now left with his prostrate destroyed and requires a catheter and regular attendance at Urology. Mr Personal Informati is also cross that he is still awaiting an operation on his knee from June 2015. Mr Personal Informati is threatening legal action regarding the above.	
16.11. 2015	Email from Ms Troughton to Mr O'Brien	Re Patient complaint re 3 south Personal Informatio contacted me today. He is this lady's son and next of kin. He was furious on the phone and has requested that he speaks to you or someone with authority. His mother is due to be discharged home today, he said he and his GP are of the opinion there is no sense of discharging her in the condition she is in following her catheter removal. He told me that 3 staff nurses have told him 3 different things about the results of a scan that was taken 6 days ago. First said it was lost, second said it was inconclusive and a third said it hadn't arrived. He also did not think he was qualified to organise an injection in STH next week where he had to ask advice about blood thinning medication and also antibiotics. He feels there are plenty of staff on the ward more qualified than him that are standing about doing nothing that could organise this. He wanted me to say that he is refusing to lift his mother until he speaks with yourself or a someone in authority that are able to answer his questions. He said he would go to his MP or Steven Nolan if he has to. He said he just wants to find out the truth about his mother.	TL5 page 3599 AOB-75794
24.11. 2015	Email correspondence between Ms Corrigan and Mr O'Brien	Issue raised by Personal Information redacted by the USI , in relation to his mother. Notes that in January/February his mother had been advised that has further surgery. Since then significant issues with incontinence. Mother suffers from poor mental health. Asks when surgery may occur. Email sent on 19 October 2015 to the Chief Executive. Thereafter a series of emails, including with AOB, in relation to a date for surgery (placed on clinical judgment). On 13 November it was noted that Heather Trouton had spoken to Mr O'Brien and that he was going to list her for surgery "*soon".* Date requested from Mr O'Brien on 24 November 2015	Doc File 1 Pages 889 – 893 AOB-00889 - AOB-00893
Janua ry to	Staff Appraisal Documentation	Entry in 2016 Appraisal with comments on the issues which had been raised by the Trust by that stage.	2016 Appraisal

<table>
<tr>
<td>December 2016</td>
<td></td>
<td>
<table>
<tr><td colspan="3">Review of last year's Personal Development Plan</td></tr>
<tr><td>Development needs</td><td>Actions agreed</td><td>Has this been achieved (Yes, No, or partially - why was it not fully</td></tr>
<tr><td>To address in a durable and effective manner my long waiting list, and in so doing, to reduce the inequity in waiting lists.</td><td>A Trust issue to be discussed and agreed</td><td>No. Even though I conduc operating sessions that available, there was no addi strategy by Trust manageme the issue.</td></tr>
<tr><td>To address long waiting list for urological cancer reviews</td><td>A Trust issue to be discussed and agreed</td><td>No. As above</td></tr>
<tr><td>To reduce the numbers of new patient consultations</td><td>A Trust issue to be discussed and agreed</td><td>No. Politically unacceptable</td></tr>
<tr><td>Attend course in Urology</td><td>To attend Annual Meeting of Irish Society of Urology</td><td>Attended September 2016</td></tr>
</table>
</td>
<td>Page 12

AOB-22842</td>
</tr>
<tr>
<td>January to December 2016</td>
<td>Incidents – Consultant Appraisal 1 January 2016 to 31 December 2016</td>
<td>Record Name:
Personal

Incident Date:
21/10/21016

Description:
Male child scheduled for circumcision on emergency list. Not consented as Consultant working alone, no reg/sho cover.

Action Taken:
Discussed with Sr Johnston, agreed to child been consented in department due to above circumstances & to minimize distress to child.</td>
<td>2016 Appraisal Page 42

AOB-22872</td>
</tr>
</table>

Jan 2016	Draft 6 Root Cause Analysis Report on the Review of a Serious Adverse Incident, Case Identifier Personal information redacted by	**1.0 EXECUTIVE SUMMARY** Patient 10 is a Personal information old lady with a past medical history of colon cancer in 2010 and breast cancer in 2013. While Patien t 10 was under review and follow up by the Breast Surgeons in June 2014, a Computer Tomograpy Scan (CT Scan) of the abdomen and pelvis was arranged a this was performed on 24 June 2014. This CT scan reported a number of cysts in b kidneys. On the right side, there was a large upper pole cyst, a small lower pole cy and a cyst on the anterior aspect of the right lower pole which had increased in size with increased complexity from scans completed in 2010. An Ultra Sound Scan (US of kidneys was recommended and this was completed on 24 July 2014. A Magneti Resonance Image with contrast (MRI) was advised, and this was done on 26 September 2014. The MRI report did not comment on the anterior cyst about which concerns were raised, but did confirm a cyst with no abnormal enhancement. On the basis of this incomplete MRI report, Patient 10 GP made routine referral to the Urology Team in Craigavon Area Hospital (CAH). This GP letter was received by th CAH Booking Centre on 29 October 2014. This letter was given to the Urology Surgeon of the week on 30 September 2014 to triage. There is no evidence that thi GP referral letter was triaged or returned to the Booking Centre for processing. As direct result of triage omission, Patient 10 was managed as a 'New Routine' patient, and waited until 6 January 2016 to be seen by a Consultant Urologist. A wait of 64 weel Patient 10 was diagnosed with a probable cystic renal tumour. Surgery was scheduled for January 2106 but this was postponed due to the recurrence of breast cancer at this same time. Right partial nephrectomy was performed on 31 October 2016. The Review Panel agree that there are 2 main contributing factors which directly impacted Patient 10 delay in diagnoses. The first contributing factor was the content of t MRI report dated on the 29 September 2014. The wording of the report appears truncated and does not reference the main clinical focus, which was anterior cyst o the right kidney. The Reporter did not grade the cyst. As a result, the Breast Surgeo Dr 3 and the GP Dr 5 reading this report, did not appreciate there was growth in siz of the right cyst. This was a significant missed opportunity for clinicians to expedite Patient 10 referral to Urology. The second contributory factor is that Patient 10 GP referral letter was not triaged by the Urology Consultant on call. The Review Panel agree that if a Consultant Urologist would have viewed Patient images at triage - Patien t 10 would have been upgraded as a Re Flag referral in October 2014. As a direct result of no triage, Patient 10 waited 16 months be assessed by the Urology Team and diagnosed with renal carcinoma.	Doc File 2 Pages 59 – 66 AOB-00952 - AOB-00959
06.01. 2016	Email from Mr Personal informati	Mr Personal Informati needs response to complaint but none has been received yet. Notes that it is not right that he has had to wait over 1 year for further treatment and blames the Trust for his condition. He will be seeking legal advice	TL6 Page 27 – 31 AOB-76114 - AOB-76118
21.01. 2016	Letter from Ombudsman & medical opinion/advice	Re Mr Personal Information redacted by the	TL6 page page 585 - 599
03.02. 2016	Letter of response to complaint from Trust	Re Mr Personal Informati *"Ms Corrigan has spoken with Mr O'Brien your consultant with respect to the points that you raised specifically within your complaint. There appears to be a case of two different perspectives regarding your perception of the events with Mr O'Brien. Mr O'Brien assures us that he never uses such an inappropriate manner. He refutes these allegations and feels that there is no substance to these he would ask that you withdraw these as they are deformation of his character.* *Regarding the meeting in* Irrelevant redacted by the USI *again there appears to be a different perspective of this meeting. Mr O'Brien advises that you approached him whilst he was in* Personal Information redacted by the USI *and that*	TL6 Page 274 – 276 AOB-76361 – AOB-76363

		you asked him about an appointment in respect to an MRI and whilst Mr O'Brien did not want to appear "rude" and did talk to you on this occasion he advises that he did feel uncomfortable regarding this and felt that it was not at all appropriate to be discussing your health issues in a public area. *Ms Corrigan has confirmed that she has investigated the concerns that you have raised in respect to your appointment and she advises as follows:* *That you attended an outpatient appointment with Mr O'Brien on 1 April 2014, when Mr O'Brien requested that you have an urodynamics procedure carried out and advised that he would review you after that,* *The Urodynamics test was carried out on 20 May 2014 after which a review was requested by Mr O'Brien and this was held on 5 January 2015, after this review Mr O'Brien advised you that he would add you to his waiting list for hydrostatic dilation of bladder which is a daycase procedure.* *Your first appointment for this procedure was sent out on 24 April 2015, but it is noted that this was cancelled with "other being the reason". Then you were sent for again on 24 July 2015 and this was cancelled again by you as being an unsuitable date. Since you had by this stage been given two dates for your procedure you were then discharged back to your GP. This decision was made in accordance with the Integrated Elective Access Protocol which is guidance issued by the Department of Health which all Trusts must follow in respect to offers to patients for procedures.* *Ms Corrigan has also checked your hospital notes and the patient administrative system and there is no record of you having been sent an appointment letter for either an outpatient or day procedure fo 25 March 2014, nor for 28 January 2015. It was noted from your complaint that this latter appointment was for 8pm, which is unusual as Mr O'Brien never holds evening clinics in the hospital. I can confirm that all outpatient letters are generated from the Patient Administrative System and a record is then captured for when letters are sent out on this system. So therefore Ms Corrigan would like to advise you that Mr O'Brien did not personally ask for letters to be sent out to you nor were these routinely generated by the computer system.* *Ms Corrigan can confirm that the Trust have received a further GP routine referral on 7 August 2015 and this has been added to Mr Glackin's outpatient waiting list, she also notes that a further referral has been received on 4 January 2016 which Mr Glackin has upgraded to Urgent and as his waiting list is now 10 weeks this means you should receive an appointment for mid-March with Mr Glacki, which I hope will resolve your issues.* *In respect to the other areas that you have raised in your complaint, "too much botox", the out of hours GP and district nurse making a complaint, I confirm that I am unable to comment on any of this as we have no evidence of any of*	

		this actually occurring *… "*	
13.02. 2016	Letter of complaint	Re Ms [redacted] *"I noticed a lump protruding out of my vagina 6 weeks after my son was born in March 2013. I was referred to physio as they misdiagnosed it as a prolapse. Six months later it was getting bigger and causing pain. I was then referred to gynae and they gave me a pessary ring to use. I seeked further medical advice from my own GP as it wasn't helping. I went for a MRI scan and it was then I was told I had a 3cm v 3cm cyst on my urethra. This was in Sept 2014. It has not got a lot bigger since then and I have contract Mr O'Brien in Craigavon but my enquiries keep going unnoticed. My own GP has write to them numerous times as well and still no response.* *This has well and truly went on long enough. Nearly 3 years now. It has caused me mental stress. I cant exercise or even pick up my own son without leaking urine. As for intercourse with my fiancée, that's totally out of the question and has been for nearly 2 years now. I just want it sorted so I can get on with life and get back on track."*	TL6 page 538 – 542 AOB-76625 – AOB-76629
24.02. 2016	Letter of Complaint	Re Mr [redacted] *"This letter concerns the care my dad has received at Daisy Hill and Craigavon Hospitals since February 2014. My dad is now [redacted] old and was initially admitted to Daisy Hill in February 2014 with acute urinary retention due to an enlarged prostate. He was subsequently discharged with a urinary catheter. After several tries without catheter Mr Brown asked his junior doctor to refer my dad to urology with view to having a TURP, surgery so that he might become catheter free. In the summer of 2014 I contacted urology but they had yet to receive the referral. On speaking to Daisy Hill, Mr Brown contacted me toe explained that the referral had now been sent.* *In October 2014 I brought my dad to see Mr O'Brien and the pre assessment nurses. I was told surgery was unlikely to be this side of Christmas. So my dad would have the urinary catheter until surgery available.* *Since September 2015 my dad has had 4 hospital admissions. The first two were fairly uneventful in the Downe hospital. I did ring urology secretaries at this point explaining my dad having hospital admissions due to the catheter, recurrent urinary infections. It was explained to me that my dad was still on the urgent list for surgery but no date had yet been allocated.* *On October 31st an ambulance brought my dad to Daisy Hill A&E dept. When I got there he was distressed as it was apparent his catheter was blocked. The dr, a locum I believe, wanted to put in a 3 way catheter and set up bladder irrigation. He was informed by the nursing staff that they didn't do that and my dad would have to go to Craigavon. The A&E dr contacted urology at Craigavon. I believe they asked for a surgical opinion. I could hear the conversation at*	TL6 page 549 – 554 AOB-76636 – AOB-76641

		the nurses station and the telephone conversations. Soon as surgical dr stood at the nurses station. He said "frank haematuria, send him to urology". The A&E dr asked if he would like to see my dad. He said "I have seen him. Send him to Craigavon". He did not speak to my dad or me, or come near us. My dad by this point was clearly agitated, climbing off the trolley telling to get him a dr as he needed to pee and couldn't. I had to stop him leaving the cubicle. He has Alzheimer's and just knew he needed the toilet. I had been there a couple of hours at this point, My dad was now standing unsteadily in front of me wearing a tee shirt with his groin and legs covered in blood. When I asked a nurse for wipes and a towel so I could clean my dad she did offer to help, but I declined her offer. It felt up to that point that no-one wanted to do anything for him. There was no attempt at a bladder washout. He did get some relief if he walked. I believe it made clots move and he was able to pee an amount into the bad. At 1am when I called for help a young nurse came in. She helped me walk him round the cubicle, and he passed some urine into the bag. She was also the only one who changed his trolley, bloodstained blanket and pads. An ambulance came at 2am to take him to Craigavon. *Looking at his chart in Craigavon, it was apparent he became unwell at 6am, but this was dealt with efficiently by nursing and medical staff.* *He was discharged from urology on November 5th 2015. I discovered on the way home to* Personal information redacted *that my dad was faecally incontinent with diarrhoea. When I got him home he was wearing a nappy type pad which he had soiled on the journey. Also from washing it was apparent this was ongoing. 3-4 pairs of pyjamas were badly soiled. My dad had never been incontinent before. I had nothing in the house to deal with this so I left him alone and went to the chemist to buy pads and wipes. While doing his washing a couple of hours later I heard the front door slam. I ran out to find my dad in his pyjamas walking into two lanes of traffic. This was also something new.* *My dad was placed in a nursing home the next day as an emergency placement. He continued to have diarrhoea. By the week starting 9th Nov 2015 he looked like he would die. The GP sent him to Daisy Hill on the 13th Nov 2015. After my previous experience I was somewhat reluctant about this, but on that day the staff were excellent.* *He was moved to a medical ward. I did inform all about the diarrhoea and the IV antibiotics he had been on in Craigavon. The nurse on the ward told me he had been assess as non-infective. After a few days on the open ward they did move him to a side room as the diarrhoea persisted. He was discharged a couple of days later, back to the nursing home. They sent a stool sample which confirmed clostridium difficile.* *My main areas of concerns* *At pre assessment if we had been told a realistic timescale for the waiting time for surgery he would have looked into*	

		getting dad the surgery privately *Not a lot I can say about the surgical opinion my dad received in A&E. My dad may now be an* Personal Information *old with Alzheimer's, but he worked his whole life. I do not remember him ever taking a day off work sick. He was the longest serving* Personal Information redacted by the USI *in N Ireland when he retired.* *An elderly man with full bladder and blocked catheter. Nothing was done to try and give him some relief.* *I was not informed that he was having diarrhoea. If I had known I would have already obtained pads etc.* *Were any stool samples sent when he was in hospital."*	
23.03. 2016	Letter to Mr O'Brien from Mr Mackle	Re concerns with Mr OB clinical practice 1. Untriaged outpatient referral letters (253 triage letters) 2. Current review backlog up to 29 February 2016 (679 patients) 2013 41 patients 2014 292 patients 2015 276 patients 2016 69 patients 3. Patient Centre letters and recorded outcomes from clinics (no discharge on patient centre or in patient's notes) causes frustration for other colleagues as no record of your consultations/discharges Patient notes at home – an ongoing issue for years and needs urgently addresses. We request that all SHSCT charts that are in your home or in your care be brought to the hospital without further delay.	Doc File 2 Pages 86 – 87 AOB-00979 - AOB-00980
03.06. 2016	Response letter to complaint	Re: Ms Personal Information redacted by the USI	TL6 Page 1351 – 1356 AOB-77437 – AOB-77442
06.06. 2016	Letter of Complaint	Re Mr Personal Information redacted by the USI Waiting for urology procedure that has 2 year waiting list. Has private health insurance and they asked him for the procedure code for the procedure he requires. Has requested code from Personal Information redacted by the USI on 11th March and has contacted her on several occasions but hasn't received it. Wishes to get code to receive treatment through Beneden	TL6 page 1357 – 1359 AOB-77443 – AOB-77445
28.07. 2016	Major/Catastrophic Incident Checklist	Re Patient 13 Summary: Patient 13 is a Personal Information old male referred to urology following an episode of haematuria on 28/07/2016. It appears the letter was not triaged and thus Patient 13 was place on a routine waiting list. As part of an internal review Patient 13 was upgraded to red flag referral and was reviewed at OPD, subsequent investigation diagnosed a Pt4 TCC of bladder and prostate. MDM	TRU-02868 – TRU-02871

		09/03/2017 Patient 13 has locally advance bladder cancer	
28.07.2016	Major/Catastrophic Incident Checklist	Re: Patient 11 Summary: Patient Patient 11 – was referred to Urology Outpatients on 28 July 2016 for assessment and advice elevated PSA. Referral was marked urgent by the GP. Referral was not triaged on receipt. As a result of a look back exercise the referral was upgraded to red flag and patient was seen in clinic on day 217, on day 270 the patient had a confirmed cancer diagnosis. There has been a resultant 9-month delay in OP review and recommendation of treatment for a prostate cancer. Patient is aware of diagnosis but not delay and has is currently thinking about his options for treatment	TRU-02872 – TRU-02875
05.08.2016	Ombudsman Report	Re Mr Personal Information Conclusion *"My conclusion is that this is a very typical complex plain case with the frustrations and dissatisfaction expressed by the patient not only understandable from his perspective but an important indicator of the potential underlying complex issues. The pain service could have been at risk of causing iatrogenic harm but wisely avoided this and I think managed this patient safely and sensibly.* *The greater learning point from this case is the urgent need for clinicians of all disciplines to recognise promptly the markers of complexity and to assess patients more fully as only by doing so will we be able to support patients with distressing and disabling symptoms appropriately."*	TL6 page 1675 – 1719 AOB-77760 – AOB-77804
31.08.2016	Part of Email chain between Mark Haynes, Alana Coleman, Charlie McAllister and Martina Corrigan	Email exchange between Mark Haynes and others. Raises the possibility of an SAI in relation to Patient 93. Suggestion is that he went for triage to AOB on 5 May 2016, had a raised PSA of 34, referred by a GP as routine. When investigated 3.5 months later CT showed a metastatic disease from a prostate primary. Haynes notes "*Wouldn't chase the outcome. SAI?"* Note email from Alana Coleman to Mark Haynes of 31 August 2018 which states: "*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."*	Doc File 2 Pages 138 AOB-01031
09.09.2016	Email correspondence between Ms Corrigan, Mr Weir and Mr Young	Michael Young email in relation to Patient 93. Comments include the following *"If booking centre has not received a triage back then I agree that they follow the GP advice……"* "*…although non-curable I would have thought that treatment would still have been offered in the form of anti-androgen therapy at some stage over the subsequent few months….."* *"Following our current Routine waiting time would have resulted in the patient not being seen for a year….."* *"The apparent delay of just a few months has however not impinged on prognosis."*	Doc File 2 Pages 143 – 144 AOB-01036 - AOB-01037

13.09. 2016	Oversight Group Meeting, Notes & Action Points	**Oversight Group Meeting Minutes** **Medical MHPS Cases, Doctors in Difficulty, GMC and NIMDTA issues** Present: Dr Wright, Ms Toal, Ms Gishkori, Mr Gibson & Mr Clegg Oversight group informed of formal letter sent to Mr OB on 23 March 2016 outlining a number of concerns about his practice. He was asked to develop a plan detailing how intended to address these concerns but no plan has been provided and concerns continue 6 months later. Prelim investigation has taken place on paper. Following steps agreed: 1. Mr Gibson to draft letter for Mr Weir and Mr Carroll to present to Mr OB 2. Meeting with Mr OB to happen next week 3. Letter should inform Mr OB of Trust's intention to proceed with informal investigation under MHPS. Is should include action plans for the 4 "main" areas of concern 4. Ms Gishkori to go through letter with Colin, Ronan and Simon prior to meeting with Mr OB Mr OB should be informed that formal investigation may be commenced if sufficient progress has not been made within 4 weeks	Doc File 2 Pages 152 – 155 AOB-01045 - AOB-01048
13.09. 2016	Letter to Mr Gibson from Dr Fitzpatrick	**Letter to Mr Gibson from Dr Fitzpatrick** Re telephone conversation about consultant urologist with number of problems and backlog of about 700 review patients. It was noted that this was different from consultant colleagues who have largely managed to clear their backlog. Very slow to triage patients.. take up to 18 weeks to triage a referral whereas the standard is less than 2 days. Takes charts home and does not return promptly. Note taking is poor and on occasions no records of consultations. Doctor has been spoken to on a number of occasions but no record kept of these discussions.	Doc File 2 Pages 156 – 157 AOB-01049 - AOB-01050
15.09. 2016	Email correspondence between Ms Corrigan and Mr Weir	Email correspondence between Mr Gibson, Mr Wright, Ms Toal and Ms Gishkori Re cancellation of meeting Email from Ms Gishkori: "*Charlie and Colin Weir already have plans to deal with the urology backlog in general and Mr OB performance was of course part of that. … I would like to try out their strategy first. I am therefore respectfully requesting that the local team be given 3 more calendar months to resolve the issues raised in relation to Mr Ob.* *I appreciate you highlighting the fact that this long running*	Doc File 2 Pages 160 – 161 AOB-01053 - AOB-01054

		issue has not been resolved. However given the trust and respect that Mr O'B has won over the years… I would like to give my new team the chance to resolve this in context and for good. Email response from Mr Wright: *"As director of the service naturally we have to listen to your opinion. Before I would consider conceding to any delay.. I would need to see what plans are in place with the issues and understand how progress would be monitored over the three month period…"* Email from Ms Gishkori to Mr Weir, Mr McAllister and Mr Carroll: "*FYI below… and my response will be? "*	
16.09.2016	Email from Ms Gishkori to Ms Toal	Email correspondence between Mr Gibson, Mr Wright, Ms Toal and Ms Gishkori Email from Ms Gishkori: "*I spoke with Richard this morning. He is happy with the direction of travel and I will be asking the AMD and CD to record their plans and actions.* *Mr O'Brien isn't back on call for 6 weeks, however work will begin immediately to address the back log. I have promised Richard a written plan of how we will be proceeding and have asked for a period of 3 months to address."*	TRU-00029
19.09.2016	Letter of complaint	Re Mr Patient 84 I am writing to make an official complaint about the neglect towards myself resulting in my total dissatisfaction on how I have been treated over the past few months. To give you the background into my situation, I was phoned by a consultant (Mr Puyson I believe) on Friday 25th March 2016 (Good Friday) to say that I had a blockage in my ureter, noticed on a recent CT scan, and that it would be best that I come into hospital as soon as possible to get surgery. I was informed that the Easter weekend would be a good time as there was some capacity to do the surgery as I was on an emergency list. I was obviously a bit alarmed and was in the middle of packing for the Easter weekend away. Of course, I realised the seriousness of my condition so I cancelled my plans and the consultant and I agreed that I would receive a telephone call on the Saturday morning to confirm bed availability. I didn't receive this call and then had to do some chasing myself. The staff currently on weren't aware of the plans for surgery. I eventually got confirmation on Easter Sunday morning to come to hospital for the surgery planned on Monday but when I arrived the staff were surprised as I shouldn't have needed to stay pre-operatively and therefore could have just came to hospital on Monday morning. This is just to highlight the severe lack of communication from the start and the fact that my weekend plans were cancelled unnecessarily. However, in saying all that, what followed is the real reason for this letter. After the surgery by Mr O'Brien, I was told that the blockage had been removed (although the stone escaped back up to the kidney) and that I did have a lot of stones in both kidneys and a stent was placed in the right ureter. I understood the logic for a stent and I was informed that it will be uncomfortable at first and that I may feel the	TL6 page 2068 – 2071 AOB-78153 – AOB-78156

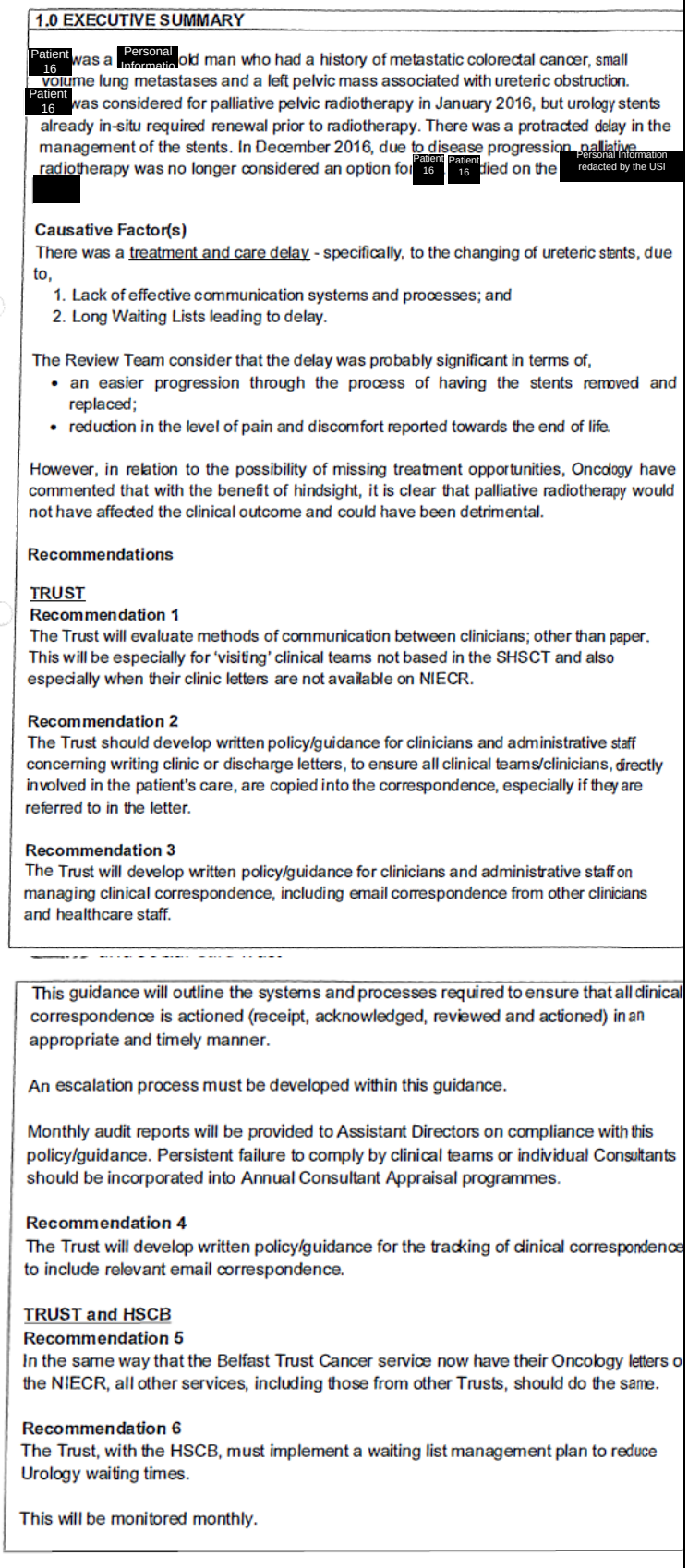
		urgency to pass urine a bit more frequently as the stent protrudes inside the bladder slightly. I was informed that the stent should be removed in 6 weeks' time. I felt that this was fine and that this would be good timing for my pre-booked holiday at the end of May. Unfortunately, from the beginning I had persistent pain with the stent at the tip of my penis particularly when passing urine, and I was passing fresh red blood post exercise and had severe urgency and severe frequency. This clearly had a major impact on my life both at home and in work. I was on regular Ibuprofen and Paracetamol to alleviate the pain but the pain was not being controlled. I was worried about my severe signs and symptoms so I contacted Mr O'Brien's secretary and asked could I speak to him or a member of his team for some medical advice and to discuss the symptoms I was feeling as I was concerned something was wrong. Unfortunately the secretary said I would not be able to speak to anybody in the medical profession but I should contact my GP and that she would send an email to Mr O'Brien. I felt my issues were not being taken seriously and I was being neglected. I contacted my GP who kindly offered some general advice but obviously it was a specialist opinion that I needed at this time. I re-contacted Mr O'Brien's secretary to ascertain where I was on the waiting list for my stent removal but this information was not even available. Again, I was informed that an e-mail would be sent to Mr O'Brien. My symptoms as mentioned were getting worse and I was getting increasingly concerned at this point as I was going on holidays to Personal Information and didn't want get ill abroad. Mr O'Brien's team were aware of my concerns regarding the stent still being in situ while I was abroad as by this stage the stent had been in for 6 weeks. So again I had to contact my GP, who prescribed Amoxicillin based on signs of a urinary infection. On holidays the pain was unbearable at times. I had severe urgency so it meant finding public toilets whenever we were out and making sure I was near one or knew the location of one at all times. I had severe frequency especially at night. I was determined not to let this ruin my holidays with my Personal Information redacted by USI . I went to the local chemist and had to get more Ibuprofen equivalent and continued to drink as much water as I could, being very aware of the fact I was in a warmer climate. I phoned the secretary again on my return expressing my concerns, again the same response. She'll send an email and Mr O'Brien will phone me directly to let me know when the appointment is arranged. I also phoned my GP who was concerned and I believe a letter was sent to Mr O'Brien. In desperation from knowing I was unwell I had to continue making calls to the secretary but I was made to feel like a nuisance and never actually got to speak to a medical professional or get an appointment for surgery. I was informed that the waiting list was over 200, this however is not acceptable and I do feel like I was severely neglected. Three courses of antibiotics (Amoxicillin (x2) and Ciprofloxacin) and regular paracetamol and ibuprofen brought me to the weekend of 6th August, 5 months later. I felt lethargic on Saturday but felt it was due to another disturbed sleep as I woke 3 times to pass water. I endured it as usual as this had been daily since discharge but when I woke on Sunday I felt very unwell and had pain in my right side. At this stage I had been unwell and had the stent in for	

		5 months and I had an increasing concern that the stent could affect the long-term function of my kidneys. I went to A&E at 11am, and was later taken up to 3 South at around 7pm because the urine sample I submitted had “all kinds of things in it” and my white blood cell count and CRP count were very high. I was relieved to be finally admitted as I wanted the stent removed and my kidneys cleared of stones. However I was very frustrated that my concerns of being unwell had not been taken seriously and I had to basically wait until I became so unwell that I had to attend A&E and be admitted to hospital, all of which could have definitely been avoided. I was told by my new consultant Mr O’Donoghue that potentially surgery would be on Tuesday 9th August but thought it was best to postpone it until Wednesday due to the infection. Although a minor point, I was still fasted from 12pm on Monday night; but this again highlighted the miscommunication within the Urology department. On Tuesday the ward got a call from the microbiologists saying that I had “very nasty bacteria” in my urine that produced Extended-Spectrum Beta-Lactamases (ESBLs). This was likely a result of the overuse of antibiotics taken to date which all could have been avoidable if the stent had been removed in the appropriate timeframe. As a result the current IV antibiotic wasn’t working so I was given Tazocin and that the surgery would need to be postponed to a later date until the infection cleared as it could be very dangerous if they were to continue, all of which was very concerning as I was starting to hear the word ‘Septicaemia’. I also learned from a further CT scan that a stone was still in my Ureter and it lay next to the stent. Following this I grew more annoyed however as I am certain this all could have been avoidable. Even during the pre-operative assessment on 11th August this thought was at the forefront of my mind. The doctor informed me that the stent may not be so easily removed and that there may be damage to the Ureter etc. I know the stent was the route of my long-term pain and I am absolutely convinced it was the sole reason for my infections to date. During my stay I was wide-eyed in disbelief what I was hearing from other consultants that they don’t favour stents and where they are needed they target the removal in 5 weeks, for the exact reason of potential UTIs etc. I am aware that they can sometimes stay in for 6 months, but given my known complications and my signs and symptoms, I should have been taken more seriously before I became so unwell. I was in hospital (3 South) from 7th – 14th August for this period. I was discharged on the Sunday 14th August, but I hadn’t felt well afterwards, which I put down to being a bit tired after the surgery. However I had tenderness in my kidneys on Monday night affecting my sleep, Tuesday I felt quite lethargic but by Wednesday I had a high temperature. I got a GP appointment for 4pm that day who sent me straight to A&E. I was very worried about the issue of blood poisoning at this point. Following a blood test in A&E, my white blood cell was high as was my CRP level, so I was put on another antibiotic called Meropenum based on the advice that the doctor sought from the microbiologists. I was then transferred to 3 South, with possible Sepsis and I was on another IV antibiotic for 7 days. I was in hospital (3 South) from 17th – 24th August for this third period. I was discharged on Wednesday 24th and was given further antibiotics that I needed to take for 10 more	

		days. It also led me to question if I should have been discharged without further antibiotics the previous time. I want to make it clear that the staff during my stays were excellent but the duty of care potentially with serious implications between March and August was incredibly poor. If I had been dealt with in the correct manner after the insertion of the stent with it being removed after a 5-6 week period, not only could I have avoided enduring all that pain for 5 months but I wouldn't have to stay in the hospital for 2 full weeks to clear up a serious infection and the procedure could obviously have been much more straightforward. I suggest you vastly improve consultant and patient communication when the patient is not in the hospital, particularly knowing they are required to return to finish a procedure. Medical concerns should be addressed by the consultant or a member of his/her medical team, not by administrative staff. I understand there is a risk that the consultant could find all his time taken up with external patient concerns, but maybe this is where his/her administrative team and a member of his medical team work together to screen non-urgent/ less important issues, then a window in the day is left for the consultant to phone patients with real urgent concerns. If Mr O'Brien hadn't ignored my many calls and failed to return any of them, I wouldn't have been in this situation and the tax payer's money would be better spent. I can't understand in this cost conscious NHS system why it seemed a better plan to ignore my issues for so long and wait until I needed to be admitted to hospital for a 2 week period; taking up a bed, using up time, resources and antibiotics in addition to the impact on my health. I look forward to hearing from you and hope for the sake of others, this letter makes a difference to patient care, so there is no future repeat in this type and level of car	
05.10. 2016	Letter of complaint	RE Ms Personal Information redacted by the HSI Relates to waiting over 4 years for procedure & lack of communication between Secretary and Mr O'Brien with this patient	TL6 page 2173 – 2177 AOB-78258 – AOB-78262
12.10. 2016	Minutes of Oversight Committee Meeting	Oversight Committee Minute of meeting Present: Dr Wright, Ms Toal, Ms Gishkori, Mr Gibson & Mr Clegg Mr OB planned surgery in November and likely to be off for a considerable period. Mr OB had not been told of the concerns following the previous Oversight Committee Meeting. Noted that a plan was in place to deal with range of backlogs during his absence.	Doc File 2 Pages 186 – 187 AOB-01079 - AOB-01080
16.10. 2016	Mr O'Brien response to Complaint	Re Mr Patient 84 In responding to the letter of complaint from Mr. Patient 84, I firstly emphasise that I have much sympathy for him. It would appear that Patient 84 had haematuria assessed in 2002 and 2003 when he was found to have renal calculi associated with a left hydronephrosis, and for which reason he may have later undergone ureteroscopy in 2007. Having reported recurring right lower abdominal pain, his GP requested a plain radiograph of his urinary tract and which was performed on 25 September 2015. It was reported on 17	TL6 page 2210 – 2214 AOB-78295 – AOB-78299

		November 2015 that he probably had bilateral renal calculi and a probable right upper ureteric calculus. He was referred to our Department, four months later, on 29 January 2016. Upon receipt of the referral, Mr. Glackin wrote to the patient, advising that he had requested a CT scan of his urinary tract and requested that an appointment be arranged for Patient 84 to attend the Stone Clinic at Craigavon Area Hospital. A not uncommon occurrence, he was offered an appointment at the Stone Clinic on 04 March 2016 and prior to the diagnostic CT scan being performed on 22 March 2016. Whilst the bilateral renal calculi were evident on the XRay of the urinary tract performed on the 04 March 2016, the right ureteric calculus was not. On renal ultrasound scanning on 04 March 2016, he was reported to have gross right hydronephrosis and hydroureter. When Patient 84 did have CT scanning performed on 22 March 2016, he was found to have a stone located in the upper third of his right ureter, and associated with severe right hydronephrosis which appeared to have been of long-standing as it was associated with marked loss of cortical tissue. It also reaffirmed the presence of several calculi in both kidneys. I am not familiar with the communications regarding his admission to hospital on Sunday 27 March 2016 as I do not recall being involved. If I had been personally involved, I would hope that there would have been a greater awareness by other staff of his impending admission, though the best of efforts have not guaranteed that in the past. I do believe that it was correct to have him admitted on Sunday 27 March 2016, if it were hoped to be able to perform ureteroscopy on an emergency list on Monday 28 March 2016, as there may well not have been a bed for him on the morning of intended surgery. Rather than there being a serious lack of communication, I believe that this is one example of too much wrong communication from those who may not be there the following morning. Patient 84 had right ureteric stenting performed on 28 March 2016 following ureteroscopy and migration of the obstructing stone into the hydronephrotic right kidney. Another example of wrong communication is the advice, information or assurance that Patient 84 claims to have been given that the stent would or should be removed during or after six weeks. In almost 25 years as a consultant urologist, I have never, ever committed myself to perform a procedure within any particular time unless I have actually fixed a date. However, during those 25 years, such commitments have been given to patients on numerous occasions by junior staff who have never once seen a waiting list. In my view, it would have been ideal or optimal for Patient 84 to have had his stent removed and to have had ureteroscopic lithotripsy two to four weeks later as stent-induced, ureteric relaxation by then would have been adequate to permit ureteroscopy. If it had been possible for Patient 84 to be readmitted after such an interval, then all of his subsequent morbidity would have been avoided. It is in that regard that I have complete empathy for him. Unfortunately, that was not possible as he was then competing for readmission with scores of other patients waiting for longer periods with similar	

		priorities. In my defence, I have been entirely aware of the morbidity, sometimes serious, associated with ureteric stents since the 1980s. Most substantively, I have used every available, additional operating session during those months in an attempt to reduce the waiting times for patients in similar situations, and have done so without remuneration. As a consequence, the total number of patients on my inpatient waiting list has been reduced from 275 on 28 April 2016 to 232 on 13 October 2016. Unlike Patient 84, or my colleagues whose sessions I used, I did not have any family holiday during that time. To some degree as a consequence, I have not had the time to read every email sent to me each day, never mind resolve the issues raised. An email was sent to me advising me that Patient 84 had a holiday in Personal Information booked from Personal Information redacted by the USI, and that he was wondering whether he could have his surgery performed before then. I was unable to facilitate that request. I did not read the email of the 05 May 2016 requesting that I contact Patient 84 to give him advice concerning his stent while on holiday. I did read the email of 17 June advising that Patient 84 had had urinary infection and requesting his admission as soon as possible. Once again, other patients in an identical situation were waiting longer to have the same procedure. I was unaware that I had ignored numerous calls made by Patient 84. I have tried my very best to contact and communicate with as many patients as possible but have found it physically impossible to contact all of them. It is necessary to contact patients during their waking hours. Contacting and communicating with patients during their waking hours has resulted in administrative work being displaced to their sleeping hours, and rendering it all the more difficult to complete that work, even with the use of most of my supposedly free time. More importantly, with a total of 232 patients awaiting inpatient admission, 136 of them categorised as urgent, it has been impossible to facilitate all patients, enquiring about and seeking admission, irrespective of the gravity of the indication. However, recently circulated data has revealed that four of my consultant colleagues have had totals of 29, 77, 59 and 41 patients awaiting inpatient admission. Indeed, the total number of patients of those four colleagues awaiting urgent admission was 131 on 13 October 2016, less than the number of patients awaiting urgent admission on my waiting list. It is my view that these figures portray such a disparity in the fortunes of patients on different waiting lists as to render that disparity indefensible. Patient 84 suggested that a ‘window’ be established each day to phone patients with urgent concerns. This could well be considered an attractive and practical proposal for those who have such relatively small cohorts of patients from whom concerns may be received. I believe that it would be more profitable to pool operative resources to ensure that such patients are admitted after the shortest period possible,	

		thereby minimising the need for any such window of communication,	
Nov 2016	Root Cause Analysis report ([redacted]) "revised November 2016"	 **1.0 EXECUTIVE SUMMARY** Patient 16 was a [redacted] old man who had a history of metastatic colorectal cancer, small volume lung metastases and a left pelvic mass associated with ureteric obstruction. Patient 16 was considered for palliative pelvic radiotherapy in January 2016, but urology stents already in-situ required renewal prior to radiotherapy. There was a protracted delay in the management of the stents. In December 2016, due to disease progression, palliative radiotherapy was no longer considered an option for Patient 16 Patient 16 died on the [redacted] **Causative Factor(s)** There was a treatment and care delay - specifically, to the changing of ureteric stents, due to, 1. Lack of effective communication systems and processes; and 2. Long Waiting Lists leading to delay. The Review Team consider that the delay was probably significant in terms of, • an easier progression through the process of having the stents removed and replaced; • reduction in the level of pain and discomfort reported towards the end of life. However, in relation to the possibility of missing treatment opportunities, Oncology have commented that with the benefit of hindsight, it is clear that palliative radiotherapy would not have affected the clinical outcome and could have been detrimental. **Recommendations** **TRUST** **Recommendation 1** The Trust will evaluate methods of communication between clinicians; other than paper. This will be especially for 'visiting' clinical teams not based in the SHSCT and also especially when their clinic letters are not available on NIECR. **Recommendation 2** The Trust should develop written policy/guidance for clinicians and administrative staff concerning writing clinic or discharge letters, to ensure all clinical teams/clinicians, directly involved in the patient's care, are copied into the correspondence, especially if they are referred to in the letter. **Recommendation 3** The Trust will develop written policy/guidance for clinicians and administrative staff on managing clinical correspondence, including email correspondence from other clinicians and healthcare staff. This guidance will outline the systems and processes required to ensure that all clinical correspondence is actioned (receipt, acknowledged, reviewed and actioned) in an appropriate and timely manner. An escalation process must be developed within this guidance. Monthly audit reports will be provided to Assistant Directors on compliance with this policy/guidance. Persistent failure to comply by clinical teams or individual Consultants should be incorporated into Annual Consultant Appraisal programmes. **Recommendation 4** The Trust will develop written policy/guidance for the tracking of clinical correspondence to include relevant email correspondence. **TRUST and HSCB** **Recommendation 5** In the same way that the Belfast Trust Cancer service now have their Oncology letters o the NIECR, all other services, including those from other Trusts, should do the same. **Recommendation 6** The Trust, with the HSCB, must implement a waiting list management plan to reduce Urology waiting times. This will be monitored monthly.	Doc File 2 Pages 312 – 330 AOB-01205 - AOB-01223

09.11.2016	Email correspondence between Ms Boyce and Ms Gishkori dated 09 November 2016 with enclosure [sections of SAI report re Patient 10]	Email correspondence between Ms Boyce and Ms Gishkori Re: SAI "…*SAI that is nearing completion…..[governance leads] are concerned about its implications……cause seems to directly attributable to one of the consultants (AOB)?* *The lady's GP sent in referral in relation to an incidental finding on a CT in relation to her kidneys – it came in as routine. Then urologist of the week collected that week's letters to do triage, as per the urology arrangements but from what the investigation team found out that letter was never seen again and no instruction were received re triage appointment booking.* *Apparently this has happened before with this consultant so the booking's team way of dealing with these type of lost letters was to book them a routine appointment. As results, there was 16 month delay in diagnosing this lady's renal carcinoma…. ……..The triage consultant is meant to look at the CT as part of the triage process but the SAI team found it hadn't been looked at.* *Although this was an SAI about a single case it has come to light that the other 7 urology letters received that week are also missing..*"	Doc File 2 Page 331 AOB-01224
14.11.2016	Mr O'Brien's response to complaint	RE Ms Personal Information redacted by the USI Ms. Personal Information redacted by the USI is a Personal Information redacted by the old lady who has had a long history of lower urinary tract symptoms which have persisted in the absence of urinary infection, but which have been exacerbated by recurring infection. She derived some symptomatic relief from having hydrostatic dilatation of her bladder performed in Personal Information redacted by the USI in 2007. She had been discharged from review in Personal Information redacted by the USI in December 2007 on anticholinergic therapy and antibiotic prophylaxis. She was referred for assessment and management of similar symptoms in 2011. When I met her as an outpatient in December 2011, she reported symptoms of both voiding and storage natures, including urinary incontinence related to both urge and stress. I advised her to remain on antibiotic prophylaxis until she attend for urodynamic studies in July 2012 when she was found to have a moderately severe hypersensitivity of her bladder and probable bladder outlet obstruction to the extent that bladder voiding was found to be inadequate. The latter finding was probably spurious as bladder voiding was subsequently found to be satisfactory on ultrasound scanning in December 2012. Personal Information was placed on the waiting list for hydrostatic dilatation of her bladder and urethral dilatation. When I contacted Personal Information to offer her a date for her admission in February 2013, she was unable avail of the offer as the date was unsuitable. She was reinstated on the waiting list on 01 April 2013. When contacted again in September 2013 with a view to arranging a date for admission, she was then pregnant. She was reinstated on the waiting list in May 2014.	TL6 page 2259 – 2262 AOB-78344 – AOB-78347

		I reviewed Personal Information in July 2014 when I agreed to proceed to have her admitted for the procedure as intended. However, I intended to have her admitted to the Elective Admissions Ward to have the procedure performed as an inpatient as it is impossible to predict the severity of the haemorrhagic response to hydrostatic dilatation of the bladder or the period of catheterisation required following urethral dilatation. For these reasons, and further compounded by the distance from her home to Craigavon Area Hospital, I considered that admission to the Day Surgical Unit was inadequate and inappropriate. That decision has been the foundation in the delay in having Personal Information admitted. There remain patients on my waiting list awaiting such admission dating back to February 2014. Even though Personal would not have been suitable for admission during her second pregnancy which successfully completed in January 2016, she may still have remained on that waiting list for all of that time due to competing priorities. I receive emails every day concerning patients enquiring about dates for admission. I have to confess that I do not always have the time to deal with all of them. I therefore did not appreciate that Personal Information redacted by had been taken off my waiting list in May 2014, shortly after having been reinstated, and as a consequence of my decision to review her, not that that would have made any material difference to the length of time she had to wait. In any case, on receipt of her letter of complaint, I contacted Personal Information and had her admitted on Wednesday 02 November 2016 when the procedure was performed that day. Ironically, she was fit for discharge later that day. I have since spoken to her by telephone, have arranged further ultrasound scanning, additional medication and have arranged review in February 2017.	
22.11.2016	Letter of complaint	Re Mr Personal Information redacted by the On Personal Information redacted by the USI of this year my father Personal Information redacted by the USI (DOB Personal Information redacted by the USI) died unexpectedly whilst in the care of Craigavon Area Hospital. The aim of this letter is to bring to your attention a summary of the standard of care we witnessed my father receiving, which in my opinion fell dramatically short of what should reasonably be expected. Having successfully been treated for bowel cancer some years ago, my father was diagnosed with bladder cancer in 2014 after a long period of assessment. This latest cancer was treated under the excellent supervision of Mr O'Brien who over the past few years has done a great deal to treat my father, culminating in the successful surgical removal of the bladder tumour aided by radiotherapy. Following post-surgery discharge the bleeding did not stop and so after several blood transfusions and further scans he was re-admitted to Ward 3 South (Urology) in Craigavon Hospital on 8 September 2016 from South West Acute Hospital to undergo further assessment. The outcome of these scans and exploratory inspections identified no	TL6 Page 2348 – 2351 AOB-78433 – AOB-78436

		remaining evidence of a tumour, but that areas of the bladder wall had thinned considerably; a result of associated radiotherapy. A further surgical procedure was undertaken to stem the bleeding on 14 September, after which my father was left to recover in the hospital with an expected discharge date of 5th October. Notwithstanding the excellent care given by Mr O'Brien, his fellow consultants and surgical teams, the care on the wards throughout his stay was appalling. On the first visit by my mother she arrived to find my father unshaven and wearing a hospital gown rather than pyjamas. When asked why, a nurse replied 'we didn't know he shaved everyday' and that "he had no clean pyjamas". Upset with the dishevelled state in which she found my father, my mother pointed out to the staff the suitcase sitting adjacent to the bed complete with several pairs of clean, unworn pyjamas and proceeded to shave and dress my father in pyjamas herself. This unfortunately was to be the start of a long saga of woeful care over the next 2-3 weeks. Over nearly 3 weeks my mother struggled enormously to get any information from hospital staff as to my father's condition. Availability of nurses on the ward was sadly lacking, and those she could find did not have or did not wish to share any information. Despite asking on a visit by visit basis to see a Ward Doctor, this was not possible. She was informed doctors would be available during their normal rounds which unfortunately for our family did not coincide with bus times and so we remained in an information vacuum. My mother was limited to being visiting during fixed. Indeed as a last result both my mother and I had to call the Consultant directly on his mobile in order to get any information, this despite my mother spending several hours every other day at my father's bedside; her pleas to speak to someone with knowledge falling repeatedly on deaf ears. It is ridiculous that we had to chase, and to be honest, waste the time of a highly skilled professional consultant simply to be able to get basic information. To his credit Mr O'Brien was splendid and deserves to be congratulated. My mother last visited my father on Personal Information redacted by the USI to find him in good spirits and expecting to be released from hospital the following week. She phoned him on the morning of the Personal and again he was in good spirits, a fact later confirmed when speaking to Mr O'Brien who saw him at tea-time on the Ward and again reported him well. Just after mid-night on Personal Information my mother received a telephone call at home to say that the "Crash Team" had been called. My father died at Personal Informati before any family could arrive. As you will no doubt be aware yourself the shock and sadness causes thoughts to become confused, but my mother is not aware of having received a full account of what had caused his death by those on duty that evening. Only on receiving his death certificate and reading it fully the next day did we for the first time learn that my father had Hospital Acquired Pneumonia; indeed this is stated as the primary ailment connected with his death. It is unforgivable that the	

		family were at no times made aware of this condition. A secondary condition of kidney disease was also printed on the certificate and again reading the document was the first time these words had been mentioned. It was on reading the Certificate that a depressing connection was made. On 26th whilst visiting, my mother overheard a Physiotherapist mention to my father that she had heard he had a 'bit of a chest infection'. My mother thought nothing more of it, after all this was just conversation by one of the staff and not a nurse or Doctor treating my father, and as a smoker for most of his life this was not the first time he had suffered a chest infection. This was all in addition to dehydration that was also mentioned on the certificate which may or may not be connected to my mother repeatedly asking the staff to make my father drink more during the period of his stay as he would tend not to if not reminded. Then on the 28th an entirely separate and chance event took place. My father was to discharge into a residential home for a few days whilst my parents undertook a planned house move. As per normal practice the care home rang the hospital to check on my father's condition and to check on any needs he may have. That phone call identified that my father was on the 4th day of treatment for pneumonia i.e. the anti-biotic had commenced on the 25th. The phone call also identified that my father's weight was not being monitored as is required due to the Ward not having any working scales. My mother had visited on 2 occasions since the commencement of anti-biotic treatment to fight his chest condition and did not receive a single word as to his condition or medication. I flew overseas on Personal Information redacted by the USI blindly unaware that my father health had taken a downturn. I was to receive a phone call he had died during the night upon landing in Personal information redacted by USI on the Friday morning. I could go on about numerous other areas of more minor shortcomings but I won't. I hope the point has been made that throughout the entire time my father was under your care, the levels of on Ward care fell terribly short of what is expected by those needing your care and their families needing to be involved. The unbelievable difficulty in finding someone to speak to not over a short period but frequently over several weeks resulting in learning of his ailments by reading a Death Certificate is disgraceful. Leaving family members and indeed the patients themselves in the dark just makes periods of hospitalisation much more stressful than necessary and in the case of those patients who don't make it home, makes the experience of their families a hundred times worse. In this particular case the lack of communication and patient/family liaison ultimately led my mother and I to lose the closest of family to a complication connected with a hospital acquired condition we didn't even know he had. There is nothing that can be done to rectify our painful experiences of being completely let down, but hopefully this letter may make you consider re-looking at the care given in Craigavon in the hope that others receive a better experience.	

		Finally I would like to request under Freedom of Information a copy of my Fathers medical records for the period in September 16 during which he was being treated at Craigavon, along with a description and reasons behind how my father was exposed to the virus/bacteria that gave cause to pneumonia which by the description in the Death Certificate was 'acquired' during the period he was being treated in hospital.	
01.12.2016	Response letter to Mr Patient 84 from Ms Gishkorri	Dear Mr Patient 84 I refer to your complaint in respect of the care provided to you by the Urology Department at Craigavon Area Hospital. Thank you for taking the time to highlight your concerns and for providing me with the opportunity to address them. Firstly may I begin by apologising for the delay in responding to your letter. As part of the investigation into your concerns I have spoken to Mr O'Brien Consultant Urologist, about your complaint. Mr O'Brien advises me that you had haematuria assessed in 2002 and 2003 at which times you were found to have renal calculi associated with a left hydronephrosis. In September 2015, the radiology department received a referral from your GP requesting a plain radiograph of your urinary tract; this xray was performed on 25 September 2015 and reported on 17 November 2015. The reporting radiologist suggested that most likely you had bilateral renal calculi with a probable right upper ureteric calculus. On 29th January 2016 your GP made a referral to the Urology Department for further management. On receipt of this referral, Mr Glackin triaged the letter and then wrote to you on 2nd February 2016 advising that he had requested a CT scan of your urinary tract to assess for stones and that you would be sent an appointment to attend as an outpatient to the stone clinic. On the 4 March 2016 you were seen by Mr Young Consultant Urologist. You had an xray done during this appointment and whilst the bilateral renal calculi were evident on this xray, the right ureteric calculus was not. So when you had your CT scan on 22 March 2016 it was reported that you had a gross right hydronephrotic kidney and hydroureter. It was from this report that Mr O'Brien deemed that you needed to be admitted to have a ureteroscopy performed as an emergency. Mr O'Brien asked for his Registrar, Mr Tyson to contact you and ask that you come in for admission on the Sunday. Mr O'Brien then emailed the Ward to give them your details and advise them that you would be admitted on the Sunday for your procedure on Monday. I would like to apologise for the misunderstanding when you arrived on the Ward as Mr O'Brien's email hadn't been picked up on this occasion and therfore the ward were not expecting you. As learning from this I have asked that Mr O'Brien and his Registrars follow up with a phone call to the Ward and also that the ward ensures that they check their emails at least a few times daily.	TPH Patient 84 Page PAT-000231

		I am advised that on Monday 28 March 2016 you had a right ureteric stenting performed following an ureteroscopy and migration of the obstructing stone into the hydronephrotic right kidney. Mr O'Brien confirms that ideally patients who have a stent inserted should have this removed and have an ureteroscopic lithotripsy performed four to six weeks later. However, the demand on the Urology Service is unrelenting with an increased number of patients with suspected and confirmed cancer diagnoses requiring progression along their cancer pathway. The result of cancer urgent demand is that the waiting times for other procedures such as yours are increasing on a monthly basis. For this wait we would like to apologise and whilst not ideal nor what we want for you or any of our patients it is something that is currently outside of our control. I note from your complaint that you have contacted Mr O'Brien's secretary on a number of occasions. Mr O'Brien confirms this and advises me that an email was sent to him via his secretary advising that you had a holiday in Personal Information booked from Personal Information redacted by the USI and that you were enquiring whether you could have surgery performed before then. Unfortunately as explained in the previous paragraph with the clinical prioritisation of patients, Mr O'Brien unfortunately could not accommodate your request. At the time of your request Mr O'Brien had 232 patients awaiting inpatient admission of which 136 of them were categorised as urgent. Mr O'Brien apologies that you had to contact him on a number of occasions but with his clinical commitments and the number of patient enquiries that he receives daily it is not possible for him to respond to them all individually, but advises that you did the correct thing by going to your own GP for advice. I understand that you had two emergency admissions to 3 South in August 2016 under the care of Mr O'Donoghue and Mr Glackin who were the Urologists oncall during these admissions. I would like to apologise that you had to fast unnecessarily whilst you were in the first time but I have been advised that this was a precaution in case you were well enough to go to theatre and there was a slot available on the Tuesday and I am sorry that this wasn't communicated properly with you at the time. The Urology Department are currently working at improving the pathway for patients experiencing similar symptoms such as yours. This will involve having a 7 day week stone service with detailed information leaflets for patients with more access to health care professionals if advice is needed. It is hoped through the development of this service it will mean that patients will have their treatment and follow-up done in a timelier manner and hopefully avoid the poor experience that you had endured. On behalf of the Urology Service I would like to apologise again for your poor experience and I am advised that you have a follow-up outpatient appointment with Mr Glackin on 20 December 2016 and I hope that your health issues have improved. I hope that you will find this response has addressed the issues that you raised. However, if you are unhappy with any aspect of this response you should contact a member of our Clinical & Social Care Governance Team on Personal Information redacted by the USI or email: AcutePatient.ClientLiaison@southerntrust.hscni.net within 3 months of the date on this letter so that we can attempt to resolve any outstanding issues.	
05.12.2016	Response letter to complaint	Re Ms Personal Information redacted by the USI	TL6 2378 – 2380 AOB-78463 – AOB-78465
08.12.2016	Mr O'Brien response to complaint	Re [redacted] Mr. Personal Information was Personal Information old when found to have a caecal carcinoma in June 2008. Right hemicolectomy was deferred until September 2008 due to Mr. Personal Information having a transient cerebral ischaemic episode in July 2008. He had an uncomplicated recovery following surgery. There was no subsequent evidence of disease recurrence or progression. He was referred to our Department on 08 August 2014 for investigation of haematuria. When he attended as an outpatient on 21 August 2016, he was noted to have had chronic pulmonary disease diagnosed in 2011 and for which he used Salbutamol, Spiriva and Symbicort inhalers. He had had chronic renal functional impairment since before 2011. His mean Glomerular Filtration Rate (GFR) had been 44 ml/min in 2011, decreasing to 39 ml/min in 2012. It was 35 ml/min on 21 August 2014. He was anaemic with a Haemoglobin of 87 G/L. He was found to have kidneys of	TL6 page 2382 – 2392 AOB-78467 – AOB-78477

		reduced volume and to have a suspicion of a bladder tumour on ultrasound scanning. As he was so grossly haematuric, he was admitted to the Urological Ward from the outpatient clinic for further assessment. CT Urography on 23 August 2014 raised the possibility of a filling defect within the pelvicalyceal system of the left kidney in addition to providing further evidence of a bladder tumour. It was not possible to proceed immediately to resection of the presumed tumour because of the risk of increased, uncontrollable haemorrhage due to Mr. Personal Information having remained on both Aspirin and Dipyridamole since having the transient cerebral ischaemic episode in 2008. Following blood transfusion, and discontinuation of Dipyridamole, he was discharged on 24 August 2014 to be readmitted on 12 September 2016 for surgery. On readmission on 12 September 2014, he was again anaemic with a Haemoglobin of 79 G/L. He was transfused three further units of packed cells. At cystoscopy on 12 September 2014, his bladder contained a significant amount of clot which required evacuation to facilitate visualisation of a solid tumour located on the left posterolateral wall of the bladder at the expected site of the left ureteric orifice. The tumour was endoscopically resected. The left ureteric orifice or lumen could not be identified. It was therefore not possible to gain endoscopic access to the left upper tract in order to determine whether there was any urothelial malignancy at the site of the reported filling defect on CT Urography. Even though Mr. Personal Information had discontinued Dipyridamole preoperatively, he continued to bleed from his bladder postoperatively, requiring further transfusion and requiring further evacuation of clot from his bladder under general anaesthesia on 24 September 2014. He was fit for discharge on 25 September 2016. Histopathological examination of resected tumour confirmed that it was an aggressive, moderately to poorly differentiated, transitional cell carcinoma invasive of detrusor muscle, and with foci of glandular and signet ring differentiation. There was no evidence of skeletal metastatic disease on bone scanning in October 2014. There was no evidence of metastatic disease on CT scanning in October 2014 when he was reported to have extensive emphysematous changes affecting both lungs. He was reported to have interstitial shadowing of the bases of both lungs in keeping with pulmonary fibrosis, and to have bilateral, calcified pleural plaques in keeping with exposure to asbestos. These changes were reported to have remained unchanged since 2008. As it had not been possible to assess the left upper tract endoscopically, CT Urography was repeated in November 2014 when no filling defect was found in either upper tract and when he was reported to have marked atherosclerosis of his abdominal aorta and of the left common iliac artery. Mr. Personal Information remained very well at review in November 2014 when further management options were discussed. While he was considered unfit to undergo radical cystectomy, he was keen to be considered for adjuvant radiotherapy. He was	

		referred to the Cancer Centre following multidisciplinary discussion on 04 December 2014. At consultation as an outpatient on 27 January 2015, Mr. Personal Information agreed to proceed with high dose, palliative radiotherapy which began on 25 February 2015 and was completed on 01 April 2015. Mr. Personal Information remained very well following radiotherapy until October 2015 when he had recurrence of haematuria. He was found to have minimal thickening of the posterior wall of his bladder on CT scanning in November 2015. There was no evidence of disease progression beyond his bladder. He was again reported to have marked emphysema, left apical pulmonary scarring and inflammatory changes affecting the base of his left lung. He was found to be keeping relatively well at review on 30 November 2015. The haematuria was not as severe as it had been previously. Nevertheless, he was anaemic again with a Haemoglobin of 92 G/L. It was agreed to have Mr. Personal Information readmitted on 15 December 2015 for further endoscopic assessment of his bladder on 16 December 2015. However, he required earlier admission to South West Acute Hospital on 06 December 2015 due to worsening haematuria resulting in an increasing anaemia, with a Haemoglobin of 69 G/L, requiring further transfusion. He also had a respiratory infection during that admission. He was reported to have mild shadowing of the lower lobe of his left lung, in keeping with infection, on a chest XRay on 06 December 2015. A further chest XRay on 13 December 2015 additionally reported a small right basal consolidation in keeping with infection. Mr. Personal Information was transferred to Craigavon Area Hospital on 14 December 2015. His markedly trabeculated bladder mucosa was found to be endoscopically normal on 16 December 2015, apart from an area of the posterior wall which was haemorrhagic and to which clot was adherent. This area was resected. There was no malignancy found on histopathological examination of resected tissue. Mr. Personal Information was fit for discharge on 23 December 2015, and again remained relatively well at review in January 2016 even though he was again anaemic with a Haemoglobin of 98 G/L. However, he remained without recurrence of visible haematuria until April 2016 by which time his Haemoglobin had increased to 107 G/L without further transfusion, and even though he had remained on both Aspirin and Dipyridamole. The latter was then discontinued on 08 May 2016 prior to further endoscopic assessment on 31 May 2016. There was no evidence of disease progression on CT scanning on 11 May 2016. At cystoscopy on 01 June 2016, he was found to have an area of ulcerated fibrosis at the site of tissue resection in December 2015. There was no tumour evident in his bladder. There was no bleeding from his lower urinary tract. There was no clot in his bladder. Yet Mr. Personal Information had prolonged bleeding from his bladder postoperatively. He then incrementally had Enoxaparin and Aspirin discontinued	

		without achieving reduced bleeding. Mindful of the significantly increased risk of a thromboembolic event, increasing doses of Tranexamic Acid were prescribed, resulting in a reduction in haematuria adequate to enable his discharge on 11 June 2016. By then it had been concluded that the only possible reason for such persistent bleeding was radiation cystitis, as there was no other cause detectable. The haematuria had decreased significantly by the time of review on 20 June 2016 when he was advised to remain on Tranexamic Acid 500 mgs three times daily. Mr. Personal Information was then admitted to South West Acute Hospital on 14 August 2016 following the onset of left pleuritic chest pain, cough and dyspnoea. He was found to have bilateral expiratory chest wheeze. In view of the known risk of thromboembolism, a CT Pulmonary Angiogram was performed on 15 August 2015, excluding pulmonary embolism. However, the CT scan revealed that there had been a significant increase in the size of a subpleural, paravertebral mass in the lower lobe of the right lung compared to the previous CT scan performed in May 2016. This lesion was discussed at the Western Trust Lung Multidisciplinary Meeting of 22 August 2016 when it was concluded that its appearance and increase in size was consistent with primary lung cancer, rather than a solitary metastatic lesion from the carcinoma of the bladder, and that it should be managed by best supportive care. Mr. Personal Information required readmission to South West Acute Hospital on 04 September 2016 due to a marked worsening of haematuria resulting in clot retention. He was catheterised, had clot evacuated and had continuous bladder irrigation, all with limited success. He required transfusion as his Haemoglobin had decreased to 77 G/L by 07 September 2016. There was a progressive deterioration in his renal function, his GFR decreasing to 11 ml/min by 08 September 2016, when he was transferred to Craigavon Area Hospital. His management included intravenous antibiotic therapy for respiratory infection, prior to and after transfer. The management of the respiratory infection included Salbutamol and Saline Nebulisers and chest physiotherapy following his transfer. He required further transfusion and continued bladder irrigation in preparation for further endoscopic assessment on 14 September 2016. By then, his Haemoglobin had increased to 114 G/L whilst his renal function had improved to a GFR of 31 ml/min. There had been a deterioration in Mr. Personal Information's clinical status noted on 10 September 2016 in that he was noted to have increased heart and respiratory rates. Electrocardiography revealed that he had right bundle branch blockade and left anterior hemiblockade, resulting in ST segment depression and prolonged QT interval, and compensatory premature complexes. These findings illustrated that Mr. Personal Information had cardiac conduction dysfunction. At cystoscopy performed under general anaesthesia on 14 September 2016, his bladder was found to be fully distended by organised, adherent clot. His prostate gland was irregular and obstructive, and was endoscopically resected to facilitate	

		endoscopic evacuation of clot. During the course of endoscopic evacuation, the ulcerated, fibrotic site of previous resection perforated, most of the clot rapidly migrating into the left hemipelvis. All remaining clot was evacuated from the bladder and an irrigating urethral catheter inserted. Then by way of a lower midline incision, all clot was removed from the peritoneal cavity. The site of perforation of the bladder was repaired. A drain was left in the peritoneal cavity and the abdominal wound closed. As bladder irrigation was clear on the first postoperative day, Tranexamic Acid was discontinued and anticoagulant prophylaxis was initiated by prescribing a reduced dose of Enoxaparin, 20 mgs daily, in view of impaired renal function. Mr. Personal Information made satisfactory clinical progress during the first several days following a significant surgical intervention for a Personal Information old man with his chronic respiratory, renal and cardiovascular, comorbid status. The singular disappointment was the recurrence of haematuria, leading to recurrence of anaemia and the need for further transfusion. It became evident that he would continue to bleed from his bladder, unless he had a salvage cystectomy performed and which it was considered he would probably not survive. The persistence of bleeding de facto indicated that he would not completely recover. That apart, Mr. Personal Information continued to make progress on several fronts. He was able to slowly mobilise and to incrementally resume eating and drinking, supplemented by intravenous fluids. He remained on intravenous antibiotic therapy and continued to have chest physiotherapy as he continued to have the clinical and biochemical features of a chest infection. He was reported to have evidence of new infiltrates in the lower lobe of his right lung, suggestive of infection, on a chest XRay on 17 September 2016. As he had had twelve days of intravenous antibiotic therapy by 20 September 2016, intravenous antibiotic therapy was discontinued that day. By 24 September 2016, he had made good progress, eating and drinking normally, sitting out of bed, with a Haemoglobin of 105 G/L following transfusion, and with an improved renal function of 39 ml/min. The haematuria persisted. On the morning of 25 September 2016, he was chestier than usual. He was mildly pyrexic with a temperature of 37.5C. Air entry to the bases of both lungs was reduced. A chest Xray was repeated. It was reported that there were areas of shadowing affecting the lower lobes of both lungs, slightly more so affecting the right lung than the left. It was considered that this most probably indicated acute consolidation, probably due to infection, and that the appearances were similar to but slightly worse than previously. The diagnostic impression was recorded as a hospital acquired pneumonia. Therefore, intravenous antibiotic therapy was resumed that day, in addition to continued chest physiotherapy and oxygen therapy as required. There was no record of any deterioration in any aspect of Mr. Personal Information's clinical status during the next few days, apart from a	

		progressive decrease in his Haemoglobin to 84 G/L, in response to which he would have required a further transfusion in due course. His C-reactive protein level was decreasing, indicating that there may have been a progressive improvement in the respiratory infection since intravenous antibiotic therapy had been resumed. There had been a decrease in his renal function from a GFR of 39 ml/min on Personal Information redacted by the USI 2016 to 31 ml/min on Personal Information redacted by the USI 2016. The deterioration was noted by medical staff on the morning of Personal Information redacted by the USI 2016. The nursing staff recorded that there were no evident concerns when they attended to Mr. Personal Information at 11.10 am on Personal Information redacted by the USI 2016. At 1.30 pm, it was reported to medical staff that the urethral catheter was not draining any urine. When the administration of intravenous fluids did not result in a urinary output, it was appreciated that the urethral catheter was blocked by clot. The catheter was unblocked, three litres of haematuric urine and clots drained from his bladder, and following which the catheter drained well. However, Mr. Personal Information had complained of abdominal pain, and was considered to have a fairly rigid abdomen, prior to the catheter being unblocked. After catheter drainage was restored, he complained of some upper abdominal pain. He was found to have some epigastric tenderness, but there was no peritonism. He did feel nauseated, and vomited once. His nausea was resolved by the administration of Ondansetron. In parallel with the clinical course of that day, it had been noted that there was a dramatic increase in his total white cell count to 22,000 that morning. Similarly, his C-reactive protein level had increased dramatically to 222.27 mg/L from 93.3 mg/L the previous day. His renal function had deteriorated further, his GFR having decreased to 14 ml/min. The attending medical staff were cognisant of these changes in requesting ultrasound scanning of his urinary tract which was performed during the evening of Personal Information redacted by the USI 2016. It was reported that there was mild dilatation of both renal pelvices, unchanged from previously, that the urinary bladder was empty apart from the catheter contained within and that there was a small amount of ascites. As Mr. Personal Information was then comfortable and settling for the night, it was considered that all of the symptoms, clinical findings and laboratory derangements had been due to the urethral catheter having become blocked by clot, leading to bladder distension and upper tract obstruction, and that having restored catheter drainage had resolved the situation. Mr. Personal Information had a light dinner after ultrasound scanning. It was recorded at 07.30 pm that he was comfortable. He had intravenous hydration continued, was administered oxygen therapy, used his inhalers and had intravenous antibiotics given. He was repositioned in an upright position prior to settling for the night. He vomited a small amount of brown fluid after 11.00 pm. He vomited a further 100 mls of similar fluid at 11.30 pm. His clinical status deteriorated rapidly thereafter. His oxygen saturation rapidly decreased to 72% even though he continued to have 2 litres of oxygen delivered each minute. Oxygen saturation did not improve during the next ten minutes even though oxygen delivery was increased	

		to 10 Litres per minute. He had become tachycardic during that period and progressively hypotensive, prior to asystolic, cardiorespiratory arrest. Despite cardiopulmonary resuscitation, airway suction and intravenous administration of adrenalin, asystole persisted. Resuscitation was discontinued a Personal Information redacted by the USI. **Comments** I do believe that there are several issues of concern in the letter of 22 November 2016 from Mr. Personal Information's son, Personal Informatio. The first relates to the actual causes of his death. It is for this reason that I have detailed his clinical history in this response. Mr. Personal Information was Personal Information old when found to have an aggressive carcinoma invasive of the muscle of his urinary bladder. It was remarkable that there was no metastatic disease at the time of diagnosis. It was my considered view at that time, and of my colleagues in the multidisciplinary setting, and of Dr. Darren Mitchell, Consultant in Clinical Oncology, that he was not a candidate for radical cystectomy. We came to that view, not only because of his age, but also in view of the clinical and radiological evidence of significant respiratory dysfunction due to lifelong smoking which Mr. Personal Information continued to do until August 2016. Without adjuvant radiotherapy, disease progression would have occurred, leading to his demise. Unfortunately, oncologically effective radiotherapy resulted in a haemorrhagic cystitis which is usually refractory to intervention short of salvage cystectomy which I believe he would have had less prospect of surviving than having had radical cystectomy in the first instance. In attempting to reduce the bleeding from his bladder, I had withdrawn the dual antiplatelet therapy that Mr. Personal Information had been taking since having had an episode of cerebral ischaemia in 2008. In addition, I had added Tranexamic Acid in an attempt to reduce fibrinolysis and promote clotting. In doing so, I was particularly conscious of the risk of precipitating an acute thromboembolic event which may well have been fatal. There certainly had been evidence of carotid arterial atheroma on Doppler ultrasound scanning in 2008 and of abdominal aortic atheroma on CT scanning in 2014. I do believe that I shared that concern with Mr. and Mrs. Personal Information on more than one occasion. Mr. Personal Information's son, Personal Informatio, expressed his concern that the primary cause of his father's death was hospital acquired pneumonia. There is no doubt that Mr. Personal Information's death was sudden and unexpected, and due to cardiac asystole. It is possible that the increased total white cell count and C-reactive protein levels that day were reflective of an acute worsening of the chest infection, leading to cardiac arrest. It is possible that the cardiac arrest was unrelated to the respiratory infection. It is possible that he may have aspirated whilst vomiting, the aspiration precipitating cardiac arrest. It is possible that asystole was unrelated to either. It is possible that he suffered an acute coronary thrombosis converting incomplete conduction blockade to complete blockade.	

		Therefore, I believe that it could not be asserted with certainty that his respiratory infection had been the primary cause of his death. I did visit Mr. Personal Information at approximately 06.00 pm on Personal Information redacted by the USI 2016, when he was feeling well and did not appear to have a respiratory infection imminently the cause of his death. However, I must emphasise that I must defer to the clinical judgements of my colleagues who were responsible for his daily, postoperative care. I believe that the use of language and diagnostic labels are important. Personally, I have not used the term 'pneumonia' to describe a lower respiratory tract infection for decades, though I acknowledge its validity to describe an infective pulmonary consolidation. I have never used the term 'hospital acquired pneumonia' which I presume to infer that the patient acquired a serious lung infection that he or she would not have done, had he or she not been in hospital. It could be said that Mr. Personal Information a pneumonia, even a hospital acquired pneumonia, in December 2015 as he was found to have right basal consolidation on chest radiography then. He did have chest infections due to several infecting organisms found on sputum culture from March 2016 to July 2016. He was considered to have a chest infection on admission to South West Acute Hospital on 04 September 2016. Intravenous antibiotic therapy for a chest infection was initiated in South West Acute Hospital, and continued following his transfer to Craigavon Area Hospital. There was radiological evidence of slight worsening of the infection on chest radiography on 25 September 2016. It is my view that the recently diagnosed carcinoma of the lower lobe of the right lung was the factor which would have progressively rendered this particular infection refractory to treatment. I have no doubt that the compromised cardiovascular, respiratory and renal function that Mr. Personal Information was known to have for years would have been contributory factors in his death. I have been surprised to learn that Mrs. Personal Information was unaware that her husband had significant, chronic renal functional impairment. Previously referred to as 'chronic renal failure', this too has in recent years become referred to as 'chronic kidney disease', another term which I have never used. However, I do accept responsibility for not having appraised her of her husband's longstanding renal functional impairment. I believe that it is important to emphasise that I was not personally responsible for Mr. Personal Information's inpatient management following his surgery of 14 September 2016, as that was the responsibility of the consultant 'urologists of the week'. I have no doubt that my consultant colleagues would have been only too willing to meet with Mrs. Personal Information at times that would have suited her, if requested. So much of the grievance expressed in Mr. Personal Information's son's letter is related to the failure to respond to his mother's requests to meet with doctors who would have been able to share with her a report of his status, progress or otherwise. Mr. Personal Information redacted by the USI asserted in his letter that his mother was advised by nursing staff that doctors would only be available to meet with her during their normal rounds. If that was the	

		case, it is both regrettable and wrong. The one time when doctors do not normally wish to meet with relatives is when they are doing ward rounds. Even though the consultant 'urologist of the week' may not always be available to meet with the spouse of a seriously ill patient because of other commitments, such as emergency operating, either the consultant or registrar should be available on most occasions to do so. Mr. Personal Information redacted by the USI 's letter also refers to concerns relating to the care of his father by nursing staff, and which I believe would better be addressed by the Ward Manager. Irrespective of the exact causation of his father's death, these concerns are equally valid and require addressing. **Summary** I believe that Mr. Personal Information 's death was inevitable as a consequence of haemorrhagic radiation cystitis, or as a consequence of the recently diagnosed lung cancer, or from an acute thromboembolic event, or some combination of all three. It has been all the more difficult for his widow and his son to deal with his death not having realised the extent of his comorbid status. I accept responsibility for my failure in adequately advising them of these important issues. Conversely, I believe that it may not have been possible to be certain that his chest infection was the primary cause of his death, and for which reason, it is possible that too much significance is attributed to its role in a death which was inevitable. However, irrespective of the inevitability and the mechanism of his death, I regret that his care in his final weeks may not have been optimal. I do hope that this response will be of some assistance to Mrs. Personal Information and her son, Personal Informatio, in the loss of her husband and his father.	
05.12.2016	Complaint Letter from Patient	This complaint relates to poor communication between oncology and urology. In short, a stent was inserted in March 2015. They were informed the stent would be due to be removed directly after treatment ended as its life span was 6-9 months. They requested updates from the Oncologist and Surgeons and began to ring Mr O'Brien's secretary in an effort to have the procedure completed. When he allegedly underwent treatment in June 2016 the procedure was complicated "*the kidney was significant distended and the stent was encrusted and dislocated.* This led to septicaemia and 12 days in hospital. The concern was that the delay in removal of the stent was undeniably linked to the removal of cancer options for his father thereafter.	Doc File 2 Pages 340 – 342 AOB-01223 - AOB-01235
15.12.2016	Letter to Ms Boyce	***[Enclosures with this letter showing "samples of comments from undictated charts" & "Patient Pathways x4" & "urology outcome rotas for October 2016"]***	TRU-00638 – TRU-00660

		• In May 2014, there was an informal process was implemented to monitor/manage Urology letters which had not been returned with management advice (not triaged). It appears that this process was created in an effort to limit risk of harm to the patient. The presence of this process implies that it was accepted that triage non-compliance was to be expected by a minority of consultants within the Urology specialty. On 6 November 2015, an email from the AD of Functional Service formally implementing this process. The Review Panel are anxious that the current process does not have a clear escalation plan which evidences inclusion of the Consultant involved. In addition, this process has not been effective in addressing triage non-compliance. From 28 July 2015 until 5 October 2016, there are 318 patient letters which were not triaged. Currently the Trust cannot provide assurance that the Urology non-triaged patient cohort are not being exposed to harm while waiting 74 weeks for a Routine appointment or 37 weeks for an urgent appointment. • During the manual look-back exercise on 14 November 2016, Personals patient chart could not be found on Trust premises. Personals chart did appear in the Acute Governance office the week commencing 28 November 2016. After informal queries, it is understood that patient notes are not transported via Trust vehicles to or from Dr 6's outlying clinics (inc SWAH). This could compound efforts to establish any chart location or outstanding dictation. The Review panel acknowledge that processes should not be drafted to address one issue with one specialist team. On balance, the Review team agree there is sufficient cause for concern that Trust documentation may be leaving Trust facilities and the process of record transportation for this Specialty does need urgently addressed. • There is clear evidence that this patient Personals letter was not triaged by week ending 30 October 2014. Personal was seen in SWAH by Dr 6 in January 2015. The outpatient letter was dictated 11 November 2016 and typed 15 November 2016. The Review panel have grave concerns that there are other Urology patient letters not being dictated in a timely manner. Upon further investigation, the Panel have found that the Trust does monitor the number charts needing audio-typing of dictation but there does not appear to be a robust process to monitor if post-consultation patient dictation has been completed. This has the potential to be compounded if patient charts are leaving the Trust facilities. The SAI Panel are anxious that assurance is sought that there is reasonable compliance in relation to the timely dictation letters by Dr 6.	Doc File 2 Pages 352 – 353 AOB-01245 – AOB-01246

22.12.2016	Minutes of Oversight Committee Meeting	**Southern Health & Social Care Trust** **Oversight Committee** **22nd December 2016** **Present:** Dr Richard Wright, Medical Director (Chair) Vivienne Toal, Director of HROD Ronan Carroll, on behalf of Esther Gishkori, Director of Acute Services **In attendance:** Simon Gibson, Assistant Director, Medical Director's Office Malcolm Clegg, Medical Staffing Manager Tracey Boyce, Director of Pharmacy, Acute Services Directorate **Dr A O'Brien** **Context** On 13th September 2016, a range of concerns had been identified and considered by the Oversight Committee in relation to Dr O'Brien. A formal investigation was recommended, and advice sought an received from NCAS. It was subsequently identified that a different approach was to be taken, as repo to the Oversight Committee on 12th October. Dr O'Brien was scheduled to return to work on 2nd January following a period of Perso nal leave, but an ong SAI has identified further issues of concern. **Issue one** Dr Boyce summarised an ongoing SAI relating to a Urology patient who may have a poor clinical outco due to the lengthy period of time taken by Dr O'Brien to undertake triage of GP referrals. Part of this S also identified an additional patient who may also have had an unnecessary delay in their treatment fo the same reason. It was noted as part of this investigation that Dr O'Brien had been undertaking dicta whilst he was on Perso nal leave. Ronan Carroll reported to the Oversight Committee that, between July 2015 and Oct 2016, there were letters not triaged, of which 68 were classified as urgent. The range of the delay is from 4 weeks to 72 weeks. **Action** **A written action plan to address this issue, with a clear timeline, will be submitted to the Oversight Committee on 10th January 2017** **Lead: Ronan Carroll/Colin Weir** **Issue two** An issue has been identified that there are notes directly tracked to Dr O'Brien on PAS, and a proportion o these notes may be at his home address. There is a concern that some of the patients seen in SWAH by D O'Brien may have had their notes taken by Dr O'Brien back to his home. There is a concern that the clinica management plan for these patients is unclear, and may be delayed. **Action** **Casenote tracking needs to be undertaken to quantify the volume of notes tracked to Dr O'Brien, and whether these are located in his office. This will be reported back on 10th January 2017** **Lead: Ronan Carroll** **Issue three** Ronan Carroll reported that there was a backlog of over 60 undictated clinics going back over 18 months. Approximately 600 patients may not have had their clinic outcomes dictated, so the Trust is unclear what the clinical management plan is for these patients. This also brings with it an issue of contemporaneous dictation, in relation to any clinics which have not been dictated. **Action** **A written action plan to address this issue, with a clear timeline will be submitted to the Oversight Committee on 10th January 2017** **Lead: Ronan Carroll/Colin Weir** It was agreed to consider any previous IR1's and complaints to identify whether there were any historical concerns raised. **Action: Tracey Boyce** **Consideration of the Oversight Committee** In light of the above, combined with the issues previously identified to the Oversight Committee in September, it was agreed by the Oversight Committee that Dr O'Briens administrative practices have led to the strong possibility that patients may have come to harm. Should Dr O'Brien return to work, the potential that his continuing administrative practices could continue to harm patients would still exist. Therefore, it was agreed to exclude Dr O'Brien for the duration of a formal investigation under the MHPS guidelines using an NCAS approach. It was agreed for Dr Wright to make contact with NCAS to seek confirmation of this approach and aim to meet Dr O'Brien on Friday 30th December to inform him of this decision, and follow this decision up in writing. **Action: Dr Wright/Simon Gibson** The following was agreed: Case Investigator – Colin Weir Case Manager – Ahmed Khan	Doc File 2 Pages 387 – 388 AOB-01280 – AOB-01281 TRU 00058 – 00059

<table>
<tr><td>22.12.2016</td><td>Email between Client Liaison, Acute Patient, Ms Reid and Ms Connolly</td><td>Email from David, Client Liaison, Acute Patient :

“Hi Trudy and Connie, I am sending this out for investigation as a complaint but copying to you also to see if it needs screened as an SAI.”</td><td>Doc File 2 Page 389

AOB-01282</td></tr>
<tr><td>23.12.2016</td><td>Email correspondence between Ms Clayton, Mr Carroll and Ms Corrigan</td><td>Email correspondence between Wendy Clayton, Ronan Carroll and Martina Corrigan.

Re: Audit of 11 SWAH clinics. 183 patients attended, audit on 98 charts and 55 were tracked to AOB = 56%

Also notes “I have ran a PAS query to see how many charts are tracked out to Mr O'Brien. I believe this will be useful for your meeting next Friday:”

<table>
<tr><td>Tracking code</td><td>Description</td><td>No. of charts tracked to AOB</td></tr>
<tr><td>CU2</td><td>Mr AOB O'Brien</td><td>8</td></tr>
<tr><td>COABO</td><td>AOB office</td><td>210</td></tr>
<tr><td>CURWDO</td><td>AO Brien Urology cl</td><td>0</td></tr>
<tr><td>CURWOB</td><td>AOB urology CAH</td><td>0</td></tr>
<tr><td>EURAOB</td><td>Enniskillen AOB urology</td><td>147</td></tr>
<tr><td>Totals</td><td></td><td>365 charts</td></tr>
</table></td><td>Doc File 2 Page 401

AOB-01294</td></tr>
<tr><td>23.12.2016</td><td>Email from Ms Boyce to Mr Carroll</td><td>Query as to whether the complaint from Mr [redacted] Patient 16 satisfied criteria for SAI</td><td>TRU-01366 – TRU-01392</td></tr>
<tr><td>28.12.2016</td><td>Email from Ms White to Mr O’Brien</td><td>Re Agenda for meeting with Dr Wright

1. To discuss an investigation into alleged irregularities of patient note keeping and review triage, under the framework of maintaining higher professional standards.

2. To discuss the date of your planned return to work.

3. To clarify Trust expectations regarding the return of patient notes that have been tracked out to you.</td><td>TL6 page 2492 – 2493

AOB-78577 – AOB-78578</td></tr>
<tr><td>28.12.2016</td><td>Email from Mr Gibson to Ms Hainey and Dr Wright</td><td>Mr Gibson noted that he was drafting correspondence on behalf of Dr Wright to give to Mr O’Brien but after advise from NCAS, discussion with Mr O’Brien may be purely verbal.</td><td>TRU-00044</td></tr>
<tr><td>28.12.2016</td><td>Email correspondence between Ms Toal and Ms Hainey</td><td>Email correspondence between Ms Lynne and Ms Toal

Re: another MHPS case received.</td><td>Doc File 2 Pages 404 – 406</td></tr>
</table>

		"*Irrespective of oversight decision he needs to be excluded to allow investigation to run and to ensure patient safety.* *Richard hoping to meet him this week and advise of exclusion."*	AOB-01297 – AOB-01299 TRU-00041 – TRU-00043
28.12.2016	Email correspondence between Mr Carroll, Ms Boyce, Mr Wright, Mr Gibson and Mr Haynes dated 28 December 2016 with enclosure	Email from Mark Haynes to Ronan Carroll: "*I mentioned in discussion the management of PP's by Mr O'Brien. I suspect that he is not the only individual who brings patients into the NHS and onto NHS theatre lists. However, given recent events I feel this practice should also be looked into.* *Attached is a PP letter from Mr O'Brien. This patient was seen by Mr O'Brien on 5th September privately (given the headed paper the letter Is on) and placed on his NHS theatre list on weds 21"September, waiting a total of 16 days. His actual NHS waiting list has many other patients awaiting a routine TURP (which this man had) waiting significant lengths of time. I believe, if his theatre lists were scrutinised over the past year a significant number of similar patient admissions would be identified. This practice has a negative impact on our overall waiting times and is in my view totally unacceptable.* *Do you think this should be fed into the overall investigation?"*	Doc File 2 Pages 407 - 408 AOB-01300 - AOB-01301
28.12.2016	Email correspondence between Mr Carroll, Mr Gibson, Ms Boyce and Mr Wright	Email correspondence between Mr Carroll, Mr Gibson, Ms Boyce and Mr Wright Re: Review of backlog up until 31 December 2016 135 patients – 2014 181 patents – 2015 289 patients – 2016 Also 75 charts in AOB office	Doc File 2 Pages 409 – 411 AOB-01302 - AOB-01304
28.12.2016	Email correspondence between Mr Carroll, Ms Boyce, Mr Wright, Mr Gibson and Mr Haynes with enclosures	This is a detailed analysis by Mr Carroll of Mr O'Brien's TURPs on private patients against his TURPs for other cases. **[The document needs to be referred to in full].**	Doc File 2 Pages 420 – 425 AOB-01313 - AOB-01318

From: Carroll, Ronan
Sent: 28 December 2016 11:15
To: Boyce, Tracey; Wright, Richard; Gibson, Simon
Subject: FW: Management of PP's / non chronological listing
Attachments: Personal Information .pdf

Importance: High

Please see email received from Mr Haynes which is self-explanatory. Mr Haynes came across this letter as a result of reviewing this pt with AOB being off sick & pulled this letter off NIECR
AOB Waiting time for routine – 149wks & urgent 139wks for TURPs
I have asked Wendy to run a report on all AOB TURP's completed (which is what this man had) to see are there others who have been listed the same way.
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Personal Information

From: Haynes, Mark
Sent: 23 December 2016 10:39
To: Carroll, Ronan
Subject: Management of PP's / non chronological listing

Morning Ronan

I mentioned in discussion the management of PP's by Mr O'Brien. I suspect that he is not the only individual who brings patients into the NHS and onto NHS theatre lists. However, given recent events I feel this practice should also be looked into.

Attached is a PP letter from Mr O'Brien. This patient was seen by Mr O'Brien on 3rd September privately (given the headed paper the letter is on) and placed on his NHS theatre list on weds 21st September, waiting a total of 16 days. His actual NHS waiting list has many other patients awaiting a routine TURP (which this man had) waiting significant lengths of time. I believe, if his theatre lists were scrutinised over the past year a significant number of similar patient admissions would be identified. This practice has a negative impact on our overall waiting times and is in my view totally unacceptable.

Do you think this should be fed into the overall investigation?

Mark

The Nine Patients who had TURP performed in 2016 and who had previously attended privately for consultation:

1. Personal Information redacted by the USI

Private consultation	28 February 2015
Flexible cystoscopy and urodynamic studies	27 March 2015
Intramural injection of Botulinum toxin	22 September 2015
TURP	27 January 2016
Private consultation – TURP	333 days
Previous episode – TURP	120 days

2. Personal Information redacted by the USI

Private consultation	07 March 2015
Flexible cystoscopy	13 October 2015
TURP	18 March 2016
Private consultation – TURP	370 days
Previous episode – TURP	150 days

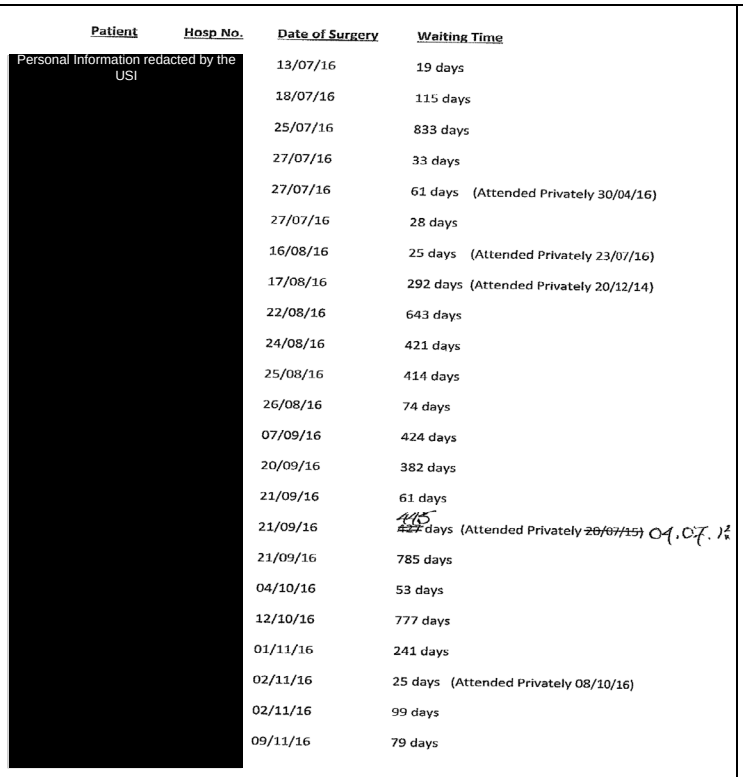
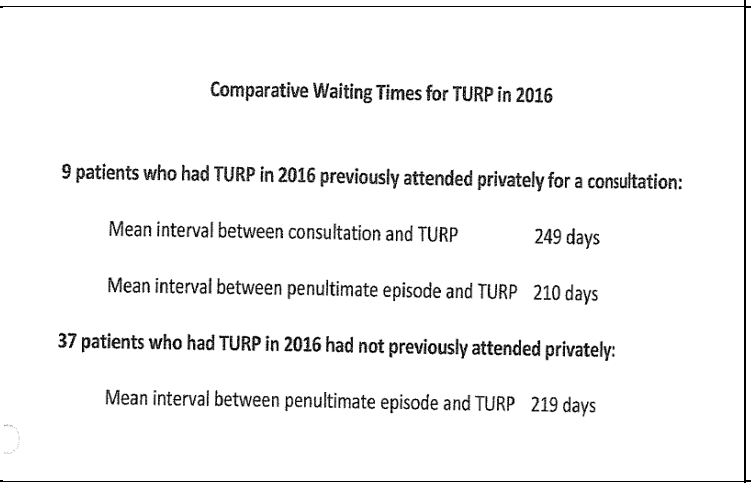
3. Personal Information redacted by the USI

Private consultation	12 March 2015
Review consultation	30 March 2015
TURP	15 June 2016
Private consultation – TURP	461 days
Previous episode – TURP	443 days

4. Personal Information redacted by the USI

Private consultation	15 August 2015
Flexible cystoscopy and urodynamic studies	07 September 2015
TURP	06 July 2016
Private consultation – TURP	326 days
Previous episode – TURP	303 days

		5. Personal Information redacted by the USI Private consultation — 30 April 2016 TURP — 27 July 2016 Private consultation – TURP — 88 days 6. Patient 121 Personal Information redacted by the USI Private consultation — 23 July 2016 TURP — 17 August 2016 Private consultation – TURP — 25 days 7. Personal Information redacted by the USI Private consultation — 20 December 2014 Flexible cystoscopy — 06 January 2015 TURP & TURBT — 09 June 2015 Flexible cystoscopy — 30 October 2015 TURP & TURBT — 17 August 2016 Private consultation – first TURP — 172 days Private consultation – second TURP — 606 days Previous episode – second TURP — 292 days 8. Patient 119 Personal Information redacted by the USI Private consultation — 04 July 2015 TURP — 21 September 2016 Private consultation – TURP — 445 days 9. Patient 122 Personal Information redacted by the USI Private consultation — 08 October 2016 TURP — 02 November 2016 Private consultation – TURP — 25 days	
		TURP 2016 **Patient** **Hosp No.** **Date of Surgery** **Waiting Time** Personal Information redacted by the USI — 27/01/16 — 12 days (Attended Privately 28/02/15) Patient 153 Personal Information redacted by the — 27/01/16 — 705 days Personal Information redacted by the USI — 10/02/16 — 23 days 10/02/16 — 12 days 24/02/16 — 26 days 26/02/16 — 14 days 09/03/16 — 32 days 09/03/16 — 83 days 16/03/16 — 23 days 16/03/16 — 155 days (Attended Privately 07/03/15) 23/03/16 — 24 days 13/04/16 — 400 days 13/04/16 — 14 days 04/05/16 — 54 days 04/05/16 — 58 days 17/05/16 — 581 days 18/05/16 — 15 days 25/05/16 — 61 days 01/06/16 — 17 days 15/06/16 — 65 days 15/06/16 — 443 days (Attended Privately 01/11/14) 29/06/16 — 427 days 06/07/16 — 305 days (Attended Privately 15/08/15)	

			
			
29.12.2016	Email correspondence between Ms Reid and Ms Toal with enclosures	This contains copies of complaints in relation to urology from January 2011 to December 2016	Doc File 2 Pages 427 – 432 AOB-01320 - AOB-01325 Clearer copy of spreadsheet at TRU-01473 – TRU-01477
29.12.2016	Email from Ms Hainey to Ms Hynds	Enclosing agenda for meeting with Mr O'Brien and Dr Wright on 30 December 2016. Ms Hainey noted that the agenda sounded misleading as it mentioned a discussion about Mr	TRU-00073 – TRU-00074

		O'Brien's return to work when the decision had already been made to exclude him	
29.12.2016	Letter to Mr Wright from Ms Grainne Lynn (NCAS)	Letter to Dr Wright from Dr Lynn (NCAS) Re: To summarise the issues discussed for both records during telephone conversation on 28 December 2016. And discussion of how Trust should deal with investigations. Case involves senior consultant urologist whom there have been increasing performance concerns. The allegations are of poor record keeping and slowness of triaging referrals and arranging reviews. Consultant is also reported to have removed a very substantial number of charts from the Trust's premises without bringing them back; despite requests that these be returned many charts outstanding. Consultant's colleagues have, on occasions, seen patients for whom there have been no notes… Recent SAI has caused concern that there is potential for patients to be harmed by the ongoing situation.	Doc File 2 Pages 434 – 436 AOB-01327 - AOB-01329 TRU 00076 – 00078
30.12.2016	Email correspondence between Mr Carroll, Mr Gibson and Ms Corrigan	Email correspondence between Mr Carroll, Mr Gibson and Ms Corrigan RE: Meeting with Mr Ob and number of operational issues as a consequence 1. Have discussed a script should anyone ask with Lynne Hainey and agreed the following: "Mr OB remains absent from work and this will be kept under review. Staff will be updated when this situation changes" 2. Mr OB is aware that an OH referral is being made 3. Mr OB will be delivering charts to your office at 11am on Tuesday.	Doc File 2 Pages 437 – 438 AOB-01330 - AOB-01331
	SHSCT, Medical Director's Office, Screening Report on Mr O'Brien (undated)	Summarises the investigation against Mr O'Brien to date. Refers to issues "*in relation to the conduct and performance of Dr O'Brien"* It provides the following conclusion:- *"This report recognises that the previous informal attempts to alter Dr O'Brien's behaviour have been unsuccessful. Therefore, this report recommends consideration of an NCAS supported external assessment of Dr O'Brien's organisational practice, with terms of reference centred on whether his current organisational practice may lead to patients coming to harm."*	Doc File 2 Pages 439 – 440 AOB-01332 - AOB-01333
30.12.2016	Letter to Mr O'Brien from Dr Wright enc Terms of	Letter to Mr OB from Dr Wright including Terms of Reference	Doc File 2 Pages

	Reference	Re: Formal Notification of exclusion and investigation under Maintaining High Professional Standards (MHPS) Confirmation that Trust intention to proceed with an investigation under MHPS with regard to a range of issues in relation to your practices. Terms of ref will focus on following areas: 1. Untriaged letters 2. Patient's notes at home 3. Unreported outcomes from clinics 4. Non-compliance of Trust policy in relation to management of private patients being seen within NHS services	441 – 445 AOB-01334 - AOB-01338 TRU 00045 – 00049 & TRU 00086 – 00087 & TRU 00094 - 00096
30.12. 2016	Letter to Dr McBride from Dr Wright	Letter to Dr McBride to Dr Wright Re: Notification of Immediate exclusion of AOB	Doc File 2 Page 446 AOB-01339 TRU 00088
30.12. 2016	Minute of meeting with Mr O'Brien, Dr Wright and Ms Hainey	Minute of meeting with AOB Present: Mr OB, Mr OB's wife, Dr Wright, Ms Hainey Meeting called to make Mr OB aware that concerns had been raised with Dr Wright on the back of a serious adverse incident (SAI) investigation. Dr Wright noted that some of these concerns had been raised with Mr OB previously and an attempt had been made to resolve the matters with no success. .. 3 issues: 1. Length of time to undertake triage (currently 318 on-triage cases) SAIs noted in poor clinical outcome for one patients and an unnecessary delay in treatment of another 2. 60 undictated clinics over a period of 18 months (approximately 600 patients) 3. Notes at Mr OB's house. Mr OB advised that was not aware of cases in question being investigated under SAI and that he had no involvement in the SAI process. .. Mr OB advised that the concerns needed to be considered in the context of the enormous pressure on him to operate. He stated that clinical outcomes are compromised because of a lack of capacity. He stated that there is an inequity within the department and gave an example that in October, he had a waiting list of 288 for inpatient admission whilst a colleague had a waiting list of 29. He advised that he previously asked that this situation be addressed. But that because of the	Doc File 2 Pages 447 – 450 AOB-01340 - AOB-01343 TRU 000117 – 00120

		waiting list the demand on him was to operate. Mr OB stated that it was important to appreciate the totality of the work that he does, and as a result he does not have time to triage non red flag referrals. He advised that the referral of these was a historical hangover from the time when it was felt there was not enough to do when on-call. The triage of non-red flag referrals was undertaken to justify on-call time. Mr OB advised however that this time is now spent on operations eg. The last week he was in work he undertook 21 operations whilst on-call. .. Mr OB advised that he had 19 additional theatre sessions and 15 extra oncology session, and is under pressure to do all. .. Mr OB reiterated that he had raised two years previous that he did not have capacity to deal with non-red flag triage. He said that it is his view that you need to speak to patients rather than ticking a box, and that to do that takes time.	
30.12.2016	Meeting with Dr Wright, Mr O'Brien and Mrs O'Brien	Page 5 (Section E -H) – Page 6 "Mr O'Brien:… I mean some of the context of this though is the enormous pressure to operate. The complaints and the enquires that I deal with every day are, when am I having my operation done? People's clinical outcomes are being compromised all of the time, day in day out, because of not only the lack of capacity as a whole but, in addition, the inequity within departments. For example, … I had 288 people on my waiting list for in-patient admission and one of my colleagues 29. And I have implored that the situation would be addressed. What was driving me back was, you know, the demands for operating. In fact, when I went off I circulated a list of the ten most urgent people to be done and the two who are waiting the shortest period of time have been done by one colleague and none of the rest. … It is very important to appreciate, you know, the totality of the work that we do. I have said when we had a meeting to deal with triage, I triaged the red flag referrals, that you don't have the time to triage. This things of triaging non-red flag referrals is a historical hangover.. And if you are a person who tries to operate on the acute admission as they come in – like last week I was on call I did 21 additional operations that week, whereas others, and particularly the person who recently left you know, and I always followed him on the week on call and then this past year more ,.. I have been supervising him and backing him up. As Martina Corrigan used to say, now you are starting your week on call after having the other week in call…. Then you picked up, you know, everything that had been up long-fingered and deferred, and when you are operating and you have already worked 12, you don't have time to sit down and triage. Dr Wright: One of things that I said in this,… there is almost inevitably a detailed look back at the Trust systems … and	Transcript File 1 AOB-56005 - AOB-56007

		they are often a contributor, so I don't doubt that that will be an issue that will be looked at." Page 6 (section F-H) – Page 7 (Section A) "Mr O'Brien: I takes me session and than I have been doing extended operating days. I know there's a context (inaudible) but I just actually – I have done 19 additional theatre sessions in the ten months of this years, my being off the last six weeks, 15 extra oncology clinics, 14 extra urodynamic sessions and all under pressure to do so and expectation to do so. And you wrote to us all about the highly recompensed consultant in the earlier part of the year, do you remember, additional session and all of that… Dr Wright: I do realise that (inaudible). I am well aware of the amount of work that you put in our behalf. So all the more reason that (inaudible) structure around that is right and that we are not actually – and the trust is not asking you to do much or so this will all give you the opportunity to explain all of that" Page 7 (Section C- D) "Mr O'Brien: I have been (inaudible) a meeting to discuss this two years ago, it must be two years ago, that I didn't have the capacity to do it and I wouldn't be doing it and I agreed that red flags certainly yes, particularly if you are doing advance triage. I mean, and there are various ways of doing triage. But you are going to sit down, you ring the patient, you get the CT scan done, and all of that rather than just ticking a box.	
30.12.2016	Meeting with Dr Wright, Mr O'Brien and Mrs O'Brien	Page 8 (Section A – H) – Page 9 (Section A -C) "Dr Wright: There are a couple of practical things. One of the things we do need you to do, and this is an absolute must, we do have a large number of (inaudible) patient notes being tracked down to you and we need any that you know of their whereabouts or (inaudible) your house or wherever, we need those returned immediately. Mr O'Brien: … I can't return them without processing them if you know I mean. Dr Wright: No. I want to be very clear about this. We need them returned by Tuesday at 11 O'Clock in the morning and I would like them returned to Martina Corrigan's office. An you can give us whatever information you are able to but we have to have them returned. I am going to be asked to account for these patient notes at a very high level and I need to know exactly where they are so we can deal with the issues and do a follow up subsequent to that. But I want to be very specific, Aidan I need those notes back by 11 o'clock on Tuesday morning. There is a (inaudible) missing. We have (inaudible) Mrs O'Brien: If you have a what? Dr Wright: If there are notes unaccounted for that we can't track, than I have a major problem (inaudible) to deal with, so I need to know exactly.	Transcript File 1 AOB-56008 - AOB-56009

		Mrs O'Brien: Did you not already say they are tracked? Dr Wright: But they are not available to me. They need to be back in the Trust. I need to see them on Tuesday. (Inaudible) we have notes that have been unavailable to other clinics. Patients have been turning up and not being able to be seen with their notes because they have been tracked out to yourself, Aidan, and unavailable to .." Mrs O'Brien: They mustn't have been requested. You have always made the notes available. Dr Wright: On this point I am being very specific. We need the notes back at 11 o'clock on Tuesday morning. (inaudible) take a stock take of where they all are and what we have and what we don't have. So it may be not a problem. If they are all there, that's grand. But if we do have notes that are unaccounted for, that would be a different issue. Mr O'Brien: What do you mean? Dr Wright: Well, there are potentially data protection issues if notes are missing and we don't know where they are. If they are unavailable, we will have to disclose to patients that we don't have them. So if you have – do you know where they are? Mr O'Brien: I mean, I have notes at home certainly. The difficult is what happens when, if I just bring them in and they haven't been processed? Do you know what I mean? … Dr Wright: That is a separate issue that the Trust will have to deal with. But, at the minute, we don't have any evidence that they are being processed, so I would like to see them on Tuesday morning (inaudible) you to have. So I am being quite direct about that. Mr O'Brien: There is no possibility of making a deferment for a two week or something of that nature so that I could process all of them? Dr Wright: No. I am going to have to account for these so I need to know where they are. (inaudible) say what we do with them when we get them, but I am being very direct about this. So now the result of that (inaudible) number of other actions)"	
30.12.2016	Meeting With Dr Wright, Mr O'Brien and Mrs O'Brien	Page 9 (Section D - H) - page 10 (section A) "Dr Wright: They are asking for an occupation health referral, Aidan, as would normally be the case before your return to work…. Mr O'Brien: When would that happen? Dr Wright: Sometime in the next few weeks I would think Mr O'Brien: So what do I do about work on Tuesday?	Transcript File 1 AOB-56009

		Dr Wright: I am about to come to that. Okay. In order for this investigation to carry on and in order for us to scope the terms of reference of it, because we have not quite determined the extent of the investigation, we would like you to remain off work for the next four weeks. Okay. So that – and this is to protect you and to protect the Trust and allow the investigation scope to be determine. “	
30.12. 2016	Meeting with Dr Wright, Mr O’Brien and Mrs O’Brien	Page 10 (Section C- H) – Page 11 (Section A-G) “Mrs O’Brien: I think there is no better person, you know, to process the thing than yourself. Nobody is going to be able to process what you need to do. Dr Wright: And that (inaudible). We will have to see the extent. I am hoping that when we get the notes back this a much smaller problem that it potentially could be. But currently I have up to 300 notes that are tracked out to you that can’t account for. So I – this could be quite a big problem or it could be a very small problem. I am hoping it will be the later, in which case we will review the situation. Mr O’Brien: You see, as Personal Information redacted by the HSE says, I would have been best able to- there- there are just people who need to be contacted or referred. … Dr Wright: We will have to put something in place to deal with that. That may well be in a very short time mean getting you back into action and dealing with these. But at the minute I need to scope the extent of the problem. I release this is distressing for you. It is not (inaudible). But faced with what is on my desk at the minute in terms of potential problem, it is unlikely you are going to be either fit enough or in a position to deliver this in the timeframe. Mr O’Brien: What do you mean by that? Dr Wright: Well, it would appear there’s quite a large number of these patients. So no one person is going to be able to sort this out within a few weeks (inaudible) measure. Mr O’Brien: But I could have. I could have. I could do some of that at home. Dr Wright: But, Aidan, we wrote to you in March outlining these issues. We have no evidence yet that that has been addressed. Mr O’Brien: It has been addressed, even though – like the greater emphasis I placed was on operating. I didn’t take any holidays at all you know. Dr Wright: However, the issues were raised with you in March and they are still here now. So, you know we haven’t got on top of them by leaving them with you (inaudible) different. “	Transcript File 1 AOB-56010 - AOB-56011
30.12. 2016	Meeting with Dr Wright, Mr O’Brien and Mrs	Page 11 (Section H) – Page 12 (section A – E)	Transcript File 1

	O'Brien	"Dr Wright: They are also issues raised about what has been dictated and what has not been dictated, so will have to review what is in those notes. (inaudible) simple. So I suppose the problem is I don't know precisely the issues at this moment in time but there are quite a lot of notes so it is going to take a little bit of time. Mr O'Brien: Well, yes, but there are no notes missing at all."	AOB-56012
30.12.2016	Meeting with Dr Wright, Mr O'Brien and Mrs O'Brien	Page 13 (Section D – H) – Page 14 (Section A-G) "Mr O'Brien: The contextual problem in all of this is, do you know whilst on leave, Richard, I spent four good days there in mid-December doing my appraisal documents because I had spent all of my SPA time either operating or reviewing cancer patients. And, you know, I do know that there are people who to the letter of the law will not do that and there are people who can – I work with people who never regard the suffering of patients as their (inaudible). It is a Trust issue. That's a trust problem. Like, I have been pleading for this past two or three years that I shouldn't even see any more new patients and adding people to my waiting lists all the time. The immorality of not being able to undertake what you have pledged to do and then you spend every additional operating session that's vacated, when other people go on holiday, to operate on them. And as a consequence other things get neglected. " Mrs O'Brien: Where is the fairness to a patient who – it's like a lottery. If they draw the straw that they are a new patient going to Mr O'Brien, they are immediately going to wait three years longer than someone else. Dr Wright: That may well be one of the things (inaudible). I don't know. (Inaudible) it that may be well something that has to change as a result of this. (Inaudible) investigation. It is a difficult issue. It has come (inaudible) conversation. The evidence is going to be presented to us. We have to investigate. That's what it is, an investigation. (inaudible). Mr O'Brien: But there is – by definition there is fault because you – there's just not enough hours in the day to be faultless and I tried it. I tried it without sleeping. I tried it without food. And that's the reality. You try to hopefully allocate the fault or the inadequacy to that area that's least likely to have consequences for patients. Mr Wright: It's probably a lot (inaudible) consolation but there would be at any one time quite a few of these investigations going on in the Trust, which to be fair (inaudible) majority of (inaudible) for yourself but it is not that unusual. (Inaudible). The process its one that (inaudible) so we have to follow (inaudible). But what I will undertake is to make sure that the timetable is ramped up as quickly as possible. (Inaudible). It may well be that it turns out that the work we are asking you to do is far too much. Your job plan is unrealistic. Mrs O'Brien: No, Aidan's job plan is realistic. It is just the job plan – he can't stay to his job plan because things are allocated to SPA, or whatever they are.	Transcript File 1 AOB-56014 - AOB-56015

		Dr Wright: Then maybe the job plan is not realistic. It is on (inaudible) what is on written down on paper and what actually happens in practice. Mr O'Brien: My job plan – Dr Wright: The job plan doesn't (inaudible) Mrs O'Brien: No, (inaudible), because when he got his first, when they come on to the new consultant contract, Aidan's first job plan was for 15.5. Then now it is down to 12. But when he was doing the 15, when it was ascertained, it was really 18 but that was unrealistic. Dr Wright: But the real answer is to find other ways to get that work done. Get other people as opposed to (inaudible) Mr O'Brien: You can't. You can't Mrs O'Brien: You would need ten consultants then. That's what it needs. Dr Wright: Then that is what we do. … Dr Wright: It seems what we are saying this is an investigation. It is not – we haven't got an outcome. I have no doubt the Trust is going to be criticised as a results (inaudible). "	
30.12.2016	Email From Mr Gibson to Ms Corrigan	Dear Martina The meeting with Mr O'Brien has just concluded. There are a number of operational issues as a consequence: 1. Have discussed a script should anyone ask with Lynne Hainey and we have agreed the following: "Mr O'Brien remains absent from work and this will be kept under review. Staff will be updated when this situation changes" 2. Mr O'Brien is aware that an OH referral is now being made. 3. Mr O'Brien will be delivering charts to your office at 11am on Tuesday. Should you need space, you could use the AMD's office – I will make sure it is clear today. **Ronan –** Mr O'Brien was informed that he was being "Immediately excluded" to allow the Trust time to scope the scale of the issues which have been identified in terms of: • Notes at home • Untriaged referrals • Undictated clinics • Conclusion of SAI • Any other areas which are identified As part of your plan, there will need to be a clinical note review of all charts/referral letters returned by Mr O'Brien to assess whether patients have a clinical management plan or require a clinical review with a Urologist. The follow-up meeting with Mr O'Brien will take place in four weeks, so potentially Friday 27th January to discuss the outcome of this scoping exercise, of which the outcome of the clinical note review will be a critical factor. Dr Wright is willing to approve any additional costs incurred for this review to be completed within this timescale. Happy to discuss if you require any further clarity.	TRU-00082
2017	MDT Operational Policy	Key worker *It is the joint responsibility of the MDT Clinical Leas and of the MDT Core Nurse Member to ensure that each Urology*	SUP 376 AOB-03859 – AOB-

		cancer patient has an identified Key Work and that this is documented in the agreed Record of Patient Management….	03882
01.01.2017 – 31.12.2017	Consultant Appraisal Complaints 1.1.17 – 31.12.17	Consultant Appraisal Complaints 1.1.17 – 31.12.17 Mr A O'Brien *First Received* *11/12/2017* *Record Name:* Personal Information redacted by the USI *Description:* *Complainant believes that her brother should not have been discharged* *from hospital as early as he was.* *Outcome:* *Advised that patient had informed nursing staff that he had no pain or concerns and would be happy to go home. Patient did not require medication from Pharmacy as he stated he had an ample supply at home.*	2017 Appraisal pages 73 AOB-22951
	Complaint report structure reflective template	Mr O'Brien's reflective template Southern Health and Social Care Trust *Quality Care - for you, with you* Complaint report structured reflective template Requirement: one for each complaint you have received. Name of doctor: Aidan O'Brien GMC No: 1394911 Date of complaint: 11 December 2017 Nature of complaint: This Personal Information old man had an elective endoscopic resection of his prostate gland performed under my care on 04 October 2017. He was apparently able to pass urine satisfactorily following urethral catheter removal on 06 October 2017 when he was keen to go home, and had arranged for a friend to collect him. However, he then had difficulty in passing urine following his discharge, having to attend the Emergency Department at South West Acute Hospital during the early hours of 07 October 2018. His sister lodged a complaint on his behalf, alleging that he had been discharged prematurely, and requesting that the Southern Trust reimburse the expenditure on taxi fares bringing him to and from South West Acute Hospital. The Southern Trust has asserted that he had not been discharged prematurely, and has declined to reimburse expenses as he is a resident of the Western Trust. His sister has appealed that decision to the Ombudsman. Status of complaint: On-going / resolved On-going Involvement of other bodies: Responsible organisation / GMC / Other Ombudsman If resolved, what were the findings? How will my practice change? The care of all inpatients, whether acutely or electively admitted, is the responsibility of the urologist of the week, who was not involved in his discharge. My practice will not change as I was not responsible for his discharge.	2017 Appraisal page 74 AOB-22952

01.01.2017 – 31.12.2017		Comments in AOB's 2017 appraisal as follows:- **Formal investigation and exclusion** I left that brief meeting wholly despondent, knowing that I would receive no supp assistance in addressing the concerns. I still remained Lead Clinician of Urology having responsibility for endeavouring to ensure that urological cancer diagnost therapeutic services were delivered to patients within the required timelin addition, I was daily conscious of the morbidity suffered by so many patients o waiting lists, morbidity which was often acute and life threatening, requiring readmission to hospital with urosepsis as a consequence of the delay in el admission for definitive surgical management. For that reason, I used every ava operating session, undertaking 22 additional operating sessions during 20 endeavour to mitigate the risk to patients. I similarly conducted an addition oncology review clinics for similar reasons. During all of this time, [redacted] However, I def in order to provide continued support t of my consultant colleagues while he was urologist of the week. When he advise that he had taken up an appointment in England, commencing in November 2 [redacted] had also received the agreem Mrs. Corrigan, Head of Service, to use my time of recovery at home to process and patients' charts returned from my home. I did so by contacting all patients by telep to update their clinical status, dictating letters to GPs and to the patients themselv doing so, I had scheduled all inpatient and day case operating for January 2017, an my secretary schedule review appointments for the more clinically significant pat at clinics in January and February 2017. In doing so, I had processed two thirds of a remaining patients.	2017 Appraisal Page 78 AOB-22956
2017 Appraisal	Other roles structured reflective template	AOB comments as follows:- They also brought the following drawbacks to my main clinical role: Being a named communicator to a large number of patients is intended to include the responsibility of resolving any clinical issues that arise. The only issue affecting Southern Trust patients to date, has been the recent identification of four patients who replied that they did not have prostate cancer, even though they had histopathological diagnoses and on continued management. All four patients will be contacted in the near future.	2017 Appraisal page 314 AOB-23192
03.01.2017	Email correspondence between Mr Gibson, Mr Wright and Ms Hainey	Mr Gibson comments on why Mr O'Brien did not have "*involvement in the SAI"* in the following terms: "*Apparently the team undertaking the SAI were advised that there was no need to speak to Mr O'Brien about this SAI as this communication would be undertaken by those commencing the investigation which had been agreed following the meeting of the Oversight Committee.* *As we are aware, Esther then decided not to proceed with the formal investigation, but an informal approach from within Acute Services. As this informal approach never started, this may then be why Mr O'Brien was never told of the SAI.* *Another lesson in why due process should be followed."*	Doc File 2 Pages 451 – 452 AOB-01344 - AOB-01345

03.01.2017	Email correspondence between Ms Gishkorri, Mr Carroll, Mr Gibson & Ms Corrigan	Ronan, I'm sure Simon will be able to answer the queries below but I just wa liberty to do what he wants off ST premises but he cannot use the se private work. Not unless the secretarial staff do the work outside core hours and don't use ar Thanks Esther. Richard/Simon/Esther Colin & Martina & I met with the urology consultants this am, at which been taking place and the decisions that had been taken. From this meeting we need to answer a few questions 1- What are the ToR for the investigation/review 2- How long would you expect the review to last? 3- What was Mr O Brien advised re the undictated outpatient cli having anything to do with the outstanding backlog 4- What is the Trust's position on Mr O Brien undertaking private staff to type private patient work whilst off? 5- What is the Trust position in regard to notes being transporte Clinics run twice mthly (2nd & 4th wks) Mr O Brien contacted Martina and advised that the notes which were office. Martina has checked and this is confirmed, these notes will be tracked to Martina on PAS and then a refreshed report will be ran to s The Team are going to think/discuss and come back to Colin & I on thu actions required associated with review.	TRU 00101 - 00103
03.01.2017	Email correspondence between Ms Hainey and Ms Haughey with enclosure	Email corrs between Ms Hainey and Ms Haughey Re: whether exclusion is on paid leave or not. Was confirmed it was paid	Doc File 2 Pages 453 - 456 AOB-01346 - AOB-01349

04.01.2017	Email from Mr Gibson to Ms Hainey, Dr Wright, Ms Corrigan, Mr Carroll, Ms Gishkori, Ms Boyce and Mr Weir	Following discussion with Richard, responses to your queries are below, cc 1- What are the ToR for the investigation/review In line with the MHPS Framework, the TOR will be determined foll which the scale of the potential problems are being considered by 2- How long would you expect the review to last? As indicated below, the scoping exercise is expected to be comple investigation is commenced, it also expected to complete within 4 complexity of the investigation and could well be extended 3- What was Mr O Brien advised re the undictated outpatient clinics having anything to do with the outstanding backlog As Mr O'Brien is excluded from work, he is unable to participate in notes from the Oversight Committee on 22nd December, it is expe be managed will be presented to the Oversight Committee on 10th 4- What is the Trust's position on Mr O Brien undertaking private wo staff to type private patient work whilst off? In line with the MHPS Framework, Mr O'Brien is not completely at outside the Southern Trust. As his Responsible Officer, Dr Wright a private work during the period of this investigation, and to inform currently excluded from his main employment. The exception to t any patient safety issues; if this was the case, Mr O'Brien was advi care to a colleague. However, I would agree with Esthers comments below in relation 5- What is the Trust position in regard to notes being transported in Clinics run twice mthly (2nd & 4th wks) This should be undertaken in line with Trust procedures; possibly t the issues identified	TRU-00112 – TRU-00015
05.01.2017	Letter to Ms Corrigan from Dr Black, Occupational Health	Confirms Mr O'Brien recovering following operative procedure. Due to both physical and psychological health problems, he would assess Mr O'Brien as being unfit to return to work. To review in four weeks.	Doc File 2 Pages 459 – 460 AOB-01352 - AOB-01353
06.01.2017	Letter to Mr O'Brien from Dr Wright dated 06 January 2016 [appears to be misdated and presumably should have been dated 06 January 2017]	Re Formal notification of immediate exclusion and investigation under maintaining high professional standards framework (MHPS) Invited to meeting to make aware of concerns that have been brought to attention as part of a Serious Adverse Incident (SAI) in relation to Mr OB administrative practices, and the possibility that patients may have come to harm as a result of those administrative practices. You will recall that we had previously attempted to address some of these issues informally (23 March letter). 1. Lengthy period of time taken to undertake the triage of GP referrals 2. Backlog of over 60 undictated clinics going back over 18 months and approximately 600 patients 3. Some patients Mr OB may have seen had notes taken back to Mr OB home and are not available in hospital Decision made to immediately exclude Mr OB from workplace effective from 30th December 2016 with full pay.	Doc File 2 Pages 461 – 463 AOB-01354 – AOB-01356 TRU 000132 - 000134

		Exclusion will be up to but no more than 4 weeks.	
06.01.2017	Email from Ms Hainey to Ms Toal	Email re charts at home References “notes from Dr AO Brien’s house” and advised how they made the right decision. [not sure what “notes” they are referring to – possibly request from Inquiry]	TRU-00122
09.01.2017	Meeting with Martina Corrigan and Mr O’Brien	Page 3 (section B –H) – Page 4 (Section A – E) “Martina Corrigan: Esther Kiscorry, the director of the acute. And then what it is, is then, whatever comes out of this meeting, I don’t know what is going to come out of this meeting. All I have to say is that you have given back the notes, that the outcome sheets have come in and what is the third thing. Mr O’Brien: That there will be none missing. That’s their big concern. Martina Corrigan: Yes. Mr O’Brien:You see, when I went that day, the first thing I was told, or – Personal Information came with me, thankfully for me, distressing for her. It was so – I was so devastated. I was glad she was there because I would not have remembered half what I was told. The first thing was – Martina Corrigan: I have not been privy to any of that Mr O’Brien: The first thing I was told was that there was a SAI. Martina Corrigan: I only about that now. I didn’t know about it. As head of services, I didn’t know about it. Mr O’Brien: I don’t even know who it is. Do you know who it is? (inaudible) Martina Corrigan: No, all I know is Patient 10. I don’t even know a name. Mr O’Brien: What? Martina Corrigan: Patient 10. I don’t even know a name. Mr O’Brien: That’s the initials Martina Corrigan: Yes. They don’t tell you. It is just through passing that I have heard. So I have no idea. Aidan, I haven’t been involved at all. I supposed that’s one thing I am saying. I haven’t been involved in any of this. Now I am because I am being asked to be the link with yourself. Mr O’Brien: We were told that there was a SAI that was not yet complete and had – during that SAI it was disordered or it was – the allegation or whatever, was that there was a delay in treatment as a consequence of a failure of triage. That is what I was told. It hasn’t been complete yet so they don’t know whether there has been a material negative	Transcript FILE 2 AOB-56020 - AOB-56021

		consequence for the patient. And that there may be a second one. And, again, we don't know. And that then drew attention to the issues that had been raised previously and the issues with the charts and so forth. Then that led on to the most important first issue in all of this. Is – there are charts missing. You know. And I say there are no charts missing. In fact, that concerns me because charts go missing from the Trust. I would have 100 per cent confident in the security of my home because I was always particular about that. Whereas I don't have the same for the Trust…. And Then there has been – an investigation would be had into, and I was completely unclear, still am to a degree. I am not certain. Is it the investigation into the SAI. And people were being appointed to this investigation and Colin would this investigator. And I was given some document – I was being excluded. I am still unclear as to – I don't even know why I am excluded. Martina Corrigan: No, neither do I."	
09.01.2017	Meeting with Martina Corrigan	Page 5 (Section E – H) – Page 6 (Section A – E) "Martina Corrigan: …. Now Michael knew late on the Friday afternoon. Him and I were brought in that Friday afternoon to be told that you had the meeting in the morning time. You might as well – honestly, Michael I thought he was going to pass out. But what I will say is on Tuesday morning I actually was – I was sitting on the desk in the MD office and Ronan was explaining to them why – what had happened. And I think the three of them were totally and utterly stunned. They just couldn't believe it and the question was, but why is Aidan being excluded? Why is he not being brought back in to do, you know, why you are not being brought in – Mr O'Brien: And what did they say? Martina Corrigan: I honestly don't know Mr O'Brien: What did Ronan say? Martina Corrigan: Ronan said, he said it was a decision that was made by the medical director and HR and the director of acute services. So we don't know why they made that decision. But what I would is I think your three colleagues feel very uncomfortable. They haven't really talked to me. I think they are just totally stunned and they probably don't know what to say to you. It is very hard. I don't think they know what to say to you. …. Martina Corrigan: Yes. I honestly – I wouldn't say it because they are very, very clear that we are a team. They are – they really don't know what to say. None of us do. We are all totally stunned. It is very hard. Even for me because, like, as said to the guys you know last Tuesday, I am part of this team as well. I am – we are the team and it is just like something – I often say I spend more time with people in work that I do with my own family. And when something happens to somebody in work it might as well happen your own family. Like, we know so much about each other's lives	Transcript FILE 2 AOB-56022 - AOB-56023

		in the sense that it's just very difficult for them. Now, I am not – like you are in a far, far difficulter position. But what I am saying it is that the guys are just – they don't know what to say. "	
09.01.2017	Meeting with Martina Corrigan and Mr O'Brien	Page 7 (Section E- H) – Page 9 (Section A) "Mr O'Brien: I just to explain to you. And the reason why I delayed this process is, you know you were saying about the clinical outcome forms for the chart to be returned but you see they are all organised as per clinics. Martina Corrigan: Yes, okay. Mr O'Brien: Some done a long time ago and all of that there. Martina Corrigan: Yes. Mr O'Brien: So – and like, January, February and March 15. You know, they are all done. Martina Corrigan: Okay. Mr O'Brien: That is – Martina Corrigan: When you say "all done" do you mean as recorded somewhere as well? Mr O'Brien: Recorded, dictated and all of that. Martina Corrigan: Okay, okay. … Mr O'Brien: And I thought it would be – anyhow. Then March. And then, I'll give you this one over there. So, by and large, the SWAH clinic ones are the cleanest if you noticed in the green charts. Martina Corrigan: Yes. Mr O'Brien: so and then – Martina Corrigan: Where's the dictated tape? Mr O'Brien: What do you mean? Martina Corrigan: Because you are saying that these ae all dictated. Mr O'Brien: No, hold on. Martina Corrigan: Sorry. Mr O'Brien: You see what is ticked? Martina Corrigan: Yes. They are already dealt with? Mr O'Brien: A long time ago. Martina Corrigan: Yes. Mr O'Brien: You know. Like just Personal Information redacted by the USI may have been	Transcript FILE 2 AOB-56024 - AOB-56026

		dealt with on 12 May 2015 and Personal Information redacted by the USI the same date and Personal Information redacted by the USI sometime later. Martina Corrigan: Yes, I understand. Mr O'Brien: What I had done, you see, was to draw a demarcation line between what had been all previously done prior to last Friday. Martian Corrigan: Okay. Mr O'Brien: and that below this line is charts returned. Martina Corrigan: Okay. Mr O'Brien: Undictated and these are your outcomes. Do you understand? Martina Corrigan: Yes, I understand. Mr O'Brien: Now, for the SWAH clinics that is a pretty neat process. I think – you see they way they are all done, done, done. Martian Corrigan: Yes I do understand Mr O'Brien: And as I was doing this, you know before last Friday in the months – in recent months and so forth, sometimes, you know, a tick and a done had different meanings. For example, if I said for urodynamics studies and flexible cystectomy on 26 February and the tick meant it was dictated and that was the outcome. But if TURP was done then I also – (pause). Do you know what I mean? I think actually this is the one that I don't think there is a demarcation line because they are so – do you see all I am just saying is where there are – where there's a tick – do you see what I mean actually? A case on CURWL for TURP, do you remember that man, in April, urgent, to come in, done. You know what I mean.. (Inaudible). In fact, it has been reviewed and all since. Martina Corrigan: Yes, that is very clear."	
09.01.2017	Meeting with Martina Corrigan and Mr O'Brien	Page 9 (Section C – H) – Page 10 (Section A- E) "Mr O'Brien: The one thing that you can be certain of is that all of those clinics, in fact the first three of those clinics, don't have any remaining charts in boxes in your office at all. Do you understand? Martina Corrigan: Yes, I understand. Mr O'Brien: I think one of the things, do you see, that I think that the evidence as presented to the medical director, I think that he felt that there had been nothing done on any patients who attended clinics. And the thing about it is, as I did a clinic, you see, one of things, I am not going to detain you. But with regard to the SWAH clinics, if I finish at 5,00 or 5.30 or sometimes 6 o'clock and went to see a patient on the ward I always had a feeling that you shouldn't be still there in out-patients. The cleaners were in. SO I would take the charts	Transcript FILE 2 AOB-56026 - AOB-56027

		home and I would take out the ones that needed their radical nephrectomy done and so forth. And then you would sit down and you would organised admissions and you wouldn't get time. That's what happened. Its as pure and simple as that. Of course, what you thought you could leave today until – again there was a risk. I have actually made out a list in all of this of the people who need to be reviewed soon. Martina Corrigan: Okay. Mr O'Brien: so then this is other clinics. Other clinics going back to December 2015. All done. It's the same kind of principle. Martina Corrigan: Yes, okay. Mr O'Brien: Probably not as neat and so forth but tick means – Martina Corrigan: Done. Mr O'Brien: Tick mean it is not in your office. Do you understand? Martina Corrigan: Yes. Mr O'Brien: So by one way or another, if you just take it random, outcomes of new clinic due to the theatre June, because these are in chronological order just to see why it is that – maybe it is all done. (inaudible). But that's the idea. That since 7 December 2015 there will be clinics for whom there is no outcome form but they're all done. Martina Corrigan: Yes Mr O'Brien: Do you know what I mean? There is here – that's a sheet of paper. This is just a good example, where, for example, Personal Information redacted by the USI, who did attend on 22 December 2015, and all the rest were long since processed and for whatever reason on a Friday evening or something, you know, I am collecting someone from a training and you put it in your bag. And that's how these things happen. It just accumulated. Hot clinic. Personal Information redacted by the USI he was to let me know after he emigrated to Personal Information who to write to and I'm still awaiting the information. Martina Corrigan: Okay. Mr O'Brien: Personal Information redacted by the USI. So there's just these five people. SO I will put that at the back. Martina Corrigan: Okay. Mr O'Brien: there is one thing that just concerns me is, do you know, if you still have it, I would be grateful if you could find a way of – the cellophane folders. There was one clinic in Armagh – Martina Corrigan: There was, yes Mr O'Brien: -- For which there was no charts available	

		Martina Corrigan: Yes Mr O'Brien: I don't think I did an outcome sheet for that. Martina Corrigan: Okay. I have it all to gather, the loose sheets that you left me"	
09.01. 2017	Meeting with Martina Corrigan and Mr O'Brien	Page 10 (Section F – H) – Page 12 (Section A – F) "Mr O'Brien: In recent months, you know, even though I had previously said I hadn't had the time, you know, to be triaging the non-red flag referrals, but in recent months I had actually just been – I started to, way back months ago, just chronologically making sure that everybody had been seen. I had actually still been doing that in – to some degree after I had taken Personal Information leave and so forth. If I came in at night and I left some stuff in with Noleen to be dictated and I would go in and lift out a bundle and deal with them and so forth. And the completely unlooked at triaging non-red flagged, they're all in my filing cabinet. One of my filing cabinets. Martina Corrigan: Okay. Mr O'Brien: In the one next to the wall because the right-hand one is for private patients Martina Corrigan: Right Mr O'Brien; So it's on the second or third drawer down. I think I got up to about June 15. Martina Corrigan: Okay. Mr O'Brien: In the course of that (inaudible) I had these together. You were asking me, it was juts very appropriate, and then I would put labels on them. So in 2015 these are the only ones that was – so this is a man who was actually reasonably elderly. He was discharged from, wherever, 3 south elective, my goodness. You talk about in-patient care. You know, sent home with a catheter in from the ward on which we – Martina Corrigan: I know. Oh I know. Don't even start me because I was on such a rant this morning about them. Mr O'Brien: He was never seen. I don't know. Martina Corrigan: Okay. Mr O'Brien: I hadn't contacted him. So I put these labels since this happened – these are really directed to you. Martian Corrigan: Yes. Mr O'Brien: Personal Information redacted by the USI was written to me by Personal Information redacted by the USI. I had checked. These were not registered. Martian Corrigan: Okay. Mr O'Brien: Asking for urodynamics studies because it was a long way to Personal Information redacted by the USI. I have written there is you would ask	Transcripts FILE 2 AOB-56027 - AOB-56029

		Jenny to chase that. Martina Corrigan: Okay. Mr O'Brien: Personal Information redacted by the USI. This is a man actually who he is patient of Michael's. He attends the stone clinic. He was stone free in September 14. He was due a review in September 15. Severe pains and pain passing urine. Actually I would have doubted legitimacy of that. I thought just if you would ask Michael to review him. Martina Corrigan: Yes. Mr O'Brien: Personal Information redacted by the USI. Now – Martina Corrigan: His name rings a bell Mr O'Brien: (Laughs) is it not Patient 10? Martina Corrigan: (laughs), no. It is just the amount of patients on waiting lists and things. Mr O'Brien: this man is interesting because I had looked this up just actually the week before this meeting. And this man actually had two referrals made by his doctor, both registered on 19 May 2015. One referral was made to general surgery in Daisy Hill Hospital, saying this man requests a vasectomy. His wife is pregnant. That was May 2015. And he then was seen by Paul Hughes, put on a waiting list, which was suspended I think once or twice because of some high blood pressure if memory serves me correctly. And then eventually he did have his vasectomy done 19 August. On the same day he was referred with passing clots in his urine, visible haematuria, but that one does not appear to have been registered. Martina Corrigan: Right. Okay. I know what you are saying. Like an admin error. They've just done the one. Mr O'Brien: I think it is an admin error. Martina Corrigan: Yes okay. Mr O'Brien: I presume, having attended several times Paul Hughes in the meantime— Martina Corrigan: Yeah, that he would have mentioned to him about the haematuria. You would hope so. …"	
09.01.2017	Meeting with Martina Corrigan and Mr O'Brien	Page 13 (Section H) - Page 14(Section A – D) "Mr O'Brien: Are you going to be able to tally all of those charts (inaudible)? Martina Corrigan: Yes. I have set aside this afternoon. (inaudible). Mr O'Brien: He was going to have to advise the chief medical office that there were no charts missing (inaudible). Martina Corrigan: So my concern about it is when I tally it up	Transcript FILE 2 AOB-56030 - AOB-56031

		(inaudible) they wont be in your name. They are probably anywhere in a number of places. You know yourself someone would come into your office and lifted a chart out of your office and not have returned it (inaudible) Mr O'Brien: (inaudible) The irony is there is one chart I know missing. It is Personal Information redacted by the USI (inaudible). Martina Corrigan: Right Mr O'Brien: And which was never seen after. You remember (inaudible). Martina Corrigan: Yes. Yes. Suppose I can ask that question whenever I go to tally them but because I've checked the charts in your own office as well. Mr O'Brien: You have done that? Martina Corrigan: Yes, I have done that as well. I have them all written out Aidan, what I am going to do is to track them to myself. …"	
10.01.2017	Minute of Oversight Committee Meeting	Minutes of Oversight Committee Meeting Present: Dr Wright, Ms Toal, Ms Gishkori, Mr Gibson, Ms Hynds, Mr Carroll and Ms Boyce Appointed to investigation: John Wilkinson as Non Exec Director Ahmed Khan as Case Manager Colin Weir as Case Investigator Siobhan Hynds as HR manager <u>Issue one: Untriaged patients:</u> From June 2015 there are 783 untriaged referrals all of which need to be tracked and reviewed to ascertain the status of patients in relation to condition for which they were referred. <u>Issue two: Notes being kept at home:</u> 307 notes returned by Mr OB from his home. 88 sets located within Mr OB office. 27 notes tracked to Mr OB still missing and go back to 2003. <u>Issue three: undictated outcomes:</u> 668 patients have no outcomes formally dictated from Mr OB's outpatient clinics. 272 from SWAH and 289 from other. The remaining 107 are still being investigated <u>Issue four: Private patients:</u> Review of TURP patients and 9 patients identified who had been seen privately as outpatients then had their procedure within the NHS. The waiting times for these patients appear to be significantly less than for other patients. It was recognised that Ronan Carroll would continue to lead the operational team through the issues identified to reach clear outcomes for all patients	Doc File 2 Pages 470 – 471 AOB-01363 - AOB-01364
10.01.	Letter of complaint	Re Mr Personal Inform	SUPAUG

2017		Complain re waiting times	
17.01. 2017	Letter to Dr Wright from Mr O'Brien	Letter to Mr Wright from Mr OB Re: Immediate exclusion and formal investigation and Mr OB concern re procedural conduct of the investigation. No written notification of the name of the Non-Exec member of the board or of his or her contact details. Did not receive minutes of meeting of 30th December 2016. Slow pace of proceedings. No communication from case investigator or notification of a meeting with case investigator to provide Mr OB with opportunity to state my case and propose alternatives to exclusion. Mr OB took initiative and spoke with Mr Weir on telephone to enquire about a date of a meeting. Was advised that meeting with HR on 26 Jan 2017 had to take place first before meeting with Mr OB. Wanted more detail of the reasons and justification for exclusion. Mr OB does not accept that Trust attempted to address the issues regarding administrative practices, informally or at all. Invited to meet with Mr Mackle and Ms Corrigan around 23 March 2016 and was advised of Trust's concerns and provided with letter. No enquiry made as to causes of concerns. No offer of a discussion of how concerns could be resolved, or of any assistance in doing so. When asked what should do to address and resolve, request was met with silence and a shrug of shoulder. No follow up meeting or to letter of 23 March 2016.	Doc File 2 Pages 472 – 474 AOB-01365 - AOB-01367
18.01. 2017	Letter from Dr Wright to Mr O'Brien	Letter noting that in line with MHPS frameworks, a note the meeting was taken which is now enclosed for Mr O'Brien	TRU-00136 - TRU-00140
20.01. 2016	Letter to Mr O'Brien from Mr Colin Weir dated 20 January 2016 (misdated appears was sent in 2017)	Notes he is the Case Investigator. Suggests a meeting on 24 January 2017 [**AOB was on** Persona **leave at this stage]**	Doc File 2 Pages 477 – 478 AOB-01370 - AOB-01371
23.01. 2017	Letter from Mr Weir to Mr O'Brien	References the concerns about the location of patient's notes and lists 13 sets which have been traced to Mr O'Brien on PAS but not located in his office or secretary's office and were not contained in 307 sets of notes returned from Mr O'Brien's home.	Doc File 2 Pages 479 – 483 AOB-01372 – AOB-01374
24.01. 2017	Minute of meeting with Mr O'Brien, Mr Weir and Ms Hynds including update from preliminary investigation	Minute of Meeting with Mr OB Present: Mr OB, Michael OB, Mr Weir & Ms Hynds Purpose of meeting was to discuss next steps in MHPS	Doc File 2 Pages 484 – 489 AOB-01377

		process following exclusion of Mr OB. Following today's meeting a case conference would be convened on 26 Jan 2017 to determine next steps. Mr OB was updated in relation of the initial 3 concerns notified to him on 30 Dec and was notified of a fourth issue of concern identified during the preliminary investigation. Update position: 1. From June 2015 783 GP referrals had not been triaged in line with the agreed/known process for such referrals. 2. 668 patients have no outcomes formally dictated from Mr OB outpatient clinics over a period of at least 18 months. 3. 307 sets of patient notes were returned by Mr OB from his home, 88 located in his office and 13 sets are still missing. Fourth issue of concern was noted to be in relation to Mr OB private practice. Mr OB referred to issue of triage referrals and noted that since issue brought to him in March 2016 he was undertaking his own validation of referrals to him. He advised that prior to this the workload volume made it impossible to do so. Mr OB advised that the returned 307 notes were not returned and some of the notes were in his office and which he left with the notes returned from home. Mr OB noted that he had a good memory of his patients and was shocked by a number of patients on the list as he was very sure the notes had been returned. Mr OB had spoken about concerns re workload with a number of clinical directors over the years with no change. Reported there is an inequity in lists and workloads which hasn't been addressed. Mr OB stated he would provide a comprehensive summary in due course however advised that significant workload pressures and additional operating session completed by him over the requirement within his job plan had impacted. Mr OB noted that he worked a high number of hours each week over and above his job plan, had undertaken chair of MDM meetings, spent a significant number of hours reviewing cases in preparation for these meetings, sometimes into the early hours of the morning and used his SPA time to undertake operations or reviews of patients in an attempt to keep on top of his workload. Mr OB made proposals to alternatives to exclusion. Mr OB noted he had raised issue of inequity of waiting lists in his appraisal signed by Michael Young.	- AOB-01382
24.01.2017	Mr O'Brien's amendments to minute of meeting on	1. Page 1, Paragraph 2 : "*It was not proposed at the meeting of 24 January 2017 that the meeting was an*	TRU-00722 – TRU-

	24 Jan 2017 (note these were provided in March 2017)	*opportunity for me to state my case. In that regard, the note is not an accurate records, and reference to it being an opportunity to state my case should be deleted. The second purpose of the meeting was to propose alternatives to exclusion i.e. the exclusion which was in place at that time and not formal exclusion".* 2. In page 1, Paragraph 5 : Reference to such process should be deleted from the note 3. Page 2, Paragraph 2 : No reference was made to an agreed/known process, this reference should be deleted from the Note 4. Page 2, Paragraph 4: Omitted to include the detailed explanation, which I gave at the meeting, of the origin of the inclusion of triage in the duties of the Urologist of the week, that I had found it impossible to conduct the triage of non-red flag referrals whilst being Urologist of the week and in the context of the additional work undertaken by my, of my having advised personnel that I had found it impossible to do, and of my views concerning the risks posed to inpatient care by the triage of all referrals by the Urologist of the week. 5. Page 2, Paragraph 5 : Omitted to relate that I provided to the meeting a written synopsis of each of the 13 patients, relating that nine of them had never been my patients. Of the four remaining, that I had no recollection of one who last attended an outpatient clinic in 1995, that the chart of another deceased patient had been returned to medical records in 2005, that the chart of another had been returned for letter typing in August 2016 and was not made available for her last outpatient clinic attendance in September 2016, and that the chart of the the fourth patient had been returned to my office from my home on Tuesday 03 January 2017. 6. Page 3, Paragraph 1 : I did not report that Mr Mackle rolled his eyes, as he did not. I reported that, on asking what I was supposed to do and what they wanted me to do, that enquire was met with silence and a shrug of the shoulders. The reference to Mr Mackle rolling his eyes should be deleted. 7. Page 3, Paragraph 2 : I reported that I had raised my concerns orally and in writing, on many occasions to a Lead Clinician, Clinical Directors, Medical Directors and a Chief Executive 8. Page 3, Paragraph 4 : Omits to refer to Mr O'Brien's expressed concern regarding the claim that this issue had emerged from a scoping of the original three issues of concern, as that is not possible, as they are unrelated. It omits to reference Mr O'Brien's enquiry as to the identity of the person(s) who initially raised this issue, and the assurance given that there	00724

		9. would be no problem in having the identity of the person(s) made available to him. It omits Mr Weir's own expressed view that he did not consider this fourth issue to be an issue of concern. It omits to relate that Mr O'Brien enquired whether there had been or would be an investigation of NHS patients who has their TURP procedures performed after a significantly shorter period than other patients. .. Lastly I made no reference to concern about reputational damage. 10. Page 3, Paragraph 5 : Omits to make any reference to our expression of concern regarding the investigation's breach of Trust Guidelines and the implications of that breach. The note omitted any reference to the issue of the large number of patients awaiting admission for surgery, and more particularly, those patients awaiting readmission for surgery. It omitted to relate my contention has this cohort of patients is the cohort at greatest risk of suffering poor clinical outcomes as a consequence of delay in admission or readmission. It omitted to make any reference to the additional numbers of elective operating sessions undertaken by me in recent years in attempting to minimise the numbers of poorer clinical outcomes and the severity of those outcomes. It omitted to refer to the extent by which the arrangement and conduct of additional operating sessions impacted upon the capacity to deal with the other issues of concern. It omitted to refer to my request of 07 November 2016, addressed to my colleagues and to the Head of Service, to have the ten most urgent cases admitted during my planned sick leave, and that only two of those patients had been admitted. Lastly, it omitted to refer to my contention that this issue of greatest clinical priority would not appear as an issue or concern for investigation.	
25.01.2017	Mr O'Brien's review of the Serious Adverse Incident (Patient Patient 10: ID Personal information redacted by the USI H&C Personal Information redacted by the USI)	Letter to Ms Gishkori from Mr OB enclosing comments on SAI Re: SAI Patient 10, H&C Personal Information redacted by the USI Enclosing report and comments *See Report for Details* *Conclusion* *Patient 10 had a complex right renal cystic lesion since December 2012. During the next two years, its potential significance had either not ben appreciated, or had been appreciated but not reported by at least two radiologists, and not reported to the urological service. Similarly, the potential significance of the lesion had not been appreciated by at least two clinicians who had requested further imaging which had been advised by radiologists in the investigation of the lesion from June 2014 to March 2015, and had similarly failed to appreciate the significance of the cyst having changed between 2011 and 2012.*	Doc File 2 Pages 492 – 501 AOB-01385 - AOB-01394

		Even though there were failures on the part of clinicians and radiologists who had assessed and investigated Patient 10 *and the index right renal lesion, I found the Review Panel's emphasis on the lack of triage of the letter of routine referral as the main cause of delay in* Patient 10 *having a urological appointment, as remarkably asymmetric. I do believe that it would be been reasonable and defensible to have relied upon the information contained in the letter of referral, and to have maintained the referral as routine. Therefore, lack of triage did not impact upon the time to consultation.* *I also do believe that the triage on non-red flag referrals should be revisited, with a commitment to accommodate all views, to discuss who, when and how this challenge can be satisfactorily resolved".*	
26.01.2017	Preliminary Report from Case Investigator for consideration by Case Manager/Case Conference	Summary states:- "*There are 4 main issues of concern to be considered as outlined above. The initial 4 week preliminary investigation has scoped the likely scale of the concerns and the numbers of patients involved.* *The investigation is at a very early stage. While initial indications suggest some patients have potentially been adversely affected/harmed as a result of failings in the practice of Mr O'Brien, the Case Investigator is reliant on completion of the review by 4 Consultants to determine the full implications.* *Given the numbers involved, it is not possible to give any definite date for the conclusion of the investigation. It is envisaged that the investigation will take as a minimum, 12 weeks to complete."*	Doc File 2 Pages 504 – 508 AOB-01397 - AOB-01401
26.01.2017	Email correspondence between Ms Toal and Mr Wilkinson	Email from Vivienne Toal providing update to Mr Wilkinson, as Designated Board Member. Noted Mr Khan "*determined that there was indeed a case to answer and a formal investigation would now be required under MHPS. All those present were in agreement."* Also notes that all were in agreement that the case could be managed by restrictions on his practice with robust monitoring in place around the areas of concern to ensure patient safety. "*Therefore we will be reporting tomorrow at Trust Board that exclusion has been lifted."*	Doc File 2 Page 513 AOB-01406
24.01.2017	Meeting with Mr Weir, Ms Hynds and Mr O'Brien	Page 3 (Section A – C) "COLIN WEIR: So we can go through it and maybe let you read it. You probably just want to read it rather than me talking for a second (pause). Mr O'Brien: So the first is, you know, since March of this year at various stages, you know, I had just been doing my own validation of referrals that had not been triaged by me even	Transcript FILE 3 AOB-56035

		though I had made it clear that I had found it impossible to do so and didn't have the time to do so and that there should be another mechanism for doing so. Colin Weir: Okay Mr O'Brien: So that brings us up to June 15 and I have no idea – obviously that's the number – that had not been triaged thereafter. So four consultants will – my colleagues obviously are undertaking that at the moment? Colin Weir: Yes.	
24.01.2017	Meeting with Mr Weir, Ms Hynds and Mr O'Brien	Page 3 (section D – H) – Page 5 (Section A – D) "Mr O'Brien: and Issue 2, notes being kept at home. So: *"It is determined that 307 notes were returned by Mr O'Brien from his home".* I just want to correct that, in that when I returned all of the notes to my office, just for completeness, I had returned all of the notes relating to private patients and I also included in the section of private patient notes those notes of private patients who were – they were already in my office. So if the total was, as you understand it, 307, some part of that were Craigavon Area Hospital charts of private patients and there were in the filing cabinets in my office so I took them out of the filing cabinet so that everyone would know that they were. If you know what I mean. Siobhan Hynds: Okay. So a proportion – what you are saying this is a proportion of the 307, were existing in your office but you had left them with ones that you had returned. Mr O'Brien: Only the private ones, yes. Siobhan Hynds: Private patients. Okay. Mr O'Brien: *"88 sets of notes located within Mr O'Brien's office."* Goodness. *"And 13 sets of notes tracked to Mr O'Brien are still missing going back to 2003, going back to 1993 as you will have seen going back to.."* "Colin Weir: (inaudible) Mr O'Brien: "*going back to 1988"* Michael O'Brien: Do you have – is there a list of when those sets of notes, the 13, were tracked out? Is there a list of dates? Colin Weir: I don't have that – no, I was asking that earlier. I don't have that information yet. …. Mr O'Brien: -- notes are tracked to me, that they were ever tracked to me, that they were tracked to a clinic at which I was at and other people were at. I have a very, very good memory for patients and when I saw that list and saw Personal Information redacted by the Personal's names on it, someone whom I knew intimately, I was just flabbergasted that if his chart was tracked to me, even though I returned it in September 2005 …. And when I	Transcript FILE 3 AOB-56035 - AOB-56037

		learned that I said, well, I don't need his chart anymore from the point of view of his testicular turn out. So him and Personal Information redacted by the USI, whose chart was not available when I last reviewed her on 19 September … and not only was there – sometimes when – if records know that a chart has not been delivered to you they'll deliver the pocket folder with continuation sheets and previous documentation, but there wasn't even that…. And then the last one was Personal Information redacted by the USI…. It was definitely. I did it in bold, "returned" on Tuesday 3 January. Colin Weir: (inaudible) all the things that you have said and forwarded to the investigating team to make that very clear that that's on record and a very detailed response has ..	
24.01.2017	Meeting with Mr Weir, Ms Hynds and Mr O'Brien	Page 6 (Section A – E) "Mr O'Brien: One of them is – Mr Personal Information is an infant, born on Personal Information redacted by the USI, discharged one week later. He's still "infant", he doesn't even have a name. Colin Weir: Okay. Michael O'Brien: It is happening under the auspices of an investigation into my dad's professional practices and you are investigating 13 files, nine of which, I understand, have never been seen by you, as part of the investigation into him. That connection seems to be (inaudible). I can understand why you would want to ensure that your system of tracking out files is sufficiently robust but it is falling into an investigation into an individual's practice whenever – before it is really determined that it has any connection to the individual's practice (inaudible). That aspect, for example, when you have for example, charts that aren't even (inaudible) his patients. Colin Weir: Well, you've a chance to – I suppose part of it was notes of a number at your home. That I suppose was an issue which is why this then progressed into, where are these notes, in which case this came up. I suppose if you hadn't any notes at home then this would never have arisen in the first place. I suppose it is just a strand that has to be worked through unfortunately because there were notes at home and I think that's maybe – I can't make judgement. I am not making any judgements on this. We are just going through an investigative process to get the facts from everybody.	Transcript FILE 3 AOB-56038
24.01.2017	Meeting with Mr Weir, Ms Hynds and Mr O'Brien	Page 6(Section G – H) – Page 7 (Section A – E) "Mr O'Brien: it is also important to come from the stand point. I have never mislaid a set of notes in my career whereas the hospital does regularly. Colin Weir: Fair enough. Mr O'Brien: I can name you one or two patients whose charts are lost by the hospital. Colin Weir: Okay	Transcript FILE 3 AOB-56038 - AOB-56039

		Michael O'Brien: Can I ask you about the notes being kept at home issue? Is the Trust saying that that in and of itself (inaudible) charts being at a house for any length of time is a matter of concern that requires investigation? Siobhan Hynds: I don't think that is what we are dealing with here. And, again, we are at the very early stages in terms of determining what the issues are. But what we are looking at currently is for some time notes that have been unavailable to the wider hospital, other services, clinics etc, because they have been at home. That is the concern – Michael O'Brien: so it is the length of time rather than the fact of them being there? Siobhan Hynds: Well, yes. I mean, what's part and parcel of what we look at in terms of our investigation is what are the normal practices around this, what are our information governance requirements around all of this. The scale of the notes that weren't available is a concern. They're now back and we are looking to ensure that we have tracked everything initially. We will then look as part of the investigation in terms of the concern around how long they were at home and did that have an impact on the ability for other services to access those and potentially did that have an impact on patient care as a result. Mr O'Brien: I must say in my defence I have complied with every single request to return a chart. I have delivered charts on occasion. I would get an email from Pamela Nelson saying somebody is being admitted to South Tyrone Hospital on Saturday morning for OGD. I have delivered it there myself. I have delivered them to the wards. I don't know of a single patient's chart that was inappropriately delayed. I have returned each and every one of them. Colin Weir: Okay.	
24.01.2017	Meeting with Mr Weir, Ms Hynds and Mr O'Brien	Page 7 (Section F – H) – Page 8 (Section A-C_ "Michael O'Brien: It is also – what I find a little bit strange about that from a procedural point of view is the Trust have known of (inaudible) charts (inaudible) that fact's been there for years and that is acknowledged by the Trust. What I find strange about that is from 30 December 2016 he is informed that not only is this now a very serious issue but it is going to form the basis of a formal investigation and you are going to be excluded on the foot of that, despite the fact that the Trust knew about if for many years and has made no – given no indication that this was an issue of severity in and of itself. So I don't know if either you know why that is or what is the explanation for the escalation if you like with no previous touching base/ Siobhan Hynds: Again, that will form part and parcel of our investigation in terms of we are – Colin Weir: You know we will be looking at previous	Transcript FILE 3 AOB-56039 - AOB-56040

		correspondence and communication in relation to this. Siobhan Hynds: What has been the timeline, what has been the significance of that. Colin Weir: Has this been raised as an issue before. Michael O'Brien: Yes. You are aware that there was a letter of 23 March. You will be aware of that. Siobhan Hynds: Yes. Michael O'Brien: Which is (inaudible) basically registers the fact there are some issues that need to be dealt with, an administrative backlog and no follow up, no suggestion we should have a meeting. You are aware of the time constraints that your employees are under regarding the workload that they have and there is no follow up to that (inaudible) Mr O'Brien: It didn't constitute an informal process at all, Colin	
24.01.2017	Meeting with Mr Weir, Ms Hynds & Mr O'Brien	Page 8 (Section H) – Page 11 (Section A - D) "Mr O'Brien: The letter was just telling me that others shared my concerns. And the biggest concern that I had then for years and had since then was the big elephant in the room, which is not on any of these things, and that is the sheer numbers of patients awaiting admission and re-admission for procedures and operations and suffering poor clinical outcomes as a consequence. Siobhan Hynds: Can I ask who you were raising that with at a point? Mr O'Brien: at a point Siobhan Hynds: No I mean at the various points, who was it you were raising that with? Mr O'Brien: I have raised that with everybody that I can think of over 20 years. This is – have raised this with – the titles have changed its that long. Clinical directors, Ivan Sterling, Liam McCaughey, John Templeton, Michael Young. And they sort of , cliched response that these are Trust issues. Except for the fact, regrettably, the Trust doesn't make them an issue. It is – I mean, I do have already prepared, I have gone through all of my operating over recent years, and in fact whilst I would like to have the opportunity at a subsequent time when meeting both to share these with you, but like, for example, in 2013, as far as the job plan would go I would have been expected to do 84 sessions. I did 113 elective sessions that year. Colin Weir: Is that operating? Mr O'Brien: Operating. I would have been expected to do 79 sessions in 2014 as the urologist of the week was introduced that year and I did 101. 2015, 70 sessions according to my job plan. I actually did 95.5 four hour sessions. You multiply that by four for every hour. In 2016, up until I left, I would been pro rata expected to do 61 sessions. I did 83.25.	Transcript FILE 3 AOB-56040 - AOB-56043

		And in the doing of that and the organisation of that – that's just operating I mean, I am not talking about other activities as well, like extra clinics and so forth, I have been directing in a sense in a lonely manner without any response to raising the concerns with regard to the inequity involved in such lists. Like in October of last year when performance data were published, which is a contradiction in itself because they didn't publish performance data they published the things that still needed to be performed you know, and when I had 223 I think patients on my in-patient waiting list at that time one of my colleagues had 29. Can you get that addressed? No. And just to – Ill do this all in detail in due course, but I do think actually two things about it. One is, when you have been raising it and talking about it and worrying about it and trying to get a response for 20 odd years, you know, you stop talking about it. And lastly, do you know, I was – I must say after these 25 years I was so disappointed. On 07 November I sent Martina and my colleagues a list of ten patients whom I really wanted to have done next and come the end of December they weren't even addressed. I was coming back after having my prostate resected too early. Why? Because of the need to address this. … Colin Weir: So, Aidan, issues over these 20 years are just that; the workload and the capacity to do the workload. Is that what you – the gist of it? Mr O'Brien: Colin, if I were to put my case in one sentence, if I had not been overworked, if I hadn't agreed to be overworked, I wouldn't be in this position today and others are not in this position today. Colin Weir: Because they manage – Mr O'Brien: because they didn't overwork Colin Weir: Control Mr O'Brien: no, they wouldn't Colin Weir: Okay. … Colin Weir: Just to get the general tenor of what you are saying about workload and you tried to engage with the Trust's management over an extended period of time to help manage that in some way. Mr O'Brien: Yes. Colin Weir: but the work has just kept coming Mr O'Brien: and a failure of management to deal with it. Colin Weir: To deal with it. Right ok"	

24.01.2017	Meeting with Mr Weir, Ms Hynds and Mr O'Brien	Page 12 (Section A – H) – Page 12 (Section A) "Mr O'Brien: So issue 3. It is determined that 633 patients have no outcome forms (inaudible). The only figure that sticks out is 272 from the SWAH clinic because I think – I have left this date at home – I thought it was 110 charts returned from the SWAH clinics undictated so I don't know where 272 comes from. Nor do I know where 289 comes from either. Colin Weir: I don't know what that means. Other clinics, does mean – where else would you do a client except SWAH? Mr O'Brien: Here and Armagh Colin Weir: Armagh. Mr O'Brien: and the remaining 107 patients are still being (inaudible) – oh, the remaining of that 668. I don't know. Colin Weir: So you think those figures are just plain wrong? Mr O'Brien: I have no idea. The only one I am kind of – very surprised about because the reason that we conducted this exercise, which I have left at home, was the inference that there were 60 clinics unprocessed and that there may be over 600 patients whose outcomes are unknown. Colin Weir: Yes. Siobhan Hynds: (Inaudible) information given to you in December, yes. Mr O'Brien: Yes. And when we conducted this exercise and went through the clinics and the outcome forms, there were 110 remaining from South West Acute hospital and I think there were 47 from other clinics. And that the percentage of patients who had attended the clinics that I was aware of that had been processed were 62 per cent, so that the majority had been dictated and processed. So I don't recognise these figures at all. Michael O'Brien: Can I ask where the figures come from? Siobhan Hynds: Again, that's an initial scoping exercise that's being done within the directorate which we will have to validate clearly as part of our investigation Colin Weir: So we will – Mr O'Brien: Can I also ask, the – historically, you know, you may have had an outcome without dictation. I don't know if you ever do that Colin. I would do that quite routinely. For example, If I did somebody's urodynamic study today , and so forth, and was going to have them admitted to day surgery for hydrostatic dilation in one months' time I would purposefully – Colin Weir: Not. Mr O'Brien: -- not and I do the whole thing in one letter."	Transcript FILE 3 AOB-56044 - AOB-56045

24.01.2017	Meeting with Mr Weir, Ms Hynds & Mr O'Brien	Page 13 (Section F – H) – Page 14 (Section A – E) "Mr O'Brien: Issue 4 is a new issue. Siobhan Hynds: Yes. Mr O'Brien: Where has this come from? Siobhan Hynds: That has come up as part of this initial scoping and that what we needed to say to you. It has been flagged as being a particular issue of concern in relation to these TURP patients. And what we know to date is nine that have been previously seen as out-patients, then had procedure within the NHS, their waiting times appear to be significantly less than for other patients. So in terms of what we can tell you other than that at the moment, we don't have the detail. What we are going again is back in to look at – Mr O'Brien: And who has flagged this? Siobhan Hynds: That has been notified to us by that scoping exercise in terms of the overall look at the charts that are being – Mr O'Brien: So the interesting thing about this of course, you see, is that it reminds me, Colin, of years ago when there was the emergency theatre book Colin Weir: Yes Mr O'Brien: There were three categories of patient. There was emergency or urgent and private. Colin Weir: Yes. Mr O'Brien: and I said but, sure, private is not a category of clinical surgery. I mean, are they also going to look at all of the public patients who had shorter waiting times for TURP than other urgent patients – than other public patients? Siobhan Hynds: That will be for us to look at Mr O'Brien: I have had the experience previously , you know, of, for example, a TURP being taken off the waiting list when beds were short because it wasn't red flag but yet it was. It was prostate cancer that they had and it was part of their management. Do you know what I am saying? These nine patients may have been – in fact, actually one of the patients whom I was going to have admitted on 4 January this year was a man who I saw privately two years ago. I just happened to actually meet him and he said he was going to contact me because he had barely been able to pass urine, and I have every sympathy with this condition in the past year. And I said after two years, you know, there was a patient who had attended privately. So I am very circumspect about this being another issue."	Transcript FILE 3 AOB-56045 - AOB-56046
24.01.2017	Meeting with Mr Weir, Ms Hynds & Mr O'Brien	Page 18 (Section D – F) "Mr O'Brien:… What has happened has happened. It is in the	Transcript FILE 3

		past. I can't undo it. I will provide a good contextual reason as to why it happened in the first instance and I wish it had been otherwise. People would have suffered gravely as a consequence of the measures that would have had to be taken in order to get 307 charts, or whatever it was, out of my home to process the remaining clinics. If I had been advised in March, you know, that this could lead to this, and even in the absence of any help or accommodation from the Trust to address it, sure I could have taken a months annual leave, I could have taken off six weeks, I could have done whatever at whatever cost and cleared it and I wouldn't be sitting here today"	AOB-56050
24.01.2017	Meeting With Mr Weir, Ms Hynds & Mr O'Brien	Page 18 (Section H) – Page 19 (Section A – B) "Colin Weir: … I am also conscious of the fact that I – and this is difficult because – the difficult bit of this and is why I didn't want to do it, is because I know what your – clinically, and do you know what I mean, I know what you do in the things that you have just said, urologist of the week and your operating, those extended operating days that you do, remember we've done your job planning not that long ago, so I've been part of that process as well so … Mr O'Brien: I mean, this is all – up until I met with Colin, in October, all un-job planned, unremunerated work. I am not here to talk about money"	Transcript FILE 3 AOB-56050 - AOB-56051
24.01.2017	Meeting With Mr Weir, Ms Hynds & Mr O'Brien	Page 20 (section F – H) – Page 21 (Section A – F) "Mr O'Brien: Can I also ask the question? Will the Trust actually be considering as well by virtue of my practice and what I have done in recent years, whether harm was avoided and good was done? I am not meaning in a sort of altruistic manner. I mean, I could keep a committee going with SAIs. I have not never completed an SAI in my life. I mean, there are people suffering severely because of delays. I mean, in the data that I will submit to you, I haven't missed an operating session availability during 2016. Even if I took a couple of days off, I never took off on a Wednesday. I refused to even go to court on behalf of the Trust or be available as an expert witness in defence of cases if it interfered with operating on a Wednesday. I have used every available opportunity and I have actually prevented poor definite clinical outcomes in scores of patients. And even in spite of all of that overperformance, I still haven't succeeded because I know of poor clinical outcomes of patients that are—have occurred and one of which has occurred since I took off. I know about that. I mean, this is – this is the enormous elephant in the room that is not being addressed at all. And you are asking me, Colin and Siobhan, in a sense, who have you raised this with before and I am raising it now. It will never appear on this A4 sheet of paper. Michael O'Brien: You have your formal meetings (inaudible) your meetings on Thursday Mr O'Brien: Yes, we have departmental meetings. And occasionally what we have done is say, wonder if you take	Transcript FILE 3 AOB-56052 - AOB-56053

		ten or 20 patients from Michael's list and my list and give to the others and then that's done for another six months Colin Weir: (inaudible) explore that. You have departmental meetings every Thursday (inaudible). So you have a degree of governance and oversight on the team. The team are kind of – you are discussing cases and you have conferences (inaudible). Mr O'Brien: We are discussing – well, I chair, and this is another issue that will be used in my defence or mitigation. I took over as lead clinician and chair of MDM in April 2012. I chaired every MDM that occurred each week until I had the idea of having a rotation for chairing in September/October – September 2014. So you know, I would do my operating. I would finish at 8 o'clock in the evening operating. Sometimes 7.30. Sometimes I would over run. I would always do my administration. I was very particular about that with regard to outcomes of patients following surgery and I'd do it by email to my secretary, or whatever. And then I would leave the hospital at 9 o'clock and I'd go home and get something to eat. And then I would sit down for three to four hours, you know, until 2/3 o'clock in the morning previewing 35, 40, 45 cases. Its like doing an enormous cancer clinic. Most of the patients you don't know. Reviewing all the digitalised images and so forth and getting if you are lucky, two or three hours of sleep and coming in the following day. I did all that. "	
24.01.2017	Meeting with Mr Weir, Ms Hynds & Mr O'Brien:	Page 22 (Section D – H) – Page 23 (Section A- C) "Mr O'Brien: I understand. But when you are, for example, asking for no further patients – review patients to (inaudible) Mr O'Brien: Absolutely Colin Weir: I am not (inaudible) Mr O'Brien: For two years I don't want – Michael O'Brien: And (Inaudible) Mr O'Brien: One of my colleagues in – Tariq Sami in Birmingham, if your in-patient waiting list exceeds eight weeks you do not see another new patient until it is less than six weeks. Michael O'Brien: it's that kind of thing Mr O'Brien: On 1 February now mine is three years. Michael O'Brien: But then we're talking – Mr O'Brien: And this is not an issue. Mr O'Brien: For the exclusion, do you have at this stage, if you like, beyond the, if you like, a particularised version of what particular concerns you might have about a return to work in relation to patient safety. We are dealing with administrative matters, so it would seem to me that undertakings in respect of each administrative matter being	Transcript FILE 3 AOB-56054 - AOB-56055

		raised going forward can be achieved. Colin Weir: Yes. … Colin Weir: I think there's a long term, you know, thing about your workload and how you manage it. Mr O'Brien: Absolutely Colin Weir: And I think you'll need to – that will need completely relooked at and you will have to work with whoever to help fix that problem. Because the problem is the workload which you can't control, but there are things that you can control. So I think that is a longer-term solution….. "	
24.01.2017	Meeting with Mr Weir, Ms Hynds & Mr O'Brien	Page 23 (Section E – H) – Page 24 (Section A) "Mr O'Brien: I can see, in terms of in-patient management as a urology of the week, I mean, there has never been a concern, do you know. I am meticulous in that regard. Colin Weir: Okay. Mr O'Brien: To the extent that I find it not possible to triage non-red flag referrals, as I said a couple of years ago. And, secondly – Siobhan Hynds: When you say, I am sorry, can I put you back over that, when you say you have said that a couple years ago, in what context was that? Mr O'Brien: That was at a meeting that we had with personnel from appointments. I cant recall or don't have a record of the date of that meeting Siobhan Hynds: Was that agreed then at that stage that you wouldn't triage referrals? Mr O'Brien: No, you see – you know, it's like we've been discussing this at home in recent times. Do you know when you have a meteing convened by A and B they're not always interested in hearing what C and D have to say. In fact actually, you know, I have had the terrible experience of having a situation where as lead clinician of MDT the regulation is that clinicians have to provide a clinical summary for their patient to be discussed. There is no expectation for a cancer tracker to be taken excerpts or cannibalising a copy of a letter. They're not to do that. Well, I tried for three, four years to get my colleagues to do that and sometimes even the majority will just walk out, fail to do it or in fact just say you know, I refuse to do that. Michael O'Brien: It will be important to try and get the minutes of that meeting (inaudible) personnel and it was said that you couldn't do non-red flags. Siobhan Hynds: Those are the sort of things (inaudible) Mr O'Brien: So I said that, you know, I had found it impossible to do. I can explain to you – do you want me to	Transcript FILE 3 AOB-56055 - AOB-56056

		explain to you now actually my view on the whole thing or the relationship between it and urologist of the week or leave it for another day? Colin Weir: No, tell me quickly because it would be pertinent to – Mr O'Brien: I'll tell you, Colin. First of all actually, and I don't know how you recognise this. There is a difference between being surgeon of the week and being the surgeon on call. Practically and conceptually they can be two very different things. Urologist of the week was to be, in my view, hands-on in-patient management as a consultant with your junior staff, as have seen you doing when you are surgeon of the week. It is also about responding to calls for assessment and management from other wards in our hospital, from the emergency department, and in our case, in urology, we also have to respond similarly to such calls from Daisy Hill Hospital and South West Acute hospital. We have – I have raised and we have discussed, all of us, our concerns that some of those calls from elsewhere are not being attended to. …"	
24.01.2017	Meeting with Mr Weir, Ms Hynds & Mr O'Brien	Page 26 (Section E – H) – Page 27 (Section A- D) "Mr O'Brien: And that's distinction. I didn't even consider it as a reply. I didn't know what I had to reply. My response was to continue. I did extra clinics. I continued to do additional operating. I haven't missed one Wednesday this year from annual leave as I have said before. And in fact actually – Siobhan Hynds: (Inaudible) Mr O'Brien: -- even though I had stated previously that I had found it impossible to do all of these no-red flag referrals, triaging in the manner than we are talking about – we call iit advanced triage – whilst being urologist of the week – following 23 March I thought, you know, well at least what I could do, if I have any spare time at all, I'll take these chronologically. I'll go through 2014 and so forth. I did get up to June 2015 when I had other greater priorities to attend to, not least the charts and the undictated outcome patients, which was even greater for me. Anyhow, getting back to exclusion. Siobhan Hynds: Can I just finish that? In terms of – so you said you didn't reply but you responded in terms of trying to clear some of that (inaudible). Mr O'Birne: My response was run faster still Siobhan Hynds: Okay. Did anybody know that? Michael O'Brien: (inaudible) – some clinics Mr O'Brien: yes, I mean – Michael O'Brien: (Inaudible) additional clinics, wouldn't you/ Mr O'Brien: Yes.	Transcript FILE 3 AOB-56058 - AOB-56059

		Colin Weir: so there is a record of additionality Mr O'Brien: Yes, I have it. I have a record of additionality Siobhan Hynds: Yes. But I suppose, I mean, I'm getting it in very simple terms in my head, is you receive a letter from someone in management to say this is a concern. Mr O'Brien: Yes. Siobhan Hynds: How do you let them know you are addressing that or did you let them know you were addressing it? Mr O'Brien: but sure, they've always Colin Weir: I think you are saying that there is a letter of concern, get on with it	
24.01.2017	Meeting with Mr Weir, Ms Hynds & Mr O'Brien	Page 34 (Section D – H) – Page 35 (Section A – E) "Mr O'Brien: Nobody has been more concerned about the issues raised that I have been. I mean, I have worked night and day to try to cope with all. I am regretful that I didn't regard, as my colleagues do, all of those patients suffering as Trust issues. Because they do. In fact, it is even written on my appraisal of last month. Michael O'Brien: Do you think that you have (inaudible)? Colin Weir: Sorry, your appraisal has been, who signs off your – Mr O'Brien: It was Michael and – Colin Weir: and so that was satisfactory? Mr O'Brien: My professional development plan raised the issue of – … Mr O'Brien: because I used all my SPA time reviewing people and operating on people. … Colin Weir: That is very naughty actually. SPA, you've got to do SPA. Michael O'Brien: He is doing SPA. He is just doing other things. Colin Weir: You've got to do SPA. Mr O'Brien: I told Richard I spent four whole dates of what was passing clots post TURP, yes, doing actually – getting my appraisal together Colin Weir: Yes, but you've got to build SPA in your (inaudible) week.	Transcript FILE 3 AOB-56066 - AOB-56067

		… Mr O'Brien: Yes, I had three professional development plans, which almost sounds like a contradiction because they are nearly a professional – personal—what do you call it? Personal recreation plans. One was to address the long waiting list. Colin Weir: That was your PDP? Mr O'Brien: to reduce the gross inequity that there is for patients and to significantly reduce the number of new patients that I would see. You know, Michael's – Michael O'Brien: It is really startling the idea – two of the five consultants have been there a long time: dad the longest and Michael Young's been there, what 15 years now at this stage? Mr O'Brien: 98 Michael O'Brien: Sorry even longer then. The three newer consultants they come in because, obviously , it is decided that the service provision requires an expansion. But the legacy of 20 years of practice remains with the two consultants who are in place. SO they are seeing new patients and not sharing the workload of the massive legacy. I think (inaudible)"	
26.01.2017	Minutes of Case Conference Meeting	In attendance: Dr Ahmed Khan, Simon Gibson, Colin Weir and Siobhan Hynds Context of meeting: *"to consider the preliminary investigation into issues identified with Mr O'Brien and obtain agreement on next steps following his period of immediate exclusion, which concludes on 27th January"*	TRU-00037 – TRU-00040

		Preliminary investigation As Case Investigator, Colin Weir summarised the investigation to date, including updating the Case Manager and Oversight Committee on the meeting held with Mr O'Brien on 24th January, and comments made by Mr O'Brien in relation to issues raised. Firstly, it was noted that 783 GP referrals had not been triaged by Mr O'Brien in line with the agreed / known process for such referrals. This backlog was currently being triaged by the Urology team, and was anticipated to be completed by the end of January. There would appear to be a number of patients who have had their referral upgraded. Mr Weir reported that at the meeting on 24th January, Mr O'Brien stated that as Urologist of the Week he didn't have the time to undertake triage as the workload was too heavy to undertake this duty in combination with other duties. Secondly, it was noted that there were 668 patients who have no outcomes formally dictated from Mr O'Brien's outpatient clinics over a period of at least 18 months. A review of this backlog is still on-going. Mr Weir reported that Mr O'Brien indicated that he often waited until the full outcome of the patient's whole outpatient journey to communicate to GPs. Mr Weir noted this was not a satisfactory explanation. Members of the Case Conference agreed, that this would not be in line with GMCs guidance on Good Medical Practice, which highlighted the need for timely communication and contemporaneous note keeping. Thirdly, there were 307 sets of patients notes returned from Mr O'Briens home, and 13 sets of notes tracked out to Mr O'Brien were still missing. Mr Weir reported that the 13 sets of notes have been documented to Mr O'Brien for comment on the whereabouts of the notes. Mr Weir reported that Mr O'Brien was sure that he no longer had these notes; all patients had been discharged from his care, therefore he felt he had no reason to keep these notes. Mr Weir felt that there was a potential of failure to record when notes were being tracked back into health records, although it was noted that an extensive search of the health records library had failed to locate these 13 charts. Members of the Case Conference agreed further searches were required taking into consideration Mr O'Brien's comments.	

		Historical attempts to address issues of concern. It was noted that Mr O'Brien had been written to on 23rd March 2016 in relation to these issues, but that no written response had been received. There had been a subsequent meeting with the AMD for Surgery and Head of Service for Urology to address this issue. Mr Weir noted that Mr O'Brien had advised that at this meeting, Mr O'Brien asked Mr Mackle what actions he wanted him to undertake. Mr O'Brien stated Mr Mackle made no comment and rolled his eyes, and no action was proposed. It was noted that Mr O'Brien had successfully revalidated in May 2014, and that he had also completed satisfactory annual appraisals. Dr Khan reflected a concern that the appraisal process did not address concerns which were clearly known to the organisation. It was agreed that there may be merit in considering his last appraisal. **Discussion** In terms of advocacy, in his role as Clinical Director, Mr Weir reflected that he felt that Mr O'Brien was a good, precise and caring surgeon. At the meeting on 24th January, Mr O'Brien expressed a strong desire to return to work. Mr O'Brien accepted that he had let a number of his administrative processes drift, but gave an assurance that this would not happen again if he returned to work. Mr O'Brien gave an assurance to the Investigating Team that he would be open to monitoring of his activities, he would not impede or hinder any investigation and he would willingly work within any framework established by the Trust.	
26.01.2022	Minutes of Case Conference (following on from above)	Dr Khan asked whether there was any historical health issues in relation to Mr O'Brien, or any significant changes in his job role that made him unable to perform the full duties of Urologist of the Week. There was none identified, but it was felt that it would be useful to consider this. **Decision** As Case Manager, Dr Khan considered whether there was a case to answer following the preliminary investigation. It was felt that based upon the evidence presented, there was a case to answer, as there was significant deviation from GMC Good Medical Practice, the agreed processes within the Trust and the working practices of his peers. This decision was agreed by the members of the Case Conference, and therefore a formal investigation would now commence, with formal Terms of Reference now required. **Action: Mr Weir** **Formal investigation** There was a discussion in relation to whether formal exclusion was appropriate during the formal investigation, in the context of: • Protecting patients • Protecting the integrity of the investigation • Protecting Mr O'Brien Mr Weir reflected that there had been no concerns identified in relation to the clinical practice of Mr O'Brien. It was agreed that, should the monitoring processes identify any further concerns, then an Oversight Committee would be convened to consider formal exclusion.	TRU-00037 – TRU-00040

26.01.2017	Minutes of Case Conference (Follow on from above)	It was noted that Mr O'Brien had identified workload pressures as one of the reasons he had not completed all administrative duties - there was consideration about whether there was a process for him highlighting unsustainable workload. It was agreed that an urgent review of Mr O'Brien's job plan was required. **Action: Mr Weir** It was agreed by the case conference members that any review would need to ensure that there was comparable workload activity within job plan sessions between Mr O'Brien and his peers. **Action: Esther Gishkori/Ronan Carroll** Following consideration of the discussions summarised above, as Case Manager Dr Khan decided that Mr O'Brien should be allowed to return to work. This decision was agreed by the Medical Director, Director of HR and deputy for Director of Acute Services. It was agreed that Dr Khan would inform Mr O'Brien of this decision by telephone, and follow this up with a meeting next week to discuss the conditions of his return to work, which would be: • Strict compliance with Trust procedures and policies in relation to: o Triaging of referrals o Contemporaneous note keeping o Storage of medical records o Private practice • Agreement to read and comply with GMCs "Good Medical Practice" (April 2013) • Agreement to an urgent job plan review • Agreement to comply with any monitoring mechanisms put in place to assess his administrative processes **Action: Dr Khan** It was noted that Mr O'Brien was s[Personal Informati] and that an Occupational Health appointment was scheduled for 9th February, following which an occupational health report would be provided. This may affect the timetable of Dr O'Brien's return to work. It was agreed to update NCAS in relation to this case.	TRU-00037 – TRU-00040
06.02.2017	Letter to Mr O'Brien from Dr Khan	Letter to Mr OB from Dr Khan Re: Formal Investigation under MHPS Informing Mr OB of decision of case conference on 26.01.2017. Was decided that Mr OB does have a case to answer and that his immediate exclusion will lift with effect from 27 Jan 2017. Mr OB to return to work with clear management plan for supervision and monitoring of key aspects of your work. To attend meeting on 09 Feb	Doc File 2 Pages 523 – 524 AOB-01416 - AOB-01417
06.02.2017	Email correspondence between Ms Hynds and Mr Wilkinson	Update from Siobhan Hynds to John Wilkinson (Designated Board Member) re case to answer and review of exclusion.	Doc File 2 Page 525 AOB-01418
07.02.2017	Meeting with Mr Wilkinson & Mr O'Brien	Page 7 (Section A – H) "Mr O'Brien: Can I just say that in addition to the radio silence the lack of any kind of plan, even any kind of query as to how these issues raised in the letter of 23 March have arisen, what is the cause of them, how can we alleviate them, how can we draw up a plan to resolve them to bring them to an end, anything of that nature. I would like to add in the clinical context, which I do appreciate we are not here to do, but the clinical context is that I am running as fast as I can to do as much work as is possible, particularly in the field of operating. At that stage I had approximately 280 odd patients awaiting on my waiting list for in-patient admission for surgery, dating back to February 2014. And using every available operating session that comes up. In fact, actually I haven't missed one	Transcript FILE 4 AOB-56079

		available operating session that could be availed. Even when I leave I came in to do this. In addition to doing additional lists or review clinics to address the back log, particularly of cancer patients and so forth. And I have been asked since the meeting of 30 December you know, did you respond to this? My response was to try to do as much as possible to address the clinical priorities of the day in every day that transpired since then. And if I had been relieved some of that pressure and expectation in some find of planned manner to address these issues, they could have been addressed but none of that happened. John Wilkinson; Okay. Mr O'Brien: And whilst I entirely appreciate from a procedural point of view that your remit is in a very restrictive manner restricted to the formal investigative process as it initiated on 30 December, it seems to me that it is inappropriate to begin there rather than 23 March and look at a nine-month period during which I was struggling health-wise as well. I mean, I should have been off having my surgery in the spring time and I put it off for as long as possible until I simply was fearful that I wouldn't be able to pass urine anymore and was having at time agonising pain in doing so. So it is a major bone of contention on my part that when I was handed this letter and I asked in these words, what I am to do? And the response was a silent shrug of the shoulder. And that letter told me nothing other than what I already knew, do you know, which were already concerns to me. The greater concern to me but wasn't even on the letter, which is the enormous number of people who are suffering poor clinical outcomes because of the length of time that they are waiting to be operated on. So that is the clinical context in which is placed our concerns about the entire process to date beginning in March and the lack of any informal process whatsoever	
07.02.2017	Meeting with Mr Wilkinson & Mr O'Brien	Page 13 (Section B) "MR O'BRIEN: I would have absolutely. I mean, if it had been -- if I had sat down around a table like with the people involved to address these issues over a period of three months or six months or something of that nature December never have happened but that was never afforded me that opportunity. JOHN WILKINSON: Yes. Okay. Okay."	Transcript FILE 4 AOB-56085
07.02.2017	Meeting with Mr Wilkinson & Mr O'Brien	Page 14 (Section A – H) – Page 16 (section A – E) " Michael O'Brien: Moving on to the origin of the investigation itself. I suppose the confusion continues in a sense. That we are not really sure why the investigation – what the origin of this current investigation because it is also mentioned that is arises out of an SAI and the serious adverse incident appeared to be into a referral that was made by a radiologist. You explain that because I'll get that wrong. Mr O'Brien: Yes. The SAI, which I hope I have here, so the SAI basically concerns a lady who had been referred in October 2014 with, on the face of it, in the referral letter asked for an assessment of this lady with a history of bowel	Transcript FILE 4 AOB-56086 - AOB-56087

		and breast cancer, and who – and in whom an MRI scan has shown her to have a large simple right renal cyst and she's having right flank pain basically. For reasons that, I don't know, we can go into if you wish, but that's more the mitigating circumstances and the contextual, all of that, basically this lady was not – she was referred as a routine referral. In my response to the draft report of the SAI investigative panel, if I had triaged it I would have kept it as a routine referral. She wasn't seen until January 2016 when she was seen by a colleague in January 2016. He realised the referral referred to the wrong lesion on the same kidney. So this lady had a three lesions: a large simple cyst on the upper pole, a smaller simple cyst on the lower pole and in the front of the kidney a complex cyst with the potential that it could malignant. So she was seen in January 2016 that was appreciated. The radiologist had somehow mistakenly and inappropriately reported and didn't make reference to that cyst. And following her initial consultation she had another CT scan done when she was found to have enlarged left axillary nodes. When they were biopsied, it was found that she had metastatic disease from her right breast carcinoma. So she underwent removal surgically of these nodes followed by chemotherapy and radiotherapy. That deferred her renal surgery, which was of lesser importance until October 31 or 30 October and when she had that lesion removed from her right kidney it proved to be a malignant lesion. My understanding is that that is when the SAI was initiated. … The referral wasn't made to me. The referral was received by the Trust during my week of urologist of the week and I didn't have time to triage it. If I had triaged it, I would have kept it as routine anyhow. But there was a whole catalogue of failings of the part of radiology and other clinicians who were looking after her to refer her but basically – I mean, I can afford you with a copy of my report and all of that there. But I think that what we are concerned about is the relationship between the investigation of the serious adverse incident and this formal investigation. … Mr Wilkinson: Is that the – really the only time really that you were involved in that case? Is that what you were saying? That during that triage period you? Mr O'Brien: I didn't triage the letter Mr Wilkinson: You didn't triage the letter Mr O'Brien: I've never met the patient Mr Wilkinson: No. And that was due to pressure of work and so forth Mr O'Brien: of course, yes. …"	

07.02. 2017	Meeting with Mr Wilkinson & Mr O'Brien	Page 24 (Section A– H) - Page 26 (Section A- G) "Mr O'Brien: It is just when I look at – I'm a clinician. I'm not as au fait with procedure and propriety as Michael is and the legal aspects of that, nor from your experience either. I look back on a situation whereby—I mean, I could give you the concluding sentence of this formal investigation. We would not be here at all if I had not been overworked as a consequence of my concerns regarding numerous patients. I bitterly regret that, you know – I am here 25 years and I have 25 years' experience of being left holding the can for patient outcomes, the Trust not taking its responsibilities. I could go into that in detail but I wont. Mr Wilkinson: I know. Mr O'Brien: I look back to 23 March and this could all have been resolved over an agreed period of time if I had been alleviated of those other expectations and pressures. I am just going to give you one snippet. On 7 November I emailed my colleagues and the head of services, the administrative head of our service, Martina Corrigan, with a list. I took a list of ten people from my waiting list whom I considered were those people who most needed to be dealt with. Were they dealt with? Not at all. The reason I was pushing the boat out to come back on 3 January was because that failure to respond to that reaffirmed by belief that the fortunes of all these patients are entirely dependent upon me. Not on a department collectively, never mind a Trust in its management looking at these issues. .. Re complaint "With a total of 232 patients awaiting in-patient admission, 136 of them categorise as urgent, it has been impossible to facilitate all patients enquiring about and seeking readmission irrespective of the gravity of the indication. However, recently circulated data has revealed that four of my consultant colleagues have had totals of 29 patients on their waiting list, 77, 59 and 41 awaiting in-patient admission. Indeed, the total number of patients on those four colleagues awaiting urgent admission was 131 on 13 October, less than the number of patients awaiting urgent admission on my waiting list. It is my view that these figures portray such a disparity in the fortunes of patients on different waiting lists as to render that disparity indefensible. Now, mind you, I just add rhetorically, I've had no response to this letter from Mrs Giskorri to whom it was addressed or whatever"	Transcript FILE4 AOB-56096 - AOB-56097
07.02. 2017	Meeting with Mr Wilkinson & Mr O'Brien	Page 27 (Section C- H) "Michael O'Brien: The final point, the investigation expanded to include an issue about whether private patients for a particular procedure were being seen more quickly than NHS patients. Mr Wilkinson: Yes, I read that	Transcript FILE 4 AOB-56099

		Mr O'Brien: Nine patients Michael O'Brien: Nine patients, yes. Now, I don't understand how that arises out of administrative practice – an investigation into administrative practice. I don't see how that can arise out of it at all. I'd be familiar with the idea that if you undertake an investigation into particular subject your note keeping, you might end up with a number of concerns some of which you did not know whenever you started that investigation. But this doesn't arise out of that at all. This is a comparison between NHS work and private work. It's remarkable that was included. Now Mr Weir did say that he didn't think there was anything in that particular issues, so that may fall away, but it does raise a question about the way in which this investigation is being conducted.	
07.02. 2017	Meeting with Mr Wilkinson & Mr O'Brien	Page 28 (Section C – H) – Page 29 (Section A – H) " Michael O'Brien: This will be something that we will put in the presentation if we have to go down that road eventually. When there was a job planning done in 2011, which is when the job planning was reduced from 15 sessions to 12, isn't that right. Dad had completed an issues – a commentary on the new job plan and raised a number of concerns, focusing entirely on the amount of time devoted to administrative work, saying I don't have enough time to o all of my administration. We can give you that at any tine. He was saying I have to triaging. I have to do this and I have to do that and I don't have enough time. That's 2011. There are a number of comments along the road where people have been unable to complete triaging. There was a meeting we found in March 2015 . Mr O'Brien: I convened a meeting actually because I was lead clinician of the cancer services. We just wanted to clarify exactly what kind of triaging we would do of the red flag referrals and – some of us were doing ticking a box. You know, yes, it stays red flag. Others were doing what is called advanced triage, including myself, which means you look at it and you say to yourself, now, this person needs a CT scan and then a flexible cystoscopy, or whatever. So I will ring the person up, some other would write to the person, and say – and organise a CT scan and then feed back to the office of cancer services. You know, this person will have a CT scan done next week, arrange an appointment he following week. … It's quite thorough. It's called advanced triaged, which other specialities don't do. But I have the minutes of that meeting here, where I couldn't get the agreement of my colleagues to do that because (a) it was too time consuming and there simply was not enough time to do when you are urologist of the week. … However, you get about four times the number of non-red	Transcript FILE 4 AOB-56100 - AOB-56101

		flag referrals and all of a sudden the reason why Personal Informati and the patient in the SAI waited 64 weeks to be seen for a routine referral, which I would have kept routine, is because I didn't do advanced triage and look into it and discover at that time that the radiologist had messed up the reporting. .. Michael O'Brien: And, for example, in his most recent appraisal it included that "*I only triage the red flag referrals".* Its there. …"	
07.02. 2017	Meeting with Mr Wilkinson & Mr O'Brien	Page 31 (Section E – F) "Mr O'Brien: As I said to Dr Wright, there are only 24 hours in a day. I have tried to increase them but it doesn't work. I have done it without sleep. I have done it without food. To give you an idea, like when I would chair MDM, I would operate all day on a Wednesday, operating ending at -- starting at 9 ending at 8 o'clock in the evening. I would usually do my administrative work arising from that by email and so forth. See the last one or two patients in recovery. Usually be in the changing room at 9 o'clock. Drive home. Arrive there at quarter to 10. Have something to at eat and then sit down and preview 40 cancer cases to be discussed at the meeting that I would chair the following case, ending at 2/3 o'clock in the morning for years. Unallocated, unrecognised.	Transcript FILE 4 AOB-56103
07.02. 2017	Minute of meeting with Mr O'Brien and Mr Wilkinson	Meeting with Mr OB with enclosed concerns set out by Mr OB Present: Mr OB, Mr Wilkinson & Michael OB Mr OB raised his comments and concerns on the following: 1. Letter dated 23 March 2016 2. The origin of the current investigation remains unclear 3. The conduct of the investigation From the discussion held with Mr OB he intimated that on numerous occasions he has made reference to his job plan, with fellow professionals and the associated time allocated to carry out administrative duties. Despite highlighting severe discrepancies in time allocation no attempt was made to address such issues by various line managers. At conclusion of meeting Mr OB expressed his desire to involve himself with mediation processes, even at this late stage, to deal with any outstanding issues. He felt sure that if he had been afforded this opportunity in March then this situation would not have presented itself at this moment in time.	Doc File 2 Pages 527 – 528 AOB-01420 - AOB-01421
09.02. 2017	Meeting with Dr Khan and Mr O'Brien	File 5 (page 29 section B – H & page 30 (section A-H) & Page 31 (section A-H) … SIOBHAN HYNDS: And the second part of that is about	Transcript FILE 5 AOB-56133 – AOB-

		scheduling of patients. I know this has been a changes in some other areas as well across the Trust. Scheduling patients then must be undertaken by a secretary who will check the list with you and then contact the patient as opposed to maybe the consultant themselves doing it. So that's in keeping with the established practice within the urology team is what I am led to understand. Is that right? MR O'BRIEN: Well. Totally foreign to me. I do – this scheduling of – just go over that again? This is aside from the private practice. You're saying to me actually that my secretary would be scheduling my in-patient – … SIOBHAN HYNDS: A patient you would see as a private .. and then is coming onto the NHS .. list that's scheduled by your secretary the list is checked with you and then contact made for their appointment. …. DR KHAN: … I suppose it's going back to – I suppose what this is all about is just stick to the Trust private practice. MR O'BRIEN: But the allegation is that there is a complete ignorance of clinical priority. DR KHAN: Again, that's going back to – the purpose of this is going forward, I suppose. This is going back. We need to look at -- obviously you don't agree with this allegation. We need to look it as part of the whole process. SIOBHAN HYNDS: It is (inaudible) private patients who (inaudible) MR O'BRIEN: It's not that I don't agree. I don't even know who the nine patients are. I would bet my bottom dollar that the person or persons who has made this allegation would have no idea whatsoever how distressed or otherwise or severely these patients need their TURPs done. I would bet equally well they have no interest in how many other NHS patients waited a significantly shorter time than other NHS patients. …. MR O'BRIEN: But as I was saying to Colin Weir, in our emergency theatre, in the old emergency theatre, there was a book and there were three clinical priorities: emergency, urgent and private. DR KHAN: Okay MR O'BRIEN: And I asked the question, why is private a clinical priority? Of course it's not a clinical priority at all. Private patients die. Private patients are emergencies sometimes and urgency sometimes. Only when that was raised by me did they eliminate it.	56135

09.02. 2017	Meeting with Mr O'Brien in relation to return to work plan	Return to work plan/job plan meeting with Mr OB – with conditions "To return to his full job plan and to include safeguards and monitoring around the 4 main issues. An urgently job plan review will be undertaken to consider any workload pressures to ensure appropriate supports can be put in place. Mr O'Brien's return to work is based upon his Strict compliance with Trust Policies and Procedures in relation to Triaging of referrals Contemporaneous note keeping Storage of medical records Private practice Agreement to comply with the monitoring measures put in place to assess is administrative processes On return Mr OB will be primarily undertaking clinics and clinical validation of his reviews, his inpatient and day case lists. This work will be monitored by the Head of Service and reported to the Assistant Director. .. A deviation from compliance with this action plan must be referred to the MHPS case manager immediately	Doc File 2 Pages 533 – 535 AOB-01426 - AOB-01428
09.02. 2017	Letter to Ms Corrigan from Dr Black (Occupational Health)	Letter to Ms Corrigan from Dr Black (Occupational Health) Mr OB not sufficiently recovered to allow him to immediately resume and as such he is unfit for work. Mr OB indicated that prior to his exclusion, he felt under increasing pressure principally due to what he felt is an excessive workload coupled with what he indicated was an inequitable balance of waiting lists comparing himself with his peers. Given these concerns, you may wish to discuss these further with Mr OB in order to address any outstanding issues.	Doc File 2 Pages 536 – 537 AOB-01429 - AOB-01430
14.02. 2017	Letter to Dr Wright from Mr O'Brien	Letter to Dr Wright from Mr AOB RE: Note of meeting with Mr OB on 30 Dec 2016 Refers to letter from Dr Wright dated 18 Jan 2017. Mr OB raised a number of factual errors and omissions re note of meeting on 30 December 2016. Issues were raised in March to Mr OB Dr Wright did not make reference to informal steps having been unable to resolve the issues previously Had previously asked that situation was addressed. Did not state it was asked to clinical director Mr OB did not state that the job plan was ok. Mrs OB did not make any reference to being "repaid" The note did not include any record of Mr OB being advised of immediate exclusion. Only ref to exclusion is in second last paragraph and query regarding private practice	Doc File 2 Pages 544 – 545 AOB-01443 - AOB-01444

		The note did not include any record of Mrs OB's concerns regarding one of the signatories of the letters dated 23 March 2016 having caused problems previously.	
21.02.2017	Letter to Dr Wright from Mr O'Brien	Mr O'Brien writes to Dr Wright advising of a number of corrections required to the notes of the meeting of 30 December 2016.	Doc File 2 Pages 550 – 551 AOB-01439 - AOB-01440
24.02.2017	Meeting with Mr Weir and Mr O'Brien	Page 5 (section F- H) Page 6 (Section A – C) … MR O'BRIEN: I just want to ask you one thing now that you're not the investigator. That is, I certainly will dictate a letter on all patients whom I see as an out-patient. I have no problem with that. And when I was discussing resuming the SWAH clinic with Dr Khan, one of the reasons that I, you know, did take them home sis that if you did a PSA the day the following day the results was there and you can actually dictate it into the thing. But, anyway, I am not going to do that anymore. COLIN WEIR: I think you are going to have to change a life time of practice, I'm afraid. I know that's a difficulty for you.	Transcript File 6 AOB-56151 – AOB-56152
24.02.2017	Letter to Mr O'Brien from Dr Khan	Letter to Mr OB from Dr Khan Re: Formal investigation under MHPS Response to Mr OB concerns raised on 07 Feb 2017 meeting. 1. Letter of 23 March 2016: purpose of letter was to set out to you those concerns on an informal basis in order to enable you to put in place measures to rectify the concerns… It was expected that as an experienced and senior consultant, this notification of concern to you was sufficient to ensure you took all necessary steps to address the concerns and to rectify the identified problems… was not aware of agreement with no meetings with Mr Mackle nor was Dr Wright aware. 2. Formal investigation: This is a relevant matter for the formal investigation process. I feel Mr Weir may be required to provide information to the investigation on this issue and therefore I have asked Mr Weir to step down from his role as Case investigator and I have asked Dr Chada to undertake this role. The SAI process alerted the Trust to a very serious issue of concern which indicated harm had come to a patient who had not been triaged properly. The issue was one of the same that had been informally raised with Mr OB in March 2016. The reason to exclude was due to serious nature of concern….. 3. Timescale of investigation: … Given the vast scale of the concerns, the numbers of patients involves, the time period over which the concerns stretch, the records which need to be reviewed and the scale of facts to be gathered, a 4 week turnaround time is not	Doc File 2 Pages 556 – 559 AOB-01449 - AOB-01452

		practicable in these circumstances. These are exceptional circumstances. … Your understanding that there is a team of case investigators looking at this case is not correct. The case investigator assigned is Dr Chada who will be assisted by Ms Hynds. However, a review of un-triaged patients must be completed to consider what, if any, impact there has been on patient care. A similar review must also be undertaken in respect of the undictated clinics. This can only be done from within the service directorate by individuals with the requisite expertise.	
01.03.2017	Letter of response to complaint	**Re Mr** Personal Notes that complaint was in relation to waiting time for urology procedure but that Mr Hayes had now undertaken the surgery	TL6 page 265 – 266 AOB-78852 - 78853
07.03.2017	Email from Ms Corrigan	References a meeting with Mr O'Brien and Mr Weir to discuss concerns Mr O'Brien raised with Ms Corrigan.	TL6 page 294 AOB-78881
13.03.2017	Letter to Mr O'Brien from Dr Wright	Letter regarding Mr O'Brien's amendments to meeting note of 30 December 2016 and enclosing amended meeting note as per the changes requested.	TRU-00170 – TRU-00175
15.03.2017	Witness Statement (unsigned) of Ms Corrigan dated 15 March 2017	**[Please note that in this chronology I am not including details of comments in the witness statement. They should be referred to separately re same.]**	Doc File 2 Pages 584 – 590 AOB-01477 - AOB-01483
15.03.2017	Root Cause Analysis Report on the review of a Serious Adverse Incident re Patient 10 (ID Personal information	This would appear to be the final signed off report. [**At the time of dictating this chronology TUGHANS has not considered the extent to which AOB's comments have been taken into account in relation to this report.]**	Doc File 2 Pages 591 – 599 AOB-01484 - AOB-01492

16.03.2017	Email from Ms Canning enclosing letter from Ms Gishkorri to Mr Patient 84	 14 March 2017 **Our Ref:** AS206.16/17 **Private & Confidential** Patient 84 Dear Mr Patient 84 Thank you for your letter dated 28 February 2017. I a you received was unsatisfactory. The contents of your letter has been shared with the U consider how best to meet the needs of patients who surgery. Yours sincerely Personal Information redacted by the USI	TL6 Page 338 – 339 AOB-78925 – AOB-78926
23.03.2017	Witness Statement (signed October 2017) of Mr Young	[**Not considered as part of this chronology]**	Doc File 2 Pages 600 – 607 AOB-01493 - AOB-01500
30.03.2017	Letter to Mr O'Brien from Dr Wright	Dr Wright indicates that he was "*verbally made aware of an ongoing SAI in late December 2016"* in relation to the period of time AOB had taken to triage a GP referral and that this SAI had identified an additional patient. Also confirms that he had been *"aware that you had been met with previously by senior management in March 2016 regarding your administration practices relating to untriaged referral letters, review backlogs, patient centre letters /recorded outcomes and patient notes being retained at home."* The letter goes into further detail in relation to steps that had been taken including primarily investigations and the need, in Dr Wright's view, for a formal investigation.	Doc File 2 Pages 613 – 618 AOB-01506 - AOB-01511
06.04.2017	Major/Catastrophic Incident Checklist	Re: Patient 14 Summary: Patient Patient 14 was referred to Urology Outpatients on 3 June 2016 for assessment and advised raised PSA. Referral was marked urgent by the GP. Referral was not triaged on receipt. As part of an internal review the referral was upgraded to red flag and was seen in clinic on day 246, on day 304 the patient had a confirmed cancer diagnosis. There has been a resultant 10-month delay in OP review and recommendation of treatment for a prostate cancer. Patient is aware of diagnosis but not delay he has decided to opt for active surveillance treatment.	TRU-02876 – TRU-02879
13.04.2017	Email from Mr Khan to Mr O'Brien	Re MHPS concerns *"informed as the case investigator has established that all un-*	TL6 page 508

		triaged referrals have now been looked at and there are a number of referrals which, in the opinion of the other consultant urologists, required to have been triaged as either red flag or urgent but were dealt with as routine due to non triage. Curretly this number is 24. Of these 24, 3 patients have been identified as having a cancer diagnosis and the cases meet the criteria for SAI. A further 5 are still unknown at present. These SAI investigations will progress as per trust SAI guidance. …"	AOB-79095
19.04. 2017	Letter from Ms Gishkori to Patient	Advising patient that an SAI process will be carried out.	TL4 page 2574 – 2578
20.04. 2017	Major/Catastrophic Incident Checklist	Re Patient 12 Patient Patient 12 – was referred to Urology Outpatient on 8 Sept 2016 for assessment and advice on lower tract symptoms and elevated PSA. Referral was marked urgent by the GP. Referral was not triaged on receipt. As a result of a look back exercise the referral was upgraded to red flag and was seen in clinic on day 151, on day 197 the patient had a confirmed cancer diagnosis	TRU-02880 – TRU-02883
12.05. 2017	Adverse Incident Reporting (IR1) Form re patient Patient 14, Reference W Personal information [undated reporting date, possibly 12 May 2017]	As far as we can ascertain this is a date on which Michael Young raised an Adverse Incident Report (IR1) in relation to patient Patient 14 in the following terms: *"Was referred to Urology Outpatients on 3 June for assessment and advice raised PSA. Referral was marked urgent by GP. Referral was not triaged on receipt. As a result of look back exercise this referral was upgraded to red flag and was seen in the clinic on day 246, on day 304 the patient had a confirmed cancer diagnosis.* *There has been a resultant 10 month delay in OP review and recommendation of treatment for a prostate cancer. Patient is aware of diagnosis but not delay he has decided to opt for active surveillance treatment."*	Doc File 2 Pages 655 – 656 AOB-01548 - AOB-01549
12.05. 2017	Adverse Incident Reporting (IR1) Form re patient Patient 12, Reference W Personal information [undated reporting date, possibly 12 May 2017]	Adverse Incident Report in relation patient Patient 12. Adverse Incident Report completed by Michael Young. "*Was referred to Urology Outpatients on 8 Sept 2016 for assessment and advice on lower tract symptoms and elevated PSA. Referral was marked urgent by the GP. Referral was not triaged on receipt. As a result of a look-back exercise the referral was upgraded to red flag and was seen in clinic on day 151, on day 197 the patient had a confirmed cancer diagnosis.* *There has been a resultant 6 month delay in OP review and recommendation of treatment for prostate cancer. Patient is aware of diagnosis but not delay and has been referred to Belfast City Hospital for further treatment."*	Doc File 2 Pages 657 – 658 AOB-01550 - AOB-01551
12.05. 2017	Adverse Incident Reporting (IR2) Form re patient Patient 13, Incident ID Personal information dated 12 May 2017	Adverse Incident Report by Michael Young in relation patient Patient 13. "*Was referred to Urology Outpatients on 28 July 2016 for*	Doc File 2 Pages 659 – 662

		assessment and advice on an episode of haematuria. Referral was marked routine by the GP. Referral was not triaged on receipt. As a result of look-back exercise the referral was upgraded to red flag and was seen in clinic in day 179, on day 187 there was decision to treat and on day 217 the patient had a confirmed cancer diagnosis. *There has been a resultant 6 month delay in OP review and recommendation of treatment a bladder cancer. Patient is aware of diagnosis but not delay and has been referred to Belfast City Hospital for further treatment."*	AOB-01552 - AOB-01555
15.05. 2017	Email complaint from Patient	Re Mr Personal Information Notes that she is dissatisfied with Trust's response. She states that was not updated on her husbands deterioration throughout his stay in hospital. She also highlights that Mr O'Brien's comments on MDT deciding that the patient was unsuitable for radical cystectomy – the patient was not made aware of this nor was she aware that the patient had a chest infection or acquired hospital pneumonia. She noted that Mr O'Brien agreed that his care in his final weeks may not have been optimal. The patients' wife concluded *"In conclusion I would point out that my husband's poor care was not an isolated incident. A friend of mine whose husband was on the same ward at the same time and who travelled from* Personal Information redacted by the USi *to Craigavon every day told me of an incident when she arrived early afternoon she found her husband sitting on a chair in his underclothes. Surely this is unacceptable care."*	TL6 page 599 – 603 AOB-79186 – AOB-79190
06.06. 2017	Email from Ms Corrigan to Ms Hynds	References "photo of GP referral letters that was in filing cabinet drawer that was not triaged"	TRU 00182 – 00183
06.06. 2017	Email from Ms Corrigan to Ms Hynds	References "blank outcome sheets that were in Mr O'Brien's filing cabinet not triaged"	TRU 00184 - 00276
06.06. 2017	Email from Ms Corrigan to Ms Hynds	References "charts at home that were left in his office for me"	TRU-00176 – TRU-00181
06.06. 2017	Email from Ms Corrigan to Ms Hynds	Referencing the four late upgraded patients who have had confirmed cancer of which Mr O'Brien is now aware	TRU - 00277 – TRU-00286
08.06. 2017	Email correspondence between Mr Carroll, Ms Corrigan and Ms Hynds	Notes as follows:- *"To update on the findings from the undictated clinics:-* *There are 110 patients who are being added to a Review OP waiting lists - a number of these should have had an appointment as per Mr O'Brien's handwritten clinical notes before now, however I would add that Mr O'Brien has a Review Backlog issue already so these patients even if they had of been added timely may still not have been seen.* *There are 35 patients who need to be added to a theatre waiting lists, all of these patients he has classed as category 4 which is routine and again due to the backlog."*	Doc File 3 Pages 49 – 50 AOB-01617 - AOB-01618

		[This appears to collate with AOB's grievance (Appendix 17) however the investigator's report says 668 charts were not dictated] Issues which appear to have been raised are as follows:- *"There were 3 patients whom the consultants have concerns on and I had arranged urgent appointments for them. One has since been sorted ……* *Other comments made by the consultant were:* *1. Patient seen by 6 times at clinic and notes written in the patients chart but no dictated letter* *2. Patient seen initially as a private patient and there is a letter in chart for private visit but none for NHS visit* *3. Patient seen x 14 times at clinics (so well looked after) but no letters so how does the GP know what is going on?* *4. Patient seen at clinic on 19/9/16 letter dictated retrospectively on 28/02/17.* *5. According to PAS the patient attended the clinic but according to handwritten notes they DNA and Mr O'Brien had asked that they be sent for again* 6. *Patient seen on 11/04/16 but letter was dictated on 22/02/17."*	
12.06.2017	Email correspondence between Mr Carroll, Dr Chada, Mr Weir and Ms Hynds	Email exchange between various. Notes that at that stage the delayed diagnosis, as a result of triage, had not been brought to AOB's attention and agreement that it should be discussed with him. Also noted the final report in Patient 10 had not been shared with him.	Doc File 3 Pages 51 – 58 AOB-01619 - AOB-01626
21.06.2017	Email from Ms Corrigan to Mr O'Brien	Notes that there has been an increase is the amount of charts in office	TL6 page 761 – 762 AOB-79348 – AOB-79349
11.07.2017	Email from Ms Corrigan to Mr O'Brien	Re Charts in office Notes that the charts are still tracked to his office (90 in total). It was requested that a meeting is set up between Mr O'Brien, Ms Corrigan, Mr Carroll and Mr Weir	TL6 page 895 AOB-79482
19.07.2017	Email correspondence between Mr Carroll, Mr Weir and Ms Johnston with enclosures	Issue raised: "*? inappropriate booking for emergency list*" at the weekend. Notes 5 urology cases on the Saturday 15/7/17 and 6 on the Sunday 16/6/17.	Doc File 3 Pages 85 – 91 AOB-01653 - AOB-01659
19.07.2017	Email correspondence between Mr Carroll, Ms Corrigan and Mr Weir	Ronan Carroll indicates "*3rd Feb chart is almost 6 mths, so……having notes in his office is against the action plan he received……* *AOB has not raised any workload concerns so again why the*	Doc File 3 Pages 92 – 95 AOB-01660 - AOB-

		volume of notes in his office? ……. *Helen Forde is running a report on the volume of notes tracked to all surgeons, so we can have a comparator."*	01663
24.07. 2017	Email correspondence between Ms Corrigan, Mr Weir and Mr Carroll	Suggestion in this email correspondence to meet with AOB at 12.30 in AMD office tomorrow.	Doc File 3 Page 102 AOB-01670
25.07. 2017	Meeting with Martina Corrigan, Colin Weir and Mr O'Brien	Page 4 (Section D – H) MR WEIR: It is just the number of charts that are sitting in your office sort of are – I think you've clawed back a bit of late but at one point there was kind of a back log. I think your results – you do your own results on the charts. Go to your office pending some sort of outcome or dictation or something. Correct me if that's wrong. And it is just that we were starting to see a back log back five – at one point in June you had five charts back to February, 11 in March, 37 April, 39. So that was building up into quite a sizeable number of charts in your office. … Waiting on an outcome or dictation. So really that's just kind of – we don't want – I suppose you don't want that to accumulate I suppose to that. MR O'BRIEN: I don't want it at all because I don't know why charts are coming to my office at all. There's no need for them to come into the office.	Transcript FILE 9 AOB-56211
25.07. 2017	Meeting with Martina Corrigan, Colin Weir, Ronan Carroll and Mr O'Brien	Page 4 (Section A – H) MR O'BRIEN: The line managers I have been told. In fact, actually I was kind of irritated by it whilst Noleen was off and I asked Paulette, who had two bundles of them, big thick charts with a PSA of 7 on the front of one of them, you know, why are you doing this? And she said we have been told by the line managers that, this is the important thing, that the results has to be signed before it is filed in the chart. But the vast majority of results and reports are never filed in charts now. COLIN WEIR: But some results will just get signed and some results you will want to see and do a letter on.	Transcript File 9 AOB-56213
28.07. 2017	Meeting with Martina Corrigan, Colin Weir, Ronan Carroll and Mr O'Brien	Page 4 (Section H) – Page 5 (Section A – C) COLIN WEIR: Does that happen in general in urology? MR O'BRIEN: I don't know is the answer to your – I don't know actually. COLIN WEIR: If that's a systematic thing or it's just Aidan's? MARTINA CORRIGAN: No. RONAN CARROLL: It's a fair question. I think we need to establish what is, even if its in general surgery as well.	Transcript File 9 AOB-56213 - AOB-56214

		COLIN WEIR: I have walked into Manus' office and seen charts piled high. Okay. So it is maybe something that we need to review. Presumably they're tracked out. You know where they are.	
28.07.2017	Meeting with Martina Corrigan, Colin Weir, Ronan Carroll and Mr O'Brien	Page 5 (Section E – H) COLIN WEIR: It is just in the context of everything we want to protect you from any perception that things are accumulating and everything else is up-to-date. The dictation you have done. The triage you have done. MR O'BRIEN: It's fixed already. MARTINA CORRIGAN: Yes.	Transcript File 9 AOB-56214
28.07.2017	Meeting with Martina Corrigan, Colin Weir, Ronan Carroll and Mr Obrien	Page 6 (Section D – H) – Page 9 (Section A- H) MR O'BRIEN: Anyhow the number at the moment is 25 charts. I have checked this morning to ensure that there have been no addition to that. That can be diminished further anyhow. COLIN WEIR: That's good. At least we know now what the problem is and we know how to stop and fix it. MR O'BRIEN: I would much to prefer have reports set on my desk on a daily basis so that I can go onto ECR. I know most patients very well anyhow, just to make sure does anything need to be done with this or not? That's all and I don't need a chart for that. COLIN WEIR: No. You know your patients better than most I would have thought. … MR O'BRIEN: There is still – maybe it is not for today's discussion, but there is still an enormous problem to be addressed with triage, but maybe it's for another day. … COLIN WEIR: We are experiencing teething difficulties, let's put it that way, with E Triage. …. MARTINA CORRIGAN: It's a (inaudible). It's not your problem. What you had said to me the last time was you go into so much detail on your patients that – MR O'BRIEN: There's a serious issue here which has been pertaining for years which has been not adequately and properly addressed. And that is in particular, now leaving aside red flags, if you were to concentrated on one particular cohort of people. We have patients who are either being referred as urgent and stay as urgent or referred as routine and upgraded to urgent who are not going to be seen for 40 weeks and they are having nothing done about them. As I	Transcript File 9 AOB-56215 - AOB-56217

		said to you in that email, it's a complex things. People are coming to casualty here with obstructive ureteric stones been given some analgesia. Their pain settles down. They go home. The pain returns tomorrow. Five days later somebody is ticking an urgent they're going to be seen in 46 weeks. MARTINA CORRIGAN: It's actually 52 now. MR O'BRIEN: 52. This is a major issue but it takes time to deal with it properly and there is not enough time as urologist of the week to do it. Now, I have it in black and white from 1 or 2 April 2015, when I tried as lead clinician of MDT to get all of us to do advanced triage for the red flags, which is a minority proportion of the total numbers this we are receiving, and I couldn't get agreement for that because there wasn't enough time to do it. It was too time consuming and there wasn't enough time to do it for the red flags. Now, even if you just do a tick box exercise, which I must say I must do from now on because it is not possible to do it whilst – otherwise I did 60. I did 60 triages, contacting patients, writing to them, organising their CT scans and so forth. 60. You cant do, as Colin said to me once, you know, he can do 100 in an hour. This is a different ball game altogether. And the important thing about this issue is the fact that someone would have to wait a year to be seen urgently. … COLIN WEIR: Is everybody experiencing this? Is this like the team, or the general, is this a pattern? MARTINA CORRIGAN: No, Aidan does the advanced triage on all the patients, not only the red flags but on all patients, whereas the rest of the team will do – you know, they'll look and read what the GP has written, so if it's an urgent it'll stay – COLIN WEIR: Stay urgent? MARTINA CORRIGAN: Stay urgent. Whereas what Aidan's saying --- COLIN WEIR: So red flag stays red flag. Urgent stays urgent. MR O'BRIEN: No, no. If I'm on the information – you can upgrade it to anything. You can upgrade a routine to a red flag and maybe the red flags will be seen in two or three week and that's the safety net. COLIN WEIR: The capacity to deal with urgent it's not there. ,,,	
25.07.2017	Meeting with Martina Corrigan, Colin Weir, Ronan Carroll and Mr O'Brien	Page 9 (Section G – H) – Page 10 (Section A – H) MR O'BRIEN: … I was advised subsequent to that an investigation was being conducted into the emergency cases I was operating on, as to whether or not they were really emergencies. Do you know anything about that? RONAN CARROLL: I don't think it was an investigation.	Transcript File 9 AOB-56218 - AOB-56219

		MR O'BRIEN: All right. What was it? You do know something about it? RONAN CARROLL: Yeah, but there was – I can't remember the origins of it but it was looking to see – there seemed to be a lot of urology cases being done at the weekend. … Someone's perception that there were a lot being done. So we asked to see what is the normal at the weekend. So we were waiting for that information. One set of figures on one weekend is neither here nor there. MR O'BRIEN: Okay. So I just find it bizarre because like I was off on Friday the 14th, Personal Information redacted by the USI ay. I was burning bushes when I got a telephone call to say, it is okay, can you do these two obstructive cases tomorrow. We'll put them on the list. The irony was what I came in one of them hadn't been put on the list and then I find that I am being – I was told I was being investigated. It has been reported that I actually had operated on a patient on the Saturday who had been admitted electively for an emergency operation. I found that sinister quite frankly. … what do you think about it? COLIN WEIR: All I can – I was made aware that there was six or five cases on a Saturday or six on a Sunday.	
28.07. 2017	Email correspondence between Mr Carroll, Ms Corrigan, Ms Johnston and Mr Weir	In this chain of correspondence there is an email from Colin Weir to Ronan Carroll and others stating:- "*Are you aware if any other patients were similarly 'booked' over the weekend? The carry over affects capacity for urgent cases and emergency theatre utilisation.* *I hope it isn't true as it would be a gross misuse of theatre emergency time.* *I suggest we investigate all urological case done over weekend."*	Doc File 3 Page 106 AOB-01674
31.07. 2017	Email correspondence between Ms Corrigan, Mr Carroll and Ms Hynds	Email exchange confirms that all charts stores in AOB's office had been removed and follow-up dictations and reports had been done in a timely manner.	Doc File 3 Pages 119 – 120 AOB-01687 - AOB-01688

30.08. 2017	Meeting with Dr Chada, Siobhan Hynds and Mr O'Brien	Page 6 (Section D – H) and Page 7 (Section A – H) DR CHADA: … "*To determine if there have any patient referrals to Mr O'Brien which were untriaged in 2015 or 16 in line with established practice or process"* So do you want to respond to that, Mr O'Brien, or – MR O'BRIEN: Well, first of all, you could (inaudible) it. The patient referrals to me are very few and far between. Those are usually from consultant to consultant, or a minority are personalised and you can count those on the fingers of one hand the number of those that you would get in a week and they can come at any time. To my knowledge, I have always responded to those. Perhaps what this is really referring to is – … MR O'BRIEN: -- during 2015 and 2016 that I did not triage. I did not triage referrals that were allocated to me during those two years as was required in line with established practice. Well, the practice was regrettably established when we established the urologist of the week system. Regrettably I say because it proved to be impossible in my view and in my experience to conduct triage in a proper manner as has been referred to whilst being urologist of the week. So it was regrettably established but then, when I found that it was not possible to continue to do so, then that is when I advised that it was not possible to continue to do so because it was just not possible. There was not enough time to do it.	Transcript File 10 AOB-56227 - AOB-56228
30.08. 2017	Meeting with Dr Chada, Siobhan Hynds and Mr O'Brien	Page 8 (Section E – H) & Page 9 (Section A – D) DR CHADA: But I think you said earlier that you didn't do the triages. Is that what you said? MR O'BRIEN: Yes. I continued to do red flag triage and I have done so throughout all of this period. DR CHADA: (inaudible). You would have lifted out the letters from the GPs that came in with a red flag on it and triaged those. Is what you are – MR O'BRIEN: The red flag referrals are delivered and handled by an entirely different office. They are handed by the office of cancer services, with which I was very much engaged because I was lead clinician for the urological MDT during all of that time in any case. DR CHADA: So those would have come in through a different system. You would have lifted those. You would have triaged those. MR O'BRIEN: Yes. DR CHADA: But the rest of them were not being triaged. MR O'BRIEN: But I didn't triage the rest because I didn't have time to do it. …	Transcript File 10 AOB-56229 - AOB-56230

		DR CHADA: … other people have said that, you know, that maybe you would have complained about that, that you didn't have time to do it. So what I am trying to clarify in my head, did you formally go along to somebody and say "I am not doing this. Just not doing it. Because I can't"? … MR O'BRIEN: … I sat there at meetings when we would have reviewed this whole system saying really essentially two things. The quantity of referrals that do come in, which currently stand at about 150 per week, is such that you cannot properly triage them. I want to emphasise the word proper triage because that word has been used, because there is a marked distinction between triage and proper triage. DR CHADA: … what you are clearly saying is there is a difference between doing a full triage, full is probably a better word, than doing just a looking at it and reading through it. Is that what you are saying? MR O'BRIEN: Absolutely.	
30.08. 2017	Meeting with Dr Chada, Ms Hynds and Mr O'Brien	Page 9 (Section B – H) – Page 10 (Section A- H) MR O'BRIEN: We have been discussing the five very important cases that were upgraded to red flag and the risks to their outcomes and so forth by potential risk by delay and so forth. … Important as they are, and they are extremely important, I am not diminishing them, numerically they pale into virtual significance compared to the numbers that are suffering poor clinical outcomes waiting on operating lists. And I am not just talking about benign pathology. We are increasingly finding it difficult to attend to matters of the gravest importance, you know life-saving surgery, and I have availed of – like, for example, in 2016 I did not take one operating day off on leave and in addition to that, I used every available operating session vacated by any of my colleague whilst on leave. DR CHADA: Yes, I accept what you are saying Mr O'Brien but I suppose though, you know, we work to a contract and we work to what the Trust expects us to do because they tell us what it is they want us to do. And I suppose there is an onus on us not to do what it is that we might like to do but what it is that – making sure that we meet those Trust requirements…. So I am not sure that saying here, I decided that I was going to spend my time in a way that I thought personally was more fruitful or more beneficial or more whatever, is a fair or appropriate. I suppose that worries me a little bit because.. MR O'BRIEN: But that's the situation we are in because no one else is going to do it. DR CHADA: But that's the situation the Trust is in…. it is not up to me to say, well, okay actually, I am not going to do that portion of my work because I think that is more important….	Transcript FILE 11 AOB-56253 - AOB-56254

		The fact is those four patients you said, well, delay didn't matter that much for those four patients as it has turned out actually it mattered to them. … MR O'BRIEN: .. You see, what happens actually if over a period of 25 years you write and you raise and you discuss and Siobhan asked me about this before. I have had – you know, I have had the experience of, you know, patients eventually dying as a consequence of delay on operating lists and have written and written and written and when the letter of complaint comes in eventually and you respond to it, including reference to what you have written, it you – I have been asked to delete the reference. You see what happens when the Trust doesn't address it. DR CHADA: That is an issue for them, I suppose, that's the point – MR O'BRIEN: And what happens when the patient rings me the following day. The patients don't ring the Trust. This is my reality, Neta. It is a very grave reality for me every day. Five patients yesterday by email, GPs, you know, desperately begging for surgery to be done. This is the reality I live with every day. I am on annual leave today. I have decided to go and sit here on an annual leave day. I spent yesterday preparing to the best of my ability. The day before was an annual leave day. I spent all of that day arranging cancer reviews, arranging urodynamics, juggling around the most urgent cases I could fit into next Wednesday, doing an additional list next Friday, when I am actually the urologist of the week. It is desperate. The circumstances in which I have worked for 25 years, and will work when I go out this room, haven't changed in 25 years.	
30.08. 2017	Meeting with Dr Chada, Ms Hynds and Mr O'Brien	Page30 (section C - H) – 35 (Section A – D) MR O'BRIEN: … "To determine to what extent any of the above matters were known to line managers within the Trust prior to December 2016.. and determine what actions were taken to manage the concerns". So the concerns being triage. I have already explained that I have advised people that I had found it impossible to do, which I felt it was, and, having done that a number of times, I felt that it was synonymous with telling people I was not doing it because I had found it impossible to do. DR CHADA: … Do you think reflecting on that now that that was a reasonable course of action, to put them in a drawer and let the default system take place? MR O'BRIEN: I wish I had left them back to copper fasten the fact that I wasn't doing triage. … But when you are so overwhelmed, as I am and have been and particularly after the March 23 letter when I asked for help and wasn't given any, no support, no nothing.	Transcript FILE 11 AOB-56274 - AOB-56279

		DR CHADA: Who did you ask? … MR O'BRIEN: Eamon Mackle… he shrugged his shoulders. DR CHADA: Was that a face to face meeting? MR O'BRIEN: Yes. … MR O'BRIEN: Yes, the letter is there – identifying concerns, here it is, untriaged out-patient referral letters. There are 253 at that time. The current review back log particularly in cancer review, which is of grave concern to me, and the patient cancer letters and recorded outcomes and the notes at home. Thereafter, trying your best to deal with all of these issues that I have identified and discussed today, particularly those people with red flag cancer issues on the waiting list, you know it is just appalling…. You are talking about talking about it and raising it and writing it and all of that, I mean, how can you just actually do your job plan expectation and forget about these people. DR CHADA: … I understand therefore that someone somewhere knew something. But I suppose what I am asking you is, in terms of how you formally or even informally raised this. So what you are saying is that you discussed this at meetings with your clinicians colleagues and management. … MR O'BRIEN: With regard to triage, yes, I have already described how I have done that. How that came in as urologist of the week in September 2014, how the default came in in November 2014. By March/April, you know, I found it impossible and so forth. DR CHADA: In terms of the rest of them, what about the other issues? Did you raise with management about outcome sheets or undictated letters or undictated letters not being done or that you didn't feel that you had the time? Why were outcomes not done? MR O'BRIEN: I didn't have the time. .. DR CHADA: You are saying that you did the outcomes for the ones that were urgent or needed to be done but you didn't do the rest. Okay. Did you raise that with someone? Did you come along and say to somebody, I am not doing all this dictation or I am not bringing these clinics back because – MR O'BRIEN: Yes, something like that – I would have – we would have – I would have – It would have been an issue that we would have discussed previously when at appraisal with Michael Young for example.	

		DR CHADA: What about other managers? That's your medical manager. What about the service managers? Would you have raised with the service managers any of those sorts of issues that there were these – I suppose, one reason I'm saying that – … MR O'BRIEN: Yes, I mean, Martina would have known that I had charts at home. In fact, actually, when I took ill and had my prostate resected on 17 November last…. That at least I could deal with some of these charts and did so on a daily basis and so forth. So that was – it's been known about for a long time. DR CHADA: You think they had an understanding? Because I have to say that I was quite surprised about the numbers.. Do you think people knew about the number of charts? MR O'BRIEN: I don't know. You would have to ask them. The purpose of your question I think is – you're asking me in a sense, have I adequately advised management?... Even though management tell me that they are aware of it. … Do you know after 25 years when you have raised and raised and raised and raised numerous times and time on one side of a desk looking at a chief executive on the other side of a desk – DR CHADA: Raised how? .. MR O'BRIEN: Verbally by meeting… by managers. After a time you stop doing it when it doesn't achieve anything. DR CHADA: And this is about the triage and about the waiting list you are talking about now? MR O'BRIEN: Waiting list…. How many times do you really expect one to meet with another official personnel in an organisation just that repeatedly refused to do anything. They listen to you, nod their head. … The most common – as in my appraisal, for example, they are Trust issues. In fact, you have articulated once again today. Except the Trust never makes them an issue. And you are left – you are – the reality of every day clinical life is that a patient's outcome is very dependent upon the clinician. … I was given this letter. I remember it very, very well because I was – it wasn't on 23 March. I think it might have been one or two days later…. It was like – just doing nothing other than telling me nothing more than I was already aware of that was emburdened with, overwhelmed by. And I asked, you know, what do you want me to do? You know, what can I do? And that was it… So I left, I left to the world that I inhabit once again and I concerned myself above all with the people who	

		are suffering poor clinical outcomes and a risk of doing so in numbers that outnumber these people emanating from triage many times over. … DR CHADA: … With no particular action plan in place? Is that what you are telling me? MR O'BRIEN: No action plan in place. You can drop the "P". It's appalling. DR CHADA: With no action plan. MR O'BRIEN: None. DR CHADA: So what changes did you make following that letter? MR O'BRIEN: Just work harder. DR CHADA: In what way? Did you have extra – MR O'BRIEN: Extra --- I have it all here. I can give it to you this whole. I can give it to you. I have all of it, all tabulated. … The review backlog. Doing extra clinics. I didn't take—I operated – I find it distressed to even talk about it really when I look back on those nine months. You know, I have been through a rough time. Embarking upon an operation and having to scrub out 45 minutes later and go to a toilet and not be able to pass urine and be in such pain. Not being able to travel. So, I did all of that (--UPSET--)	
30.08.2017	Meeting with Dr Chada, Ms Hynds and Mr O'Brien	Page 38 (section C – H) – page 40 (section A – B) DR CHADA: Do you think you work differently from your colleagues? MR O'BRIEN: Everybody works differently…. Yes. I do work differently, yes. Certainly, colleagues in varying respects work differently you know. Some them they – it can be irritating…. DR CHADA: I suppose the reason I am asking the question is because have these issues – because I suppose part of this is the comparison with other people. Okay. That's what we do. We compare what you do on your outcomes and our approach in things with what other people do. So I suppose what I am asking really is, do you think you colleagues have had similar issues? MR O'BRIEN: As these? I don't know about – obviously they haven't had the untriaged out-patient referral letters, irrespective of whether it have been properly, adequately done. In terms of current review, I have no idea what the situation there is. I know there's a review back log across the board. DR CHADA: … are other colleagues doing the triages?	Transcript FILE 11 AOB-56282 - AOB-56284

		MR O'BRIEN: Yes. DR CHADA: .. are other colleagues dictating letters on patients? MR O'BRIEN: Yes. DR CHADA: Do other colleagues do you think have note at home? MR O'BRIEN: I don't know. DR CHADA: Do you think they have 356 .. MR O'BRIEN: Don't know.. DR CHADA: Taking a clinic home every now and again MR O'BRIEN: It never crossed my mind to question DR CHADA: Do you think that there are other colleagues who have undeclared patient outcomes from patient clinics? MR O'BRIEN: I don't know. They could very well have. I have never asked. In other words, you are asking the question, does every clinic have a letter dictated from it? DR CHADA: An outcome sheet MR O'BRIEN: I don't know. I have seen them. I don't know how anybody reads them. There are, as often as not, illegible… DR CHADA: But you have seen them. You have seen other people's outcome sheets from their patients. MR O'BRIEN: Yeah, they wouldn't be like these. DR CHADA: … are you aware whether other people are having the same sort of the issues or have had the same sort of issues? MR O'BRIEN: I do know that triage is an issue for people. It is difficult. My colleagues have talked about it… but they are doing it and they're doing it in – apart from the manner in which they are doing it, but other activities during that week are suffering as a consequence. … MR O'BRIEN: very important that you appreciate that. So if you have someone who can be fixed by operating on them tomorrow morning but somehow you can manage to send them home this evening to be admitted electively from an urgent waiting list by somebody else, then you can sit down and do you tick box exercise on your trigae. If you can manage actually to not spend three hours doing the ward round, knowing every detail about the patient, but, sure, the registrar can do it instead and he can call me if there is a problem. Is that optimal care? Is that what urologist of the	

		week is supposed to be about? No it is not. DR CHADA: .. That's raises other questions. MR O'BRIEN: It raises big issues and big issues not being addressed but they will be Trust issues which the Trust will not address. I am sorry to be so cynical.	
06.09. 2017	Complaint from patient	Re Mr Personal Information Complains about the waiting times for prostate operation. Waiting over 2 years since he first contacted his GP with blood in urine and discomfort.	TL6 page 1144 – 1147 AOB-79731 – AOB-79734
06.11. 2017	Meeting with Dr Chada, Ms Hynds and Mr O'Brien	Page 7 (section H) – Page 8 (Section A – G) Michael O'BRIEN: But is that the case? Is it the case that he had additional admin time? DR CHADA: that is what we have been advised and that's in the statement. MICHAEL O'BRIEN: I understand, but is that the case when you look at the job plans for the different consultants? MS HYNDS: The PA levels are certainly different DR CHADA: Yes. MICHAEL O'BRIEN: For admin specifically? MS HYNDS: Specifically for SPA time. .. MICHAEL O'BRIEN: The job plan would have admin time. It is something like four hours a week. … MS Hynds: .,… in terms of whether there is additional admin time, we will look at the relevance of that to the overall terms of reference. And that is a point that we will get to whenever we pull all of the information together. At this point in time, what we are doing is gathering information. ..	Transcript FILE 12 AOB-56291 - AOB-56292
06.11. 2017	Meeting with Dr Chada, Ms Hynds and Mr O'Brien	Page 21 (section F – H) – 22 (Section A – H) DR CHADA: That is why – I wanted to know about that. What is additional operating session? Does that mean that she was an add on? MR O'BRIEN: No, it means actually that – I mean, I am scheduled to do two sessions of operating on a Wednesday. Michael Young and I started doing longer days when the boat was being pushed out to try and get operating done. There were resistances to having extended operating days from	Transcript FILE 12 AOB-56305 - AOB-56306

		nursing staff and theatre and, even more importantly, perhaps from anaesthetists. So over a period of time we normalised, just Michael and I, we were the first two to do it in about 2013 or thereabouts to try to tackle, you know, the demand and so forth. And then when it reached increasing acceptance other specialities, like ENT and orthopaedics, those two specialities they could see the merits in doing that. So as we grew in number as well, with limited theatre sessional capacity. How do you provide session for six people as opposed to three. So we decide then that Wednesday, on which I operate, which starts at 8am. The theatre would be available for operating from 8am to 8pm. So one of my colleagues will do from 8am to 12 noon. And I agreed – Michael and I only ones who operated beyond 5/5.30 and I would do from 12 to 8. So on a day when the person, who currently is John O'Donoghue, when he would be urologist of the week, or when he is on annual leave and he vacates that, I use it and that is what I mean by for me an additional operating session. .. That could be – it will be either I'll be spending that time operating on people instead of either administration time or the time allocated to preview for the following day MDM and there were years when I was the only one chairing MDM. So you could actually lump as administration time or SPA. So that is what I mean by additional operating session. DR CHADA: So would it have been an additional operating session for a – for a session you would normally use for SPA? MR O'BRIEN: Or administration time…. In other words, so far as my job plan is concerned, I don't have in my job plan operating prior to 12 noon on a Wednesday. DR CHADA: But sometimes you would if it is available and free. MR O'BRIEN: Yes, absolutely. DR CHADA: So on a Wednesday morning is that a SPA? I suppose the reason I am asking is about this definition of administration time I suppose. Because to me administration time is clinical administration. MR O'BRIEN: Yes. DR CHADA: And clinical administration is not a SPA MR O'BRIEN: Absolutely right. ..	
30.11.2017	Personal Development Plan	Comments by AOB in his 2016 Appraisal	2016 Appraisal page 40 AOB-22870

		Name of doctor: Aidan O'Brien Considering my comments under *Maintaining Good Medical Practice* (in my appraisal paperwork), the following strategies may help improve how I keep up to date in the next year: During 2016, I focussed on the areas which I believed were most clinically pressing, performing 25 additional, inpatient operating sessions, and 20 additional oncology review sessions, in the ten months available to me. I have no doubt that doing so significantly reduced the poor clinical outcomes and suffering of significant numbers of patients. I also have no doubt that doing so contributed to the issues since subject to formal investigation. My appraiser recorded that these were Trust issues to be discussed and agreed in 2017. They have yet to be so! Date of reflection: 30 November 2017	
08.12.2017	Minute of Meeting	Meeting with Mr Personal Information's family following letter of complaints	TL6 page 1621 – 1623 AOB-80208 – AOB-80210
30.12.2017	Meeting with Dr Wright, Mr O'Brien and Mrs O'Brien	Page 2 (section E & F) – "Dr Wright: …There have been a number of things that have come to light that we need to take action on .. So, essentially.. the Trust have been investigating a SAI investigation into this particular case, the SAI is not complete yet, in relation to a patient may have come to some harm through a delay in treatment. But during an investigation it has come to light that were other issues that were linked to this and were brought to my attention… Some of these issues were raised with you by letter in March of this year… Mostly around administration matters, patient notes" Page 2 (Section G) – Page 3 (Section A - B) "Female Speaker: Certainly the issues that we raised relate to the lengthy period of time to undertake triage of GP referrals and currently we have a number of 318 untriaged presently. The suggestion is that this may have led to a poor clinical outcome as Dr Wright has indicated for one patient and unnecessary delay of treatment for a second patient. And this has come out as I understand as part of the SAI. There is also the concern that has been raised previously informally about taking patient notes home and that these have not been returned and the concern from the Trust perspective then is that the clinical management plans for those patients remains unclear. .. Concern that the treatment may be delayed in that respect. The third concern is that there is a back log of over 60 undictated clinics going back approximately 18 months. So we have a situation where there is approximately 600 patients may not have had their clinical outcomes dictated…." Page 3 (section D – E) "Mr O'Brien: I am not aware of the case at all.. Dr Wright: I don't know it. We can certainly furnish you with	Transcript File 1 AOB-56002 - AOB-56003

		the details of it. The investigation into that is not complete yet, so I haven't seen the final report on it.. Mr O'Brien: When did it arrive? Dr Wright: It arose the last couple of months" Page 3 (Section F) "Dr Wright: .. we met as an oversight committee.. given that we have got some evidence of patient harm in once case ad potential for harm in others, to be honest I really have no choice but to formally investigate this. "	
2017/ 2018	Mr O'Brien's comments on Witness Statements	[To be referred to separately]	TRU-00738 – TRU-00743
08.02. 2018	Email from Ms Corrigan to Mr O'Brien	Notes that she would like to discuss a possible patient complaint about a patient's surgery being cancelled	TL6 page 162 - 163 AOB-80455 – AOB-80456
08.05. 2018	Email of complaint from patient	Patient - Patient 153, Personal Information redacted by the USI, Personal Information redacted by the USI DOB Personal Information redacted by the USI. H&C no. Personal Information redacted by the USI. I am writing to complain about the treatment and waiting times my father has experienced with the Southern Trust. In 2015 my father went to his GP with lung problems, and as he has coronary artery disease she organised a chest x-ray. The x-ray showed a shadow on his lung. Following a PET scan, he was diagnosed with Prostate cancer in December 2015. His consultant Mr O Brien started him on a hormone treatment. He was seen regularly by Mr OBrien for a time. He had stents fitted previous to this and during the time on the treatment he continued to have cardiac symptoms. Mr OBrien advised that he would need to have radiotherapy at some stage but would need to have his heart sorted first. At the end of 2016 he was told he needed to have his stents unblocked urgently. In October 2017, Mr OBrien advised that his PSA levels were rising slightly which indicated that the hormone treatment was starting to become ineffective as such and would require radiotherapy 'sooner rather than later'. He said hopefully would be done before Christmas and he would see him again at the end of January.	TL6 page 602 – 608 AOB-80895 – AOB-80901

		An appointment was received for the heart procedure for the week before Christmas 2017. My dad phoned to say that he had broken his leg and was in a boot, and the cath lab said they would be unable to do the procedure but would be in again within 6 weeks. On 29th March I got through to Mr.Monroes secretary who advised no out patient appointments were being carried out in the cath lab. I explained the urgency and said he would hopefully be seen in April. I also left a message for Mr OBrien. 6th April I left another message for Mr OBrien. 20th April I spoke to Mr O'Brien's secretary who told me that the latest PSA test results from the health centre had been passed to him that day and he would be in touch. My father visited his GP today with recurring heart, lung and urology symptoms. The doctor was astounded that he had not had any procedures and had not been seen by Mr OBrien since October. He said that his PSA levels had kept rising and should have been seen with urgency. At the minute, our family feels like we have been totally let down and my father has been forgotten about. His lung problems are only being followed up now (he has an appointment in 2 weeks.) He has not been seen by Mr OBrien in over 6 months, despite his blood tests showing that the cancer is active. He has been wating nearly a year and a half for an urgent heart procedure. Despite being told in October 2015 that the cancer in his prostate was medium growing, he has not had any further follow up scans to see if it has spread. We are very angry and my father has no quality of life at all. We believe that the trust is failing to adequately look after my fathers health problems. I hope that you can look into this with some urgency and I look forward to hearing from you.	
25.05.2018	Email correspondence between Ms Hynds and Ms Toal	Confirmation no concerns in relation to adherence to *"return to work action plan."*	Doc File 3 Page 245 AOB-01813

08.06. 2018	Letter from Ms Reid to Mr O'Brien	Re review of treatment provided to 5 patients under SAI process. Mr Johnson would like to meet as part of this review.	TL6 page 771 – 772 AOB-80164 -AOB-81065
11.06. 2018	Email correspondence between Ms Hynds and Ms Toal	Confirms ongoing adherence to return to work action plan.	Doc File 3 Page 248 AOB-01816
11.06. 2018	Minute of Meeting with AOB, Dr Johnston and Ms Trudy Reid	**Meeting re SAI** Patient 10 The remit of this SAI has been highlighted at all interviews and nothing outside the remit of the SAI will be noted. *JRJ highlighted the sequence of events for the Index case and this SAI.* … a look back of the 7 patients who had not been triaged did not identify any issues…. This coincided with 100'2 of GP referral letters being found in Mr AOB's filing cabinet and a review of weekly triage lists. This second look back exercise identified approximately 30 cases which met the red flag criteria. Four of these cases were identified as having confirmed cancer and are the subject of this SAI. A further SAI was added to this SAI investigation following a complaint from the patient's family, as there were also problems with a delay in diagnosis. … Mr O'Brien stated he requested management to address this and come up with a process for non-red flag referrals. *Questions re triage (see Triage Chronology)* … JRJ stated from a patient's point of view; he is aware of waiting list pressures on Mr O'Brien and his team, but from a public perspective, cancer is important.	Doc File 3 Page 249 – 264 AOB-01817 - AOB-01832
11.06. 2018	Meeting with Dr Johnson and Mr O'Brien	Page 20 (Section B-C) MR O'BRIEN: … As you increase in number, it is difficult at times. I find one of the challenges, which I have addressed and raised in recent months is, and maybe it is on foot of this investigation and my colleagues' awareness of it, is to try as a team to raise uncomfortable issues with one another without, you know, falling out and jeopardising the esprit de corps and that can be difficult you know. Sometimes then issues are pussy footed around and it's not healthy. If you can deal with these things in a non-confrontational, but honest, transparent manner.	Transcript FILE 13 AOB-56333
11.06. 2018	Meeting With Dr Johnson and Mr O'Brien	Page 21 (SECTION E – H) – Page 22 (Section A- G) Dr JOHNSON: … Your colleagues in terms, you like to work on your own – your own preferences of the way you like to work.	Transcript FILE 13 AOB-56334 - AOB-

			56335
		MR O'BRIEN: Yes DR JOHNSON: You run your clinical management of what you do and you've already painted a picture of what you do each day and what you don't do on Wednesdays and your life is well ordered. I am not criticising you. But, you know, that has filtered through into thr triage. You weren't bending, as far as they could see it, fitting in, in the team, to triage… Pre the default… Your way of working, your clinical career and your role, you did it your way. Is that – do you recognise that as a pen picture, or pencil drawing of your career? You like to work your way of doing things? You've worked your way through it and you weren't bending or changing the way you worked? MR O'BRIEN: … Of course I did it my way and everybody else I presume does it their way… But I wasn't cognisant of being unbending. I wasn't particularly asked to bend in a particular way or to sacrifice something that I was doing. I am very, very particular. I do organise my own operating lists. DR JOHNSON: Okay, It has been put to me that the triaging issue, which you say there's not enough time to do it, you wouldn't change the way you did it. And the regional rationalisation process, you mentioned a while ago, there were changes involved in that and you resisted those internally to make changes in the Southern Trust's urology service. And there were a lot of changes that were suggested on a regional basis that you had difficulty.. MR O'BRIEN: The only thing I had difficult with was the centralisation of radical pelvic surgery. I haven't had difficulty with anything else. DR JOHNSON: … How should a Trust or an organisation deal with a senior colleague who has various issues he will only do his way? MR O'BRIEN: If doing his way is in some way obstructive or jeopardising the delivery of services by the team of which he is a member, or the particular speciality or whatever, then there should be, you know, a meeting to address it. There should be – I mean, management should – DR JOHNSON: Did any of that happen as far as you – MR O'BRIEN: No, no. DR JOHNSON: So these issues that we had had didn't go upwards as such. You recalled to me – you recollect there a meeting that you had with Ivan Sterling. Did you ever meet with Paddy Loughran or – MR O'BRIEN: We had one. Michael young – DR JOHNSON: John Simpson? MR O'BRINE: No. We never had a meeting with those people at all, even though actually in witness statements people	

		refer to many meetings being – one of the things I learned is that the number of people who were having meetings with other people talking about these issues but no one ever talked to me about them.	
25.06.2018	Response to Complaint letter	**Re Mr** Patient 153	TL6 page 869 – 871 AOB-81162 – AOB-81164
June 2018	Investigators Report	**Initial Concern** A SAI investigation was commenced within the Trust in April 2017 in respect of a patient Patien t 10. A referral has 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 patients. As a result Mr Haynes completed a datix form to alert the Trust to the issue of concern.	TRU 00661 -
July – September 2018	Screening Report SEC ATICS	Re: Patient 90 (SAI) Patient admitted to ICU in extremis. Unexpected death after elective surgery. Preadmitted 03/05/2018 for Personal care of Mr A O'Brien Urology. Patient transferred to ICU CAH and died. Post Mortem to be carried out. Case with Litigation. — 31.7.18 Report being drafted 11/09/2018- as above 5.11.18 Report being drafted 15/01/2019 SAI Meeting arranged for 03/01/2019. No update. 16.1.19 Report being finalised 29/01/2019 Paula to check with Trudy if report has been approved. 8.2.19 report in draft, Trudy to discuss with Brigeen Kelly. Trudy got informaiton from Brigeen and has added to report, 11.2.19 Draft report shared with review team, some minor ammendments. Patricia to share report with the staff involved	TRU-02912 TRU-03560
28.09.2018	Case Manager Determination prepared by Dr Khan including brief on systemic issues	**Case Manager Determination to include systemic issues** *"I am satisfied that the concerns do not require a referral to the GMC at this time"* **Final Conclusion/Recommendation** *"This MHPS formal investigation focused on the administrative practice of Mr OB. 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 OB 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 OB. 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 OB.*	Doc File 3 Pages 346 – 356 AOB-01914 - AOB-01924

		In order for the Trust to understand fully the failings of this case, I recommend the Trust to carry out an independent review of the relevant administrative processes 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 wise problems to understand and learn from the findings."	
05.10.2018	Mr O'Brien's Clinical Report on complaint received by the Trust from Personal Information redacted by the USI	AOB provides report to the Trust in relation to complaint by Mr Personal Information redacted by the USI in relation to his discharge. **We do not have a copy of the complaint.**	Doc File 3 Pages 359 – 360 AOB-01927 - AOB-01928
16.10.2018	Email correspondence between Ms Clayton, Mr Carroll and Ms Corrigan	Email chain going back to 4 October. Martina Corrigan ongoing review of AOB's compliance. AOB leave that month 4 September, 17-21 September and study leave 10-12 September. In relation to triage 17 awaiting triage, 14 added today and 1 routine – 28 September and 2 routine Mr Young 27 and 28 September. 74 charts tracked to Mr O'Brien's office (**worth noting there was also reference to 37 charts tracked to Mr Young's office**) Suggestion that "*On checking today he has 91 letters outstanding dictation from 15 June 2018."* Private patients – no concerns. Wendy Clayton replies on 16 October noting 82 charts tracked out specifically to Mr O'Brien. Also notes that she will check the "*typing backlog report which will show clinic/results to be dictated, hopefully this will be through tomorrow."*	Doc File 3 Pages 361 – 365 AOB-01929 – AOB-01933
18.10.2018	Email correspondence between Ms Clayton, Mr Carroll, Mr Weir, Dr Khan, Mr Gibson, Mr Haynes and Ms Clayton	Email exchange between senior management team. Colin Weir, Clinical Director, saying "*I have NOT seen the review and results and recommendations into his practice, but I am assuming he is in breach of this given these findings."*	Doc File 3 Pages 375 – 400 AOB-01943 - AOB-01968
24.10.2018	Email correspondence between Mr Carroll and Dr Khan	Email chain in relation to compliance with return to work plan. Comments in email from Carroll to Khan "*Could I ask that the oversight committee write to Mr O'Brien reminding him of his obligations/responsibilities to comply with this AP and that it will be monitored."*	Doc File 3 Pages 415 – 418 AOB-01983 - AOB-01986
25.10.2018	Phone call between Mr O'Brien and NCAS	Page 10 section A – F Mr O'Brien: *"With absolute incredulity, you know that "I advantaged my own private patients" not nine cases of course. Not nine of course. But "at least nine cases". Even though they didn't do any comparative analysis whatsoever, but when I did one – did you know that initially I was told in writing that I had performed TURPs on nine patients who had previously been seen privately and they had been seen – they knew they had been seen privately*	Transcript File 18

		because I had their letters, their private letters, on ECR. I thought that was good practice. But when I did – when I had done 45 TURPs in 2016, nine of whom I had seen privately previously and 36 of whom I had not seen, they were NHS. And the mean waiting time for the NHS patients was 219 days and the mean waiting time for the private patients was 204 days. God, didn't really suit did it. So they went looking for more.. *It is – I am going to ask you one last question which I – do you know of anything in GMC Good Medical Practice, as I have read it many, many times over the years, that explicitly requires one to dictate a letter following every consultation?* *..* *NCAS – Not that – there's a requirement to record information about every patient.* *Mr O'Brien: Yes absolutely. I mean, I have always done that. I record. I make notes. But I am asking specifically. When we met for the case manager's determination and he give me a photocopy of Good Medical Practice, you know the failure to dictate as in – and I asked him where is it? He said it is in there. And I said, no, but show me where it is. No, it is in there. This is what you are deling with. I said it is not in there. It isn't.* *NCAS – No.*	
02.11.2018	Email correspondence between Mr O'Brien and Dr Khan	In this email chain on 23 October 2018 along with addressing issues in relation to Minutes of the Meeting of 30 December and 24 January, Mr Khan asks as follows: "*"Aidan, I take this opportunity to ask if you are adherent to agreed MHPS action plan (attached)?"* In his response of 2 November 2018 AOB notes that he will address that issue in a separate email in the coming days.	Doc File 3 Pages 425 – 428 AOB-01993 - AOB-01996
2018	Consultant Appraisal Complaints: 1.1.18 – 31.12.18	CONSULTANT APPRAISAL Complaints: 1.1.18 - 31.12.18 Mr A O'Brien NIL CONSULTANT APPRAISAL Incidents: 1.1.18 - 31.12.18 Mr A O'Brien Nil	2017 Appraisal page 383 AOB-23261
Jan	Referral form from Trust	In the referral to the GMC the Trust acknowledge in	Doc File 3

2019	to GMC undated but likely late January 2019	relation to the question of whether or not the Doctor raised their concern "*Has raised concerns throughout about waiting lists which are well recognised."*	Pages 550 – 559 AOB-02118 - AOB-02127
06.02. 2019	Email from Mr O'Brien to Ms McCaul	Re: Patients Awaiting Results Re consultants requesting bloods having to ensure they are DARO first pending the results. Mr O'Brien responds with his own concerns on this issue. Mr O'Brien requested that Ms McCaul considers withdrawing her directive as it has profound implications for the management of patients, and certainly until it has been discussed with clinicians.	TL4 page 289 – 290 AOB-07566 – AOB-07567
07.02. 2019	Email from Mr Haynes to Ms McCaul	Re: Patients awaiting results Mr Haynes disagrees with Mr O'Brien's concerns with the directive and confirmed that he did not think there was an issue with the described process.	TL4 page 294 – 296 AOB-07571 – AOB-07573
07.02. 2019	Email from Ms Robinson to Ms McCaul	Re: Patients awaiting results Ms Robinson backs up that this process was introduced by Dr Rankin many years ago but noted that Mr O'Brien's secretary does not use DARO and the fact that it has been raised with his secretary the concern with not implementing the DARO process fully.	TL4 page 297 – 300 AOB-07574 – AOB-07577
11.02. 2019	Email from Ms Kingsnorth to Mr O'Brien , Mr Glackin & Others	Re: Appendix 4 to SEA Final Draft [redacted] Date of incident [redacted] *[redacted] was admitted to Craigavon Area Hospital on [redacted] 2018 for elective urology surgery (cystoscopy, replacement of ureteric stents and bilateral ureterolysis). Following the procedure on [redacted] 2018 [redacted]'s condition deteriorated and he was admitted to the Intensive Care Unit in extremis. [redacted] suffered a cardiac arrest which was managed as per Adult Life Support guidelines. Following discussion with [redacted]s wife cardipulmoary resuscitation was stopped and [redacted] died on [redacted] 2018. [redacted] was discussed with the coroner and a post mortem was requested*	TL4 page 368 – 381 AOB-07645 – AOB-07658
March 2019	GMC Colleague & Patient Feedbacks & Reflective Templates March 2019	GMC Colleague & Patient Feedbacks & Reflective Templates March 2019 includes	2017 Appraisal page 352 & 353 AOB-23230 - AOB-23231

Participant: Dr Aidan O'Brien - GMC No: 1394911

Section 1: Overall Summary

This section of the report provides a summary of your overall ratings as viewed by you and your colleagues.

The self column for Q5 displays how you rated yourself. The scoring for the average column is as follows: Poor=1, Less than satisfactory=2, Satisfactory=3, Good=4, Very good=5.

The number below each column displays the number of colleagues who rated you in that area. Colleagues who answered 'Dont Know' are not included in the average.

	Poor	Less than Satisfactory	Satisfactory	Good	Very Good	Don't Know	Self	Colleague Average
1. Clinical Knowledge	0	0	0	0	17	0	Good	5
2. Diagnosis	0	0	0	0	17	0	Good	5
3. Clinical Decision Making	0	0	0	3	14	0	Good	4.82
4. Treatment (including practical procedures)	0	0	0	1	14	2	Good	4.93
5. Prescribing	0	0	0	0	12	5	Good	5
6. Medical record keeping	0	0	1	1	14	1	Good	4.81
7. Recognising and working within limitations	0	0	0	2	14	1	Good	4.88
8. Keeping knowledge and skills up to date	0	0	0	2	12	3	Satisfactory	4.86
9. Reviewing and reflecting on own performance	0	0	0	1	15	1	Satisfactory	4.94
10. Teaching (students, trainees, others)	0	0	0	3	8	6	Less than Satisfactory	4.73
11. Supervising colleagues	0	0	0	0	13	4	Good	5
12. Commitment to care and wellbeing of patients	0	0	0	0	16	1	Good	5
13. Communication with patients and relatives	0	0	0	0	14	3	Good	5
14. Working effectively with colleagues	0	0	0	1	16	0	Good	4.94
15. Effective time management	0	1	2	7	7	0	Satisfactory	4.18

		Participant: Dr Aidan O'Brien - GMC No: 1394911 Strongly Disagree / Disagree / Neutral / Agree / Strongly Agree / Don't Know / Self / Colleague Average 16. I am confident that this doctor respects patient confidentiality: 1 / 0 / 0 / 1 / 15 / 0 / Agree / 4.71 17. I am confident that this doctor is honest and trustworthy: 1 / 0 / 0 / 0 / 16 / 0 / Agree / 4.76 18. I am confident that this doctor's performance is not impaired by ill health: 1 / 0 / 0 / 0 / 14 / 2 / Agree / 4.73 No / Yes / Don't Know / Self 19. I am confident that this doctor is fit to practice medicine.: 0 / 16 / 1 / Yes	
08.03.2019	Email from Mr Haynes to Mr O'Brien	Re Mr Patient 110 complaint Requesting Mr O'Brien's input into complaint [No details of complaint have been provided]	TL4 page 626 AOB-07903
20.03.2019	Email from Ms Corrigan to Mr O'Brien	Re: no outcome Patient is on day 124 and is confirmed cancer (muscle invasive bladder). Was reviewed by mr O'Brien on 11th March but no outcome of clinic so no idea of what further management will be.	TL4 page 694 – 698 AOB-07971 – AOB-07975
31.03.2019	Email from Ms Corrigan to Mr O'Biren	RE: Uro Oncology Review Backlog until end of March 2019 Approx 173 patients on Mr O'Brien's list	TL4 page 858 – 862 AOB-08135 – AOB-08139
10.04.2019	Email from Ms Graham to Ms Corrigan and Mr O'Brien	RE; Outcome escalation Patient on day 82, attended clinic with Mr O'Brien on 20 March 2019 but no outcome can be found	TL4 page 946 – 947 AOB-08223 – AOB-08224
18.04.2019	Screening Template	Re: Personal information redacted Diagnosed with penile cancer, recommended by cancer MDM fro CT scan of chest, pelvis and abdomen to complete staging. Same delayed by 3 months	TRU-02889
21.06.2019	Email from Ms Corrigan to Mr O'Brien	Highlighting that 19 red flag referrals outstanding for triage from 17th June 2019	TL4 Page 1289 AOB-08566
16.07.2019	Mr O'Brien's Clinical Report on complaint received by the Trust re Personal Information redacted by the USI dated 16 July 2019 and documentation relating to complaint	This is a report from AOB responding to a complaint in relation to patient Personal Information redacted by the USI. The complaint is difficult to make out and understand. AOB considers that the complaint relates to an or overarching grievance in relation to the degree of support and assistance provided by the Southern Trust. Also note the impression that surgery carried out in 2012 was not adequate [**NB this**	Doc File 4 Pages 15 – 31 AOB-02176 - AOB-02192

		surgery was not carried out by AOB] In overall terms the complaint does not appear to relate to AOB.	
17.07.2019	Email from Ms Corrigan to Mr O'Brien	Re: Urology Escalation Patient is Day 82 and added to waiting list 8 January. Was suspended in May due to medical reasons. Note – Mr O'Brien responded to this to note that he had been trying to contact this patient 10-12 times but never got a response or answer to his phone calls. (TL4 page XX)	TL4 page 1577 - 1579 AOB-08854 – AOB-08856
17.07.2019	Email from Ms Corrigan to Mr O'Brien	Re: Urology Escalation Patient on day 146 awaiting date for cystoscopy.	TL4 page 1580 – 1583 AOB-08857 – AOB-08860
17.07.2019	Email from Ms Corrigan to Mr O'brien	Re: Urology Escalation Patient on day 43 of pathway and was seen n day 28 but no outcome available.	TL4 page 1584 – 1585 AOB-08861 – AOB-08862
17.07.2019	Email from Ms Corrigan to Mr O'Brien	Re Urology Escalation Patient on Day 79 of pathway. Was seen by Mr O'Brien and advised that may need MRI if PSA elevated but no MRI has been requested. Consultant advised further review appointment and repeat PSA. PSA repeated and remains elevated. No letter available on NIECR from 05 July 2019 and no MRI requested	TL4 page 1586 – 1588 AOB-08863 – AOB-08865
25.07.2019	Screening Template	Re: Patient 2 Patient diagnosed with a slow growing testicular cancer (Seminoma) had delayed referral to oncology and therefore delay in commencing chemotherapy	TRU-02890
05.08.2019	Email from Ms Corrigan to Mr O'Brien	Re: Review backlog 7 patients waiting on Mr O'Brien's backlog to be seen from 2016.	TL4 page 1730 – 1733 AOB-09006-09009
05.08.2019	Email from Ms Corrigan to Mr O'Brien	Re: Review backlog Another patient was added for SWAH so leaves 8 patients on Mr O'Brien's backlog	TL4 page 1734 – 1737 AOB-09010 – AOB-09013
06.08.2019	Email from Ms Elliot to Mr O'Brien	Re: Patient query Phoned to say he saw Mr O'Brien on 22 July 2019. No dictation on system. Patients aid Mr O'Brien was to bring him in for biopsies but has not received a date yet.	TL4 page 1742 AOB-09018

06.08.2019	Email from Ms Elliot to Mr O'Brien	Re: Patient query Patient's wife phoned. Patient attended SWAH 22 July 2019 and Mr O'Brien told them would bring patient in on 14th August but have not heard anything to confirm this. No dictation on system	TL4 page 1743 AOB-09019
13.08.2019	Email from Ms Dignam to Mr O'Brien	Re: Patient query Patient called re date for cystoscopy. Anxious to get a date but secretary advised that Mr O'brien's list is running slightly behind	TL4 page 1781 - 1782 AOB-09057 – AOB-09058
14.08.2019	Email from Ms Moore to Mr O'Brien	RE: Outcomes Patient was seen at clinic on 27 July 2019 but no outcomes have been put on system	TL4 page 1785 AOB-09061
28.08.2019	Screening Template	Re: Patient Patient 4 Diagnosed with high grade prostate cancer July 2019. MDM outcome "commence an LHRHa, arrange a CT Chest and bone scan and for subsequent MDM review" Seen in OP 20.08.19. commenced on 50mg Bicalutamide. Radiological investigations requested on 4/10/19 (6.5weeks after OP attendance). No subsequent MDM review. Admitted with local progression January 2020 requiring transurethral resection and ureteric stent/nephrostomy. During inpatient admission it was not recognised that he had not been started on an LHRHa and he subsequently started standard treatment for his locally advanced prostate cancer (Degeralex) February 2020.	TRU-02891
05.09.2019	Email from Ms Corrigan to Mr O'Brien	Re: Backlog report Advising Mr O'Brien that it will need to be addressed 25 discharges awaiting dictation (oldest date 27 June 2016) and 49 clinic letters to be dictated	TL4 Page 1917 AOB-09193
20.09.2019	Letter of complaint	Re: Patient 8 Has been waiting almost 5 years for urology procedure. Aware that Trust does not have enough capacity to see all patients on the waiting list and the cancer patients take precedence. However, patient has been waiting 5 years	TL4 page 2240 – 2249 AOB-09513 – AOB-09522
26.09.2019	Letter to Ms Donnelly GMC from SHSCT	The Trust report to the GMC on 26 September 2019 "*As of Monday 16 September 2019, the operational Head of Service has notified the MHPS Case Manager of a deviation from the action plan by Mr O'Brien. The scale of this deviation is currently being scoped and a meeting will be held with Mr O'Brien once the full extent of this deviation is known. Prior to this, Mr O'Brien has been working in line with the return to work action plan."*	Doc File 4 Pages 38 – 40 AOB-02199 - AOB-02201
27.09.2019	Email from Ms Corrigan to Mr O'Brien	Re Urology Escalation Patient on day 105 of pathway. Awaiting response from Mr O'Brien re Management for patient. Confirmed cancer so will be a breach.	TL4 page 2230 – 2232 AOB-09503

			– AOB-09505
06.10.2019	Email from Mr O'Brien to Ms McIlvenna	Mr O'Brien notes that he has been behind on dictation as his secretary has been behind in typing dictation. As a consequence, patient not placed on waiting list.	TL4 page 2317 AOB-09590
14.10.2019	Email correspondence between Ms Donnelly and Dr Khan	Joanne Donnelly reports on conversation with MOK as follows:- "*A new, related, concern has risen – the exception reporting system that is now in place to ensure there are no avoidable delays in follow up after appointments has highlighted that Dr O'Brien is still not completing admin on time – delays in dictation and, therefore, in making appropriate patient referral. Consideration is being given as to what action is required."*	Doc File 4 Page 42 AOB-02203
23.10.2019	Email from Ms Corrigan to Consultants	Re: Urology escalations Patient on day 157 and remains a suspect cancer patient. Was added to WL for RF TURP on 16th April but no date has been given. Patient has been escalated previously by Mr O'Brien did not give a date. Mr Corrigan requests for another consultant to try to provide a date	TL4 page 2426 – 2428 AOB-09699 – AOB-09701
23.10.2019	Email from Ms Corrigan to Mr O'Brien	Reminding Mr O'Brien that there are 15 red flags to be triaged from 17 October	TL4 page 2429 AOB-09702
28.10.2019	Email correspondence between Ms Connolly and Mr O'Brien dated 28 October 2019 enclosing SAI ([redacted]) re [redacted], [redacted] and [redacted])	Re SAI reports Ms Connolly invites AOB "*As you were involved in these cases I would be grateful if you could read over the reports and confirm their factual accuracy. If you identify any inaccuracies I would be grateful if you would please report these back to me by Wednesday 30/10/2019."*	Doc File 4 Pages 43 – 88 AOB-02204 - AOB-02249
31.10.2019	Screening Template	Re: Patient [redacted] Diagnosed with locally advanced prostate cancer August 2019. MDM 31st October 2019 recommended ADT and refer for EBRT. Not referred for EBRT and hormone treatment not as per guidance. March 2020 rising PSA and local progression (urinary retention). Re-staged Juned 2020 and developed metastatic disease	TRU-02884
31.10.2019	Screening Template	Re: Patient [redacted] Initial assessment May 2019. Clinically felt to have a malignant prostate. Commenced on Bicalutamide 50mg OD. TURP arranged (Benign pathology). Reviewed in outpatients in July 2019. Planned for repeat PSA and further review. Emergency Department attendance May 2020 resulting in catheterisation. Rectal mass investigation and diagnosed as locally advanced prostate cancer. Commenced on Hormone treatment July 2020 and staging investigations arranged.	TRU-02885
November 2019	Policy & Procedure for the Management of Litigation Claims	4.15 *"All Trust staff have a responsibility to adhere to the requirements of the Trust's Procedure for the Management of Claims. They must provide written, factual and comprehensive information when requested to do so within*	TRU-20983 – TRU-20994

		timescales set. Failure to co-operate with the management of claims process to provide necessary information when requested can affect the Trust's ability to properly and robustly defend claims and may be considered a disciplinary matter.	
04.11.2019	Email correspondence between Ms Evans, Mr Carroll, Ms Robinson, Ms Carroll, Ms Corrigan, Mr Tyson, Mr Glackin, Mr Haynes, Mr O'Brien, Mr O'Donoghue and Mr Young enclosing backlog report	Backlog Report for all consultants. AOB's figures appear to be out of step in terms of Discharges awaiting Dictation (35), oldest date 27.06.17 and Clinic letters to be dictated (45), oldest date 23.09.19.	Doc File 4 Pages 89 – 97 AOB-02250 - AOB-02258
06.11.2019	Email correspondence between Ms Corrigan and Mr O'Brien	An invitation to AOB to meet on 8 November in relation to deviations and return to work plan. Notes: 1. Triage – 26 paper referrals outstanding following on-call week on 16 September. 19 routine and 9 urgent referrals outstanding on Etriage. 2. Undictated clinics going back to 23 September. 3. Datix raised in relation to H&C No. Personal Information redacted by the USI re outcomes from MDM on 27 June 2019 not having been actioned. Notes AOB saw the patient on 16 August 2019 and "*only dictated the letter on 4 October 2019."*	Doc File 4 Pages 98 – 99 AOB-02259 - AOB-02260
05.11.2019	Email from Ms Corrigan to Mr O'Brien	Patient offered a date but was not available over summer months. Mr O'Brien has been emailed several times for an update on this patient and when likely to be seen but no response received	TL4 page 2550 – 2553 AOB-09821 – AOB-09824
07.11.2019	Letter to Ms Corrigan from Mr O'Brien	AOB contends that the original return to work plan expired in September 2018 and an updated plan as suggested by the Case Manager in his determination to be made with the input from NCAS was never completed. As such he cannot be considered to deviate from a Return to Work Plan which had expired.	Doc File 4 Pages 101 AOB-02262
07.11.2019	Email correspondence between Mr O'Brien and Ms Corrigan	AOB provides Ms Corrigan with a detailed analysis of the ongoing care of HCN Personal Information redacted by the USI in relation to steps taken following the previous MDM.	Doc File 4 Pages 102 – 104 AOB-02263 - AOB-02265
12.11.2019	Email correspondence between Ms Donnelly and Dr O'Kane	Medical Director confirms to Joanne Donnelly the following in relation to plans with the action plan:- 1. **Triage** "*Mr O'Brien had been meeting this expectation however in August and September the completion dates have*	Doc File 4 Pages 108 – 112 AOB-02269 - AOB-02273

		extended to Tuesday or Wednesday of the following week that he has finished his triage. As the waiting times to first appointments for urology are significant (recently was 67 days), this has not impacted on patient pathways, and so this minor deviation was not considered material." 2. **Clinical Dictation** *"Escalation occurred at the end August 19 when it appeared that dictations were not done and awaiting transcription. Following further investigation this matter was resolved and no action was necessary."* 3. **Keeping Patient Notes at Home** *"No patient notes have been tracked out to Mr O'Brien's home and no reports of notes being unavailable at the location they have been tracked to (e.g. Mr O'Brien's secretaries office), or instances of notes being unavailable as not found following a consultation with Mr O'Brien have been noted."* 4. **Private Practice** *"Mr O'Brien complies with the trust private practice policy regarding transfer from private care to NHS care and there have been no identified occasions where patients transferring from private care had their treatment expedited more patients of the same urgency from NHS clinics."*	
19.11.2019	Email correspondence between Mr O'Brien and Ms Connolly	This email chain includes an email from AOB of 30 October 2019 replying to the request for a report on the draft SAIs ([Patient 16] [Patient 11] [Patient 12], [Patient 13], [Patient 14] and [Patient 15]). His comments were requested within 24 hours. Notes in relation to Mr [Patient 16]'s SAI, that it had been 2½ years since he had been notified of it and he found it "*remarkable"* to be sent a draft investigation report with a deadline to respond within two days. The trust subsequently extended to 13 November and stated "*We are Anxious to have the reports ready for both the families and the Ombudsman."* On 19 November AOB forwards his comments on Report of SAI [Personal information]. He notes that he had not as yet had the opportunity to carry out a detailed review of SAI [Personal information]	Doc File 4 Pages 113 – 117 AOB-02274 - AOB-02278
19.11.2019	Email correspondence between Mr O'Brien and Ms Connolly	Mr O'Brien forwards to Ms Connolly email correspondence between Mr O'Brien and the patient [Patient 16]/family as per requested in above email chain. The emails AOB forwarded relate to 2016 correspondence	SUP 2 Pg 47 AOB-04300 – AOB-04306

<table>
<tr><td>22.11.2019</td><td>Email from Ms Corrigan to Mr O'Brien</td><td>Ms Corrigan explains that she was tasked with weekly monitoring of the four areas of the return to work plan and this was with the view to ensuring that Aidan did not get behind in his triage and dictation, as have an obligation to Aidan to ensure they support him to avoid the situation he was previously in.</td><td>TL4 page 2627 – 2674

AOB-09942 – AOB-09944</td></tr>
<tr><td>09.12.2019</td><td>Letter from Trust to patient</td><td>Trust's response to complaint – Personal Information redacted by the USI</td><td>SUPAUG</td></tr>
<tr><td>11.12.2019</td><td>Email correspondence between Mr O'Brien and Ms Connolly</td><td>AOB submits comments on RCA Report SAI Personal information</td><td>Doc File 4 Page 122

AOB-02283</td></tr>
<tr><td>11.12.2019</td><td>Mr O'Brien's comments concerning RCA report on Review of SAI Personal information</td><td>AOB comments on RCA SAI Personal information</td><td>Doc File 4 Pages 123 – 128

AOB-02284 - AOB-02289</td></tr>
<tr><td>2019</td><td></td><td>COMPLAINTS
Consultant Appraisal 1 January - 31 December 2019
Mr Aidan O'Brien

<table>
<tr><th>First received</th><th>Record name</th><th>Description</th><th>Outcome</th></tr>
<tr><td>20/05/2019</td><td>Personal</td><td>Partner of patient who had surgery and treatment for renal cell carcinoma in 2012 is concerned atthe lack of follow-up care provided by the Trust.</td><td>Detailed explanation of care provided to patient since 1999 including surgery performed and follow up. Advised that there was no evidence of recurrence or progression of renal carcinoma 2012 and that in 2013 patient failed to attend 2 review appointments. Further review planned for 2014 and patient failed to attend on 2 occasions in 2015. No evidence of recurrence or progression of disease in 2016. Further x-rays of left knee planned for 2016 but patient did not attend. Patient then attended in June 2017 and was referred to Orthopaedic Services. Ongoing care, including palliative radiotherapy, provided to date. Consultant confirmed that no cancer was left behind in the kidney following surgery in 2012 and explained that there still has been no evidence of carcinoma present in the right kidney as recently asJune 2019. Apology offered for lack of support/ counselling services. Meeting offered for clarity.</td></tr>
</table>

INCIDENTS</td><td>2017 Appraisal page 385</td></tr>
</table>

		Consultant Appraisal 1 January - 31 December 2019 **Mr Aidan O'Brien** **NIL**	
23.01.2020	Urology Cancer Business Meeting	Note: Mr O'Brien is not in attendance but no apologies made for him. a. *Urology red flag waiting times as of 14/01/2020* i. *Urology (Prostate) 101* ii. *Urology (Haematuria) 51* iii. *Urology (other) 51* iv. *The current demand is in excess of capacity. Other services have had significant investment to address waiting times (Breast). Urology is in a much worse position than any other speciality.*	TL2 page 163 – 167 AOB-04620 – AOB-04624
30.01.2020	Letter to Mr O'Brien from GMC	GMC writes to notify Mr O'Brien that they had received a complaint from Dr Maria O'Kane. Notes that they have opened it as a "*provisional enquiry*". Requests any comments AOB wishes to make by 13 February 2020.	Doc File 4 Pages 132 - 134 AOB-02293 - AOB-02295
03.02.2020	Letter to Mr Brammall (GMC) from Tughans	Letter from Tughans to GMC. AA puts Tughans on record for AOB. Requests all information the GMC has received.	Doc File 4 Page 135 AOB-02296
06.02.2020	Email from Ms Elliot to Mr O'Brien	Re: Dictation *"I have attached the last results letter dated 26/10/18 from* Personal Information redacted by the USI *and the subsequent report of Renogram reported on the 25/11/19. This has been with me (in the Reg's pigeon hole) awaiting dictation since then.* *I have been getting a lot of grief from management regarding the length of time it is taking for this to be actioned. I would be grateful if you would do a results letter and follow up required"*	TL2 page 234 AOB-04691
06.02.2020	Email correspondence between Ms Evans and Ms Elliot	Re: Backlog reports **Ms Evans –** *"I have some concerns with regards to the results sitting from 2018, previously they had stated 2019 or no date specified. It is crucial that this information is 100% accurate and the report completed in full before sending to us. This report goes to many levels of staff so it is essential it is correct. We expect 2 reports per month – a mid-month report and a month end report, it is a secretarial duty to complete and send…"* **Ms Elliot –** *"I have attached all the previous backlog reports which all have the same date (26/10/18). Therefor I am not sure which report you are referring to"* **Ms Evans –** *"Apologies, you did declare October 18 in those 2 previous reports, unfortunately you hadn't sent them to me so I wasn't aware. They have been recorded*	TL2 page 235 – 237 AOB-04692 – AOB-04694

		incorrectly from our end and for that I am sorry".	
14.02.2020	Email from Ms Elliot to Mr O'Brien	Re: Patient query following problems after discharge Re: issues after discharge from hospital. Query whether want to see patient or not.	TL2 page 276 – 277 AOB-04733 – AOB-04734
20.02.2020	Attendance note between Tughans and Mr Brammall (GMC)	AA notes to the GMC unlikely to make extensive comments pending disclosure from the GMC.	Doc File 4 Pages 168 – 169 AOB-02329 - AOB-02330
27.02.2020	Email from Ms Corrigan to Mr O'Brien	Re: Urology Outstanding Triage *There are a number of outstanding referrals on NIECR from Mr O'Brien's still to be triaged from 24/02/20 > 26/02/20. We also have not received back any of the paper referrals sent to TDU for grading from 20/02/20 >26/02/20 from Mr O'Brien*	TL2 page 337 – 338 AOB-04794 – AOB-04795
29.02.2020	Letter to Mr Brammall (GMC) from Dr O'Kane	Letter to Chris Bramall from Maria O'Kane in response to a request from GMC regarding patient safety concerns that the Doctor may have raised. The Trust indicate he had raised issues in relation to triage, review lists, capacity of his and other consultants and the length of waiting lists in the context of MHPS process but no documentation of him raising it previously. It notes that they had identified concerns Mr O'Brien prepared for a Departmental meeting on 24 September 2018 and attached as Appendix 1. In relation to state of the current action plan the Trust state:- "*Except for the deviation from the agreed process in September 2019 (which occurred during a period of family illness for Mr O'Brien), there have been no deviations reported by the staff monitoring his adherence to the current action plan. The current action plan is still monitored weekly."* In relation to an update on the MHPS process the Trust state that Mr O'Brien's concerns in relation to the MHPS process were being "*managed by the relevant review mechanism. In the interim the Trust has taken steps to triangulate information from service user complaints, adverse incidents, serious adverse incidents and other local feedback regarding Mr O'Brien to ensure any variations in clinical practice are identified in a timely manner. Following the conclusion of this review of Mr O'Brien's concerns, the formal process will resume, based upon the recommendations of the Case Managers determination."*	Doc File 4 Pages 174 – 176 AOB-02335 - AOB-02337

02.03.2020	Email correspondence between Tughans and Mr Brammall (GMC)	Tughans email to GMC indicating they would wait further information the GMC are collecting and *"provide any comments Mr O'Brien wishes to provide at that stage.*"	Doc File 4 Pages 177 – 179 AOB-02338 - AOB-02340
10.03.2020	Email correspondence between Mr O'Brien and Ms Corrigan	Re: Outstanding triage – proforma to be returned. Martina Corrigan queried for this to be returned as it was marked as missing. Mr O'Brien confirmed that he had in fact returned the paper referrals on Thursday 4th March 2020	TL2 page 477 AOB-04934
10.03.2020	Email from Mr O'Brien to Ms O'Neill	Re: Pateint Query Mr O'Brien had intended to review patient in Feb last year (2019). Requesting that Mr O'Brien keeps him in mind for review. Mr O'Brien confirmed that he had reviewed the patient by telephone and defered further review to October 2020	TL2 page 478 AOB-04935
12.03.2020	Email from Mr O'Brien to Mr Glackin	Re: Issue that not all clinicians are making a contemporaneous note in the chart when seeing patients at clinic. *"to the best of my knowledge, I have not failed to make a contemporaneous, and hopefully legible, note on every patient that I have met as an outpatient…. It is also worthy to note that there is no explicit, specific requirement by the GMC that a letter is dictated and sent following each outpatient consultation. Nevertheless, it has been my observation over many years that many clinicians have dictated letters instead of making such a note. It is a common observation is find nothing written beneath an outpatient stamp.."*	TL2 page 488 AOB-04945
13.03.2020	Email correspondence between Mr Brammall (GMC) and Tughans	GMC disclose information to Tughans received from the Trust.	Doc File 4 Pages 200 – 204 AOB-02361 - AOB-02364
02.04.2020	Email correspondence between Mr Brammall (GMC) and Tughans	Tughans email GMC to outline difficulties in obtaining instructions given the onset of the pandemic and detailed information forwarded by the GMC. Asks for further information from the GMC for him to take instructions on.	Doc File 4 Page 214 AOB-02375
29.04.2020	Email from Ms Corrigan to Mr O'Brien	Re: Enclosing waiting list. Ms Corrigan advises that all consultants should start prioritisng the waiting list. **Ins and day waiting list as of 29 April 2020** Approx 266 patients with longest waiting from 2014. **Planned patients**	TL2 page 863 – 869 AOB-05270 – AOB-05319

		Approx 67 patients with longest waiting from 2017	
29.04.2020	Email from Mr O'Brien to Ms Corrigan	Re: Ins and day list waiting list *"I have always kept my waiting lists update in terms of clinical priority. I have done so, altering clinical priorities in response to representations and queries from patients, GP, etc. That exercise has been more scrutinous since the emergence of the pandemic. At present, I have patients being rescanned (two next Monday), awaiting the results of other investigations , awaiting optimisation of diabetic control etc. As a consequence, the next 6 patients whom I would choose today may be very different form the 6 whom I would choose next week.* *Concerns re:* *1. Risk of being infected as a consequence of admission* *2. Would it be betetr to ensure that the most recent meaures have been effective in minimising that risk, before loweing the threshold of clinical priority for elective admission* *3. Should staff be tested whether or not symptomatic to additional ensure that admission wards are as covid free as will ever be humanely possible* *4. Can the threshold be lower for one specility before others* *I am happy to be selecting patients for admission, but the above are my thought snad concersn in relation to doing so.*	TL2 page 870 – 871 AOB-05327 – AOB-05328
22.05.2020	Root Cause Analysis report on the review of a Serious Adverse Incident (Identifier: Personal information redacted by the Urology Services Inquiry)	Root Cause Analysis Report (Personal information redacted by the Urology Services Inquiry. This is a Root Cause Analysis in relation to triage delay. It was signed off on "22 May 2020".	Doc File 4 Pages 257 – 281
29.05.2020	Email correspondence between Mr O'Brien and Ms Kingsnorth	Ms Kingsnorth forwards AOB a copy of RCA Personal information redacted by the Urology Services Inquiry indicating that the Chair had considered his comments and "*advised that this is the final report."*	Doc File 4 Page 294 AOB-02455
08.06.2020	Email from Ms Neville to Mr O'Brien	Re: Patients to be added to urgent bookable Mr O'Brien sent email asking for confirmation of receipt *"As I have experience difficulty in the past with personnel not receiving emails apparently sent, I would be grateful if you would confirm receipt of the below email and attachments sent last evening2*	TL2 page 1012 AOB-05469
The 01.07.2020	Email chain between Mr O'Brien and Ms Poland	RE: Secretarial Support *"I have been advised that my secretary, Noleen Elliot, is being moved to another post today. I write to advise you that the Trust has agreed to my continued employment until at least Tuesday 14 July 2020. I believe that it is inappropriate that Noleen's tenure as my secretary has been terminated today. I would be grateful if you would ensure that Noleen remain in her current post as my secretary until at least Tuesday 14 July 2020."*	TL2 page 1088 – 1089 AOB-05545 – AOB-05546

		Ms Poland response: *"The date we were given for your retirement was the end of June which was why we had made arrangements for Noleen to then move to breast from tomorrow. We need this move to happen and it's also in Noleen's best interest to be learning a new job with a new consultant asap, without delay. There will still be secretarial support provided by the rest of the team who have agreed to share the workload and we would hope that this would be sufficient for you. We will do everything in ourpower to ensure that all your work is sorted before you leave. I appreciate this is not ideal but are restirced in having to sort many different things."*	
07.07. 2020	Letter to Tughans from DLS	This letter outlines the DLS' position on behalf of the Trust in relation to why there were delays in moving the Grievance forward. Recent developments As explained, on 7th June 2020 at 22.25, your client sent an email which was copied to Mr Mark Haynes, Associate Medical Director of our client, in which he explained that he had added 10 patients to the Trust's list for urgent admission. On an initial review of the list of patients by Mr Haynes in his capacity as AMD, he noted that 2 of the patients were stated to have been listed on 11th September 2019 and 11th February 2020 requiring *"Removal/Replacement of Stent and Right Flexible Ureteroscopic Laser Lithotripsy"and "Removal/Replacement of Stent and Right Flexible Ureteroscopic Laser Lithotripsy"* respectively. It appeared to Mr Haynes that these patients had been assessed on the dates given by your client, but the outcomes of these assessments did not appear to have been actioned by him as required with the patients being added to the inpatient waiting list on the Trust's Patient Administration System. These patients therefore appeared on the face of it to fall outside the Trust's systems with all the potentially very serious clinical risks attendant on that. Since this has come to light, the Trust has been seeking as a matter of urgency to establish the position in relation to these 2 specific patients and also to clarify whether any other patients are similarly affected. The Trust's first priority is obviously to secure the safety of any affected patients and, in particular, to ensure they are included in Trust clinical systems so that they can receive appropriate treatment in line with clinical priority.	Doc File 4 Pages 351 – 354 AOB-02512 - AOB-02515
08.07. 2020	Email correspondence between Ms Donnelly and Dr O'Kane	Email correspondence between Ms Donnelly and Dr O'Kane	Doc File 4 Page 355 AOB-02516

From: Joanne Donnelly [Personal Information]
Sent: 08 July 2020 17:55
To: 'OKane, Maria' [Personal Information redacted by the USI]
Cc: Support TeamELS [Personal Information redacted by the USI]
Subject: FTP-monitor- SHSCT - Dr O'Brien (GMC No. 1394911) - new concerns (8.7.20)

Dear Maria,

Just to confirm our conversation earlier this afternoon re Dr O'Brien (GMC No. 1394911):

- **Cohort 1 (elective/emergency admissions, discharged to outpatients for further tests):** On Friday 7 June 20, Dr O'Brien sent an e-mail asking that 10 urology patients be booked onto a surgical list, as it is unusual for this number of patients to be booked onto the surgical list at the same time, the request was examined further. Ultimately, following a review of 334 elective/emergency admissions patients (who had been admitted to Craigavon Hospital, then discharged pending further outpatient tests/investigation) under the care of Dr O'Brien between Jan 19 to June 2020, it was found that 46% of these patients had experienced avoidable delay in their treatment as a result of Dr O'Brien not ordering/not following up on tests in a timely way. It seems that Dr O'Brien had a separate system for booking in patients that required follow up - with the effect that no one else in the Trust would have been aware of these patients. The Trust is investigating further to ascertain the extent of any patient harm/patient follow up required.
- **Cohort 2 (cases identified at MDMs):** Separately, two other separate concerns have arisen through discussion at Multi-Disciplinary Meetings on cancer patient pathways:
  - Patient A: [Personal] old patient presented in May 2020 with urinary retention. The consultant who saw him at that time discovered that the patient had been seen by Dr O'Brien on 31 Oct 19 at which time Dr O'Brien diagnosed prostate cancer and concluded that the patient need to be started on treatment, however Dr O'Brien did not complete the necessary follow up to ensure treatment took place. By the time the patient was seen in May 2020 the cancer had metastasized. There is to be a Trust SAI investigation.
  - Patient B: [Personal] old patient who presented in May 2020 with urinary retention. The consultant who saw him at that time discovered that the patient had been seen by Dr O'Brien in May 19 at which time Dr O'Brien diagnosed malignant prostate gland, with possible local advancement; Dr O'Brien commenced the patient on medication however Dr O'Brien did not complete the follow up to ensure that necessary further treatment took place. Further detail is awaited on the impact on the patient. There is to be a Trust SAI investigation.
- You are seeking advice from the Royal College on the parameters of a possible lookback/patient recall exercise in relation to Cohort 1 and 2.
- Dr O'Brien had been due to (medically) retire from the Trust on 30 June 20, however he is now asserting that he submitted his notice of retirement on the basis of assurances from the Trust that he would be able to return on a part-time basis, and that as this is not now being offered he is withdrawing his notice of retirement - and has started legal proceedings in this regard. The Trust is clear that Dr O'Brien was not offered part-time work post-retirement. The Trust had extended his contract to 18 July 20, to allow time to work out his pension entitlement; Dr O'Brien may however seek an injunction to prevent the Trust from ending his contract.
- Dr O'Brien's practice has been restricted - he is not permitted to undertake any clinical duties in the Trust- correspondence has gone to Dr O'Brien to this effect.
- An new MHPS investigation is to be commenced in relation to these news concerns; you will be seeking advice from June Turkington on the impact of any change in his employment status on the MHPS investigation.
- You are concerned about the possible risks to patient safety in respect of private patients that Dr O'Brien sees at his home. For this reason you are going to write to ask him to confirm in writing that, pending the conclusion of the MHPS investigation, he undertakes not to do any clinical work at all.
- You are also going to write to Dr O'Brien advising that you are discussing the new concerns with the GMC ELA.

If there is anything in the above summary that needs to be amended please do let me know.

As discussed, I will share this information with the GMC investigation officer that is dealing with the previous concerns in relation to Dr O'Brien, and they will contact you to obtain further information; they will need you to describe as clearly as possible, in a reasonable amount of detail, the nature of each of the new concerns.

I hope this is helpful.

If you need to discuss further please do not hesitate to contact me.

Kind regards

Joanne

Steam - FTP-monitor- SHSCT - Dr O'Brien (GMC No. 1394911) - new concerns (8.7.20)

09.07. 2020	Letter to Dr O'Kane from Dr Fitzpatrick	In this letter NHS Resolution include the following comment when referring to the previous disciplinary having stalled: "*Since taking over as medical director you had reviewed his case and become concerned at his apparent lack of insight. In particular you were concerned about the interface of his health service and private practice. You had referred these concerns to the GMC."* The letter continues Following this the AMD examined a number of patient records and found some matters of concern. The trust has now reviewed over 300 records of elective and emergency patients treated by this doctor and identified matters of concern in 46% of the records reviewed. The concerns included scan results which had not been acted on in a timely manner. You quoted timescales ranging from 2 to 41 weeks. There have also been two SAIs reported by the MDM involving delays in the treatment of cancer patients. The trust has a system of MDM trackers and it appears that this system has somehow been bypassed. You have conducted a preliminary enquiry with regard to elective and emergency patients and found matters of concern. You are now minded to conduct a similar exercise in respect of cancer patients and will commission this. This sits within MHPS as preliminary enquiries as defined in MHPS section I, paragraph 15. If the concerns are substantiated you may need to follow the guidance in section I, paragraph 28 – 30. In the meantime it is important to ensure patient safety and if the concerns were substantiated they would pose a significant risk to patient safety. The doctor is not currently seeing patients because of COVID-19 precautions. I therefore suggest that he is told that he must contact you before returning to treating patients with a view to determining whether restrictions should be put in place. You were concerned about his private patients and I suggested that he be instructed to voluntarily refrain from seeing private patients which you believe he has previously done at home. If it appears that he may leave your employment before these processes are complete, I suggest that you discuss the matter with the GMC ELA as the GMC are the only organisation who will have jurisdiction once he leaves your employment. Equally if he is reluctant to stop seeing private patients, you should inform the ELA. If the patient numbers indicated by your initial survey of 300 cases are supported by further investigation, this has the potential to cause significant public concern. I therefore suggest that you alert the Department of Health.	Doc File 4 Pages 358 – 360 AOB-02519 - AOB-02521
10.07. 2020	Attendance note between Tughans and Mr Brammall (GMC)	AA advises GMC of understanding that the Trust were investigating further matters and that we cannot provide a response in a meaningful way without knowing whether issues are to be raised and, if so, what they are.	Doc File 4 Pages 368 – 369 AOB-02529 - AOB-02530
10.07. 2020	Email correspondence between NCAS and Dr O'Kane	Maria, Thank you for your telephone call earlier today. You called to correct some matters which I appear to have misunderstood from our previous telephone call. You pointed out that the grievance process quoted in my letter is not complete and the outcome therefore not known.	SUP Page 119 - 121

		You pointed out that Dr 18665 had emailed asking that patients could be put on a bookable list. The AMD had noted some discrepancies and investigated further. You pointed out that the situation regarding the MDM trackers is quite unclear at present. I would be grateful if you could let me know if I have now established the correct position. I should point that these corrections do not alter my advice on management of the issues.!	
11.07.2020	Email correspondence between Dr O'Kane and Mr Fitzpatrick	Dr O'Kane indicates that the two incidents noted by the MDM have been submitted for screening to ascertain if they meet the threshold for SAI.	Doc File 4 Pages 370 – 372 AOB-02531 - AOB-02533
11.07.2020	Letter to Mr O'Brien from Mr Haynes with enclosure of Summary of Concerns	I am writing to advise you of a number of concerns that have arisen in respect of your practice as a Consultant Urologist. On 7th June 2020 at 22.25, you sent an email which was copied to me, in which you explained that you had added 10 patients to the Trust's list for urgent admission. On my initial review of the list of patients in my capacity as AMD, I noted that 2 of the patients were stated to have been listed on 11th September 2019 and 11th February 2020, both requiring *"Removal/Replacement of Stent and Right Flexible Ureteroscopic Laser Lithotripsy"*. It appeared to me that these patients had been assessed on the dates given by you, but the outcomes of these assessments did not appear to have been actioned by you as required with the patients being added to the inpatient waiting list on the Trust's Patient Administration System. These patients therefore appeared on the face of it to fall outside the Trust's systems with all the potentially very serious clinical risks attendant on that. Since this has come to light, the Trust has been seeking as a matter of urgency to establish the position in relation to these 2 specific patients and also to clarify whether any other patients are similarly affected. A review of records back to January 2019 has been undertaken. At this stage, I enclose a summary of the concerns following initial review of patient records dating back to January 2019.	Doc File 4 Pages 373 – 375 AOB-02534 - AOB-02536

		In line with MHPS Section I paragraph 18, and following advice from NHS Resolution, the Medical Director and I have considered any necessary restrictions. We believe, that given our level of concern at this stage of preliminary enquiries, that it is necessary to put in place the following restrictions with immediate effect: **1. That you are no longer to undertake clinical work.** **2. That you do not access or process patient information either in person or through others either in hard copy or electronically.** I would invite you to consider the underlying principle in Section II paragraph 22, and request that you voluntarily undertake to refrain from seeing any private patients at your home or any other setting. I would request confirmation of this undertaking, by return, via email. **Mr A O'Brien – Summary of Concerns** **1. Details of the concerns that have arisen and when these were identified** **Concern 1 – Patients Identified with Unnecessary Delays regarding Referrals for Treatment** In an email dated 7th June 2020, Mr O'Brien put forward a list of 10 patients for admission. There was concern that 2 appeared not to have been added to the inpatient waiting list on the Trust's Patient Administration System (PAS). This raised a concern of a risk of patients being lost with an expectation that they were awaiting surgical treatment but not actually being on the inpatient waiting list on PAS, and the attendant risks of delayed treatment, in particular in regard to stented patients. **Concern 2 – Lookback regarding Emergency and Elective Surgery Activity** Due to the potential patient safety concerns associated with these possible delays the Trust conducted a lookback exercise considering Mr O'Brien's theatre activity for both Emergency and Elective care delivered between 1st January 2019 – 31st May 2020. • The Emergency care lookback found that during this time Mr O'Brien operated on 147 patients, there were 32 instances where concerns were identified with a further 14 instances highlighting issues which were subsequently corrected. • The Elective care lookback found that during this time Mr O'Brien operated on 334 patients and out of these, 120 patients were found to have undergone delays in dictation of their discharge with a further 36 patients having no record of their discharge on the Trust electronic care record (NIECR). **Concern 3 – Identification of Potential Serious Adverse Incidents** To date two potential serious adverse incidents have been identified that relate to possible deficiencies in care provided by Mr O'Brien. • Personal Information old Male Prostate Cancer – Potential issues regarding timely management. Patient subsequently developed local progression of disease (retention) necessitating catheterization and subsequent TURP. Re-staged and now metastatic.	Doc File 4 Pages 376 – 379 AOB-02537 - AOB-02540

- Personal Information old Male Prostate Cancer – Potential issues regarding diagnosis and timely management. Patient subsequently presented with complications of local progression and may have metastatic disease.

Supporting evidence in connection with these concerns

Lookback on Emergency Care Provided (1st January 2019 – 31st May 2020) - this lookback concentrated on whether the patients had a stent inserted during procedure and if this had been removed

There were 147 emergencies taken to theatre that was listed as being under the care of Mr O'Brien during the lookback period, the following table illustrates the breakdown of the findings.

No Concerns Identified (101 Patients)	• **60 patients** NOT requiring a stent in their procedure • **41 patients** who'd had their stent removed
Patient treatment complete but issues highlighted (14 Patients)	• **13 patients** were not added to the waiting lists when they should have and were mostly done a few days before Mr O'Brien had the patients admitted • **1 patient** readmitted as emergency and had their stent removed under different consultant, there appeared to be no plan to admit them by Mr O'Brien. The patient had been waiting 7 months
Concerns and or follow-up issues identified (32 Patients)	• **11 patients** who have been readmitted but we were unable to determine if they had stent removed as there is no letter dictated on NIECR. However, all 11 notes were requested and there is a record written in the notes showing that the stents have been removed. • **9 patients** will need to be followed up due to only having had their stent inserted and require a future date for removal of stent • **6 patients** that appear to have been electively treated on an emergency list • **6 patients** who had a delay and were added late to the Patient Administration System (PAS) but have since been seen

Lookback on Elective Care Provided (1st January 2019 – 31st May 2020)

There were 334 elective-in patients reviewed during the period 1 January 2019 until end of May 2020. Of these records 120 (36%) of cases were found to have experienced a delay in dictation ranging from 2 weeks to 41 weeks, the following table illustrates the breakdown of the findings.

No Concerns Identified (48 patients)	• **48 patients** who experienced delayed dictation had no concerns identified with their care
Delayed Dictation (72 patients)	• **1 patient** outside planned follow up timescale due to not being added to the outpatient waiting list – no one was aware an appointment was required • **5 patients** have concerns flagged that require clinical review • **28 patients** delayed being placed on review backlog between 1-3mths (past due appointment date) • **15 patients** waiting on procedure – appointments not made – past due appointment date • **8 patients** - needed notes to determine plan whilst there was an entry there was no detail as to what was next required (on review of notes – no concerns identified) • **15 patients** records it was difficult to determine plan e.g. *'needs to be followed up'*

In addition, 36 patients had no record of their admission on the NIECR system.

No record of their admission on NIECR (36 patients)	• **4 patients** require a clinical opinion regarding their follow-up • **1 patient** had been followed up due to an emergency admission (record and letter from this episode on system). • **8 patients** needed notes to determine plan (no concerns identified from note review) • **7 patients** a plan was found through having to do an investigation of several electronic systems (NIECR/PAS/Sectra) • **3 patients** are on waiting list for procedure past their due date – added at time of discharge by ward clerk • **13 patients** are on a review outpatient list and are over their date to be seen (in keeping with outpatient review backlog) - added at time of discharge by ward clerk

Identification of Potential Serious Adverse Incidents

Details of the two potential serious adverse incidents are detailed below.

Service User A (Male / Personal years)	The Trust Surgical Multidisciplinary Meeting (MDM) 31/10/20 note discussing Service User A states *'Review with Mr O'Brien as arranged. Service User A has intermediate risk prostate cancer to start ADT and refer for ERBT.'* Service User A was commenced on bicalutamide 50mg , was then increased to 100mg and subsequently 150mg. Service User A was not referred to oncology and subsequently developed local progression of disease (retention) necessitating catheterization and subsequent TURP. Re-staged and now metastatic. **Concerns** • MDM outcome not enacted and consequently management was outside of MDT Guidance. • Patient developed local progression and metastatic disease.
Service User B (Male / Personal years)	Service User B was referred for urinary retention May 2019, abnormal prostate examination *'... it was certainly my impression that Service User B had a malignant prostate gland, and that indeed it may have been locally advanced.'*. Service User B commenced on bicalutamide 50mg and TURP. TURP pathology benign. Planned for review (which did not happen due to outpatient review backlog). Service User B re-presented May 2020 with urinary retention and now locally advanced (T4) prostate cancer with enlarged pelvic nodes, full staging not yet completed. Biopsies have shown prostate cancer. **Concerns** • Apparent delay in definitive diagnosis despite clinical suspicion of malignancy. • Service User B subsequently presented with complications of local progression and possible metastatic disease.

14.07.2020	Letter to Mr Brammall (GMC) from Dr O'Kane	Southern Health and Social Care Trust *Quality Care - for you, with you* 14th July 2020 Ref: MOK/ec **Via email** Personal Information redacted by the USI Chris Brammall Investigation Officer General Medical Council 3 Hardman Street, Manchester Dear Mr Brammall, **RE: GENERAL MEDICAL COUNCIL - MR AIDAN O'BRIEN GMC NO. 1394911** Further to your email dated 8th July 2020 requesting further information regarding concerns raised in relation to Mr Aidan O'Brien, Consultant Urologist employed by the Southern Health and Social Care Trust, please see below itemised responses. **1. Details of the new concerns that have arisen and when these were identified** **Concern 1 – Patients Identified with Unnecessary Delays regarding Referrals for Treatment** In an email dated 7th June 2020, Mr O'Brien put forward a list of 10 patients for admission. There was concern that 2 appeared not to have been added to the inpatient waiting list on the Trust's Patient Administration System (PAS). This raised a concern of a risk of patients being lost with an expectation that they were awaiting surgical treatment but not actually being on the inpatient waiting list on PAS, and the attendant risks of delayed treatment, in particular in regard to stented patients.	Doc File 4 Pages 384 – 389 AOB-02545 - AOB-02550

Concern 2 – Lookback regarding Emergency and Elective Surgery Activity

Due to the potential patient safety concerns associated with these possible delays the Trust conducted a lookback exercise considering Mr O'Brien's theatre activity for both Emergency and Elective care delivered between 1st January 2019 – 31st May 2020.

- The Emergency care lookback found that during this time Mr O'Brien operated on 147 patients, there were 32 instances where concerns were identified with a further 14 instances highlighting issues which were subsequently corrected.
- The Elective care lookback found that during this time Mr O'Brien operated on 334 patients and out of these, 120 patients were found to have undergone delays in dictation of their discharge with a further 36 patients having no record of their discharge on the Trust electronic care record (NIECR).

Concern 3 – Identification of Potential Serious Adverse Incidents

To date two potential serious adverse incidents have been identified that relate to possible deficiencies in care provided by Mr O'Brien.

- Personal Information old Male Prostate Cancer – Potential issues regarding timely management. Patient subsequently developed local progression of disease (retention) necessitating catheterization and subsequent TURP. Re-staged and now metastatic.
- Personal Information old Male Prostate Cancer – Potential issues regarding diagnosis and timely management. Patient subsequently presented with complications of local progression and may have metastatic disease.

2. Any supporting evidence that you hold in connection with these concerns

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Concerns and or follow-up issues Identified (32 Patients)	• **11 patients** who have been readmitted but we were unable to determine if they had stent removed as there is no letter dictated on NIECR. However, all 11 notes were requested and there is a record written in the notes showing that the stents have been removed. • **9 patients** will need to be followed up due to only having had their stent inserted and require a future date for removal of stent • **6 patients** that appear to have been electively treated on an emergency list • **6 patients** who had a delay and were added late to the Patient Administration System (PAS) but have since been seen

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		3. Copies of any correspondence that you have sent to, or received from, Mr O'Brien including any correspondence about the new concerns / restrictions on his clinical practice As these issues have been brought to Trust attention recently a communication regarding these new concerns has been conveyed to Mr O'Brien on Saturday 11th July 2020. Copy of letter enclosed. **4. Any other information that you feel will be useful for us to have when assessing these concerns.** Additional information on cases is being collated and reviewed and if deemed required, can be provided in due course. This case has been discussed with NHS Resolutions who have recommended restrictions of clinical practice including a request to Mr O'Brien not to undertake private practice in his own home or other premises pending further exploration (attached). A preliminary discussion has also been undertaken with the Royal College of Surgeons Invited Review Service. I trust this provides the necessary detail required. Should you have any queries, please do not hesitate to contact me. Yours sincerely Personal Information redacted by the USI **Dr Maria O'Kane** **Medical Director**	
16.07.2020	Email correspondence between Tughans and Ms Toal	Mr O'Brien cannot comment on the broad ranging allegations contained in the document entitled "Summary of Concerns" without the underlying data upon which that document is based. It is inappropriate and unfair to ask him to do so, given the numerous patients that are referred to, yet not a single piece of supporting documentation has been provided. In any event having received correspondence on a Sunday, prior to bank holidays, allows him less than three working days to obtain advice. Such advice cannot meaningfully be obtained in the absence of underlying documentation and in the absence of the underlying documentation relied upon and in such an unreasonable timescale. Mr O'Brien notes the restrictions which have been imposed as outlined in Mr Haynes' letter. It is however concerning that such restrictions were imposed on Mr O'Brien in the absence of any opportunity for him to comment on the allegations that have been raised. Mr O'Brien has not seen private patients since the early days of the pandemic, due to the obvious risk of importing the Corona virus to his home. As a consequence, he had already decided not to resume private practice. Therefore, he has no difficulty in undertaking to refrain from seeing any private patients at his home or any other setting.	Doc File 4 Pages 392 – 393 AOB-02553 - AOB-02554
21.07.2020	Email correspondence between Mr Wallace to Mr Brammall (GMC) dated 21 July 2020	Trust confirm that the review of administrative processes as recommended by Dr Khan "*has not yet been completed, this is scheduled for conclusion by September 2020"* The Trust confirm that Mr O'Brien's employment had ceased as at 17 July 2020.	Doc File 4 Page 396 AOB-02557
22.07.2020	SHSCT Governance Team (IR2) Form reference Personal information		Doc File 4 Pages 397 – 399 AOB-02558 - AOB-02560

23.07. 2020	Mr O'Brien's Addendum to Formal Grievance dated 23 July 2020 [see separate copy of the grievance and appendices]	4. Duty of Clinical Care Update In the Grievance submitted in November 2018, I included my concerns with regard to the Trust's duty of clinical care to urological patients, and the perverse, negative impact that the Investigation had upon that duty of care. In doing so, I had indicated that the delayed triage of patients subsequently found to have malignancies would have been entirely avoided had the Trust approached their concerns in a collaborative manner, as obliged by its own policy and advised by NCAS. Scheduled reviews of patients during the early months of 2017 were cancelled due to the Trust's insistence that an Investigation be conducted. As a consequence, patients known to have malignancy suffered disease progression due to further delay in their review. Meanwhile, at that time, there were almost 600 patients awaiting admission for urgent surgery, up to a maximum of four years, while only 28 patients were waiting a maximum of 11 weeks for urgent gynaecological surgery. Two years later, only 21.9% of urological cancer referrals throughout Northern Ireland have their first definitive treatment within 62 days. There were 7,887 patients awaiting admission for surgery throughout Northern Ireland at the end of March 2020. Of these, 1,700 were patients of the Southern Health & Social Care Trust, and of these, 935 were waiting for more than one year. There are currently 352 patients awaiting admission under my care. Of these, 252 patients are awaiting admission for urgent surgery, dating back to August 2014. In the Grievance of November 2018, I referred to the incidence of prostatic carcinoma found on endoscopic resection of the prostate gland. The incidence has been reported to vary widely from 1.4% at a single, tertiary referral centre in New York, to 13.4% in men aged up years and 28.7% in men aged over 65 years, in a multicentre study in Melbourne. Ha reviewed the literature, there is no reference at all to the relationship between the leng time awaiting admission for surgery, and the incidence of carcinoma, probably an indic of how unique the length of times our patients await admission. Currently, as of July 2020, some 650 patients await admission to our department for pros resection. By August 2020, some of those patients will have been on waiting lists fo years, and some will have been waiting over four years with indwelling urethral cathe with the attendant uroseptic risks. There are currently 153 patients awaiting admissio prostatic resection under my care. Of these, 44 (29%) are aged up to 65 years, and 109 over 65 years. By extrapolation, the majority (71%) of those awaiting admission to department are aged over 65 years. Therefore, up to 25 patients aged up to 65 years, and u 132 of those aged over 65 years, will be found to have prostatic carcinoma, if they eve get admitted. These numbers of delayed diagnoses of prostatic carcinoma are of a magnit which dwarfs that arising from any of the concerns subject to investigation from 201 2018. I note that an Personal Information old man was placed on my waiting list in July 2017 for urg admission for prostatic resection. There was no suspicion of prostatic carcinoma in 2 when he had a serum PSA of 6ng/ml. He has recently been referred with a serum PSA 380ng/ml, an indication of advanced, metastatic disease. If he had been admitted earlier, would probably have had his carcinoma diagnosed at an earlier stage, and very possibly curable stage. Yet, this man will not be the subject of any SAI, or precipitate any investigation. Rather, i worthy of note that he had recently received a 'revalidation letter' from the Trust enquir whether he still wanted to be admitted. Even though my colleagues and I have been assu on a number of occasions that the Trust will no longer do so, patients are still been asked administrative staff whether they still want to be admitted, and without any clinical input the patients' response. By 17 July 2020 I had 25 patients awaiting new clinic appointments at my clinic at Craigav Area Hospital, and 434 patients awaiting new clinic appointments at my clinic at South We Acute Hospital in Enniskillen, dating as far back as February 2015. There is a total of 5 patients awaiting oncological and general urological review at my clinics at Craigavon Ar Hospital, dating back to February 2017, another 110 awaiting review at my clinic at Armag Community Hospital dating back to December 2015 and a total of 365 patients awaiti review at my clinic in Enniskillen, dating back to December 2017. The totality of this outstanding urological need, and the attendant risks to patients, is direct and largely a consequence of the inadequacy of the service provided by the Trust. Th magnitude of the risk to patients far exceeds any potential harm that arose from any of th concerns subjected to investigation in 2016 to 2018. Indeed, as indicated above, th investigation further exacerbated that risk. The greatest risk posed to urological patients is b the Trust itself. After 28 years of dedicated service, I am at a loss to understand whether th Trust lacks insight into the abdication of its responsibility, or is entirely insightful an indulges in transference of its responsibility to the individual clinician instead, seemingl with the intent of absolving itself of its institutionalised neglect.	Doc File 4 Pages 400 – 411 AOB-02561 - AOB-02572
28.07. 2020	Email correspondence between Dr O'Kane, Mr	Dr O'Kane indicates "*I met with the RCS IRS earlier today to explore the extent of any lookback".* RCS to	Doc File 5 Page 8

	Brammall (GMC), Mr Wallace and Ms Donnelly	consider and get back to the Trust.	AOB-02580
28.07.2020	Screening Template	Re Patient Patient 5 Follow up CT scan performed on 17/12/19, reported on 11th January 2020. Reported "Possible sclerotic metastasis in L1 vertebral body. Result not actioned. Patient contacted with result 28/07/20 and further assessment requested	TRU-02886
30.07.2020	SHSCT Governance Team (IR2) Form Personal information redacted by	Further datix dated 30 July 2020. Very poor copy – impossible to read.	Doc File 5 Pages 18 – 19 AOB-02590 - AOB-02591
31.07.2020	Letter to Mr Brammall (GMC) from Mr O'Brien	Letter from AOB to GMC confirming he is not in employment or seeking employment and has undertaken not to resume private practice.	Doc File 5 Page 42 AOB-02614
31.07.2020	Email correspondence between Tughans between Mr Brammall (GMC)	Tughans confirm that they are intending to provide comments to the GMC on context with Mr O'Brien's working environment at the Trust but cannot provide comments on the clinical cases due to lack of underlying data. Requests confirmation from the GMC that any comments we make at this stage will be provided to the expert "*in order that the expert may also view the cases in context*." Chris Brammall replies indicating that "*this is not something that is likely to be provided to the expert."*	Doc File 5 Page 49 AOB-02621
03.08.2020	SHSCT Governance Team (IR2) Form Personal information redacted by	Further datix of 3 August 2020. Difficult to read.	Doc File 5 Pages 54 – 56 AOB-02626 - AOB-02628
03.08.2020	Email correspondence between Tughans and Ms Hynds	Tughans indicate that they will need to consider and advise Mr O'Brien on whether the Trust can continue with an MHPS process when Mr O'Brien is no longer employed.	Doc File 5 Page 57 AOB-02629
10.08.2020	Screening Template	Re: Patient Patient 8 Patient underwent TURP on 29/1/20. Pathology reported incidental prostate cancer. No follow up or action from pathology result until brought to my attention. Outpatient review arranged on 11/8/20	TRU-02888

17.08. 2020	Letter to Mr Brammall (GMC) from Dr O'Kane	Southern Health and Social Care Trust *Quality Care - for you, with you* 17th August 2020 Ref: MOK/ec **Via email** Personal Information redacted by the USI Chris Brammall Investigation Officer General Medical Council 3 Hardman Street, Manchester Dear Mr Brammall, **RE: GENERAL MEDICAL COUNCIL - MR AIDAN O'BRIEN GMC NO. 1394911** Further to your email dated 30th July 2020 requesting further information regarding concerns raised in relation to Mr Aidan O'Brien, Consultant Urologist employed by the Southern Health and Social Care Trust, please see below itemised responses and where required, attached items.	Doc File 5 Pages 67 – 70 AOB-02639 - AOB-02642

A copy of Mr O'Brien's job plan	Copies of the last two electronic job plans that are held in our job planning system for Mr O'Brien are attached in Appendix 1. Please note that they were not signed off by Mr O'Brien. These were previously sent to the GMC in response to this communication by Zoe Parks on 30th July 2020.
Any update that you may have about contacting the RCS for advice on the parameters of a possible lookback / patient recall exercise and information that may have arisen out of any review	The Trust has hosted a discussion with the Royal College Surgeons Invited Review Service on the 28th July 2020 which explored the options for and extent of any potential lookback should this be required. A follow up call was conducted on 4th August with the Royal College of Surgeons Head of Invited Review manager where potential scale and scope of a lookback was discussed. The Trust will be discussing the potential for progressing with any lookback with the Department of Health over the next week.
An update about the new MHPS investigation that was being considered due to the additional concerns about Mr O'Brien that arose recently	The Trust has commenced preliminary enquiries in respect of the additional concerns which have now arisen under the MHPS Framework. Mr O'Brien's former clinical manager Mr Haynes, as Associate Medical Director, is the clinical manager co-ordinating preliminary enquiries under para 15 of Section I of MHPS. Mr O'Brien has been notified of this and a request has been made for his input to the preliminary enquiries process. A formal investigation has not been commenced at this point. Mr O'Brien is seeking advices in respect of his engagement in the MHPS preliminary enquires process and the Trust awaits his decision in this regard, via his solicitor.
Any updates concerning the SAI reviews for the following patients identified in the information originally sent to the GMC (if SAIs have been completed, please could you provide copies of these?): • Patien Pati • Pati • Patie • Pati Personal Information redacted by the USI	The Serious Adverse Incident Reviews for the listed patients have been completed. Copies of the review which was provided in a consolidated single report can be found attached in Appendix 2.

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Email: Personal Information redacted by

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Email: Personal Information redacted by the

		Any updates concerning the SAI reviews for service user A and service user B as identified in the new concerns that were recently sent to the GMC	Both Service User A and B have been screened and meets the requirement for a Serious Adverse Incident review and are being progressed as per regional and Trust processes. Since our last update a third case, Service User C has also been identified as meeting the requirement for a Serious Adverse Incident review.
		Any data that you may hold for comparison purposes regarding the triage process and Mr O'Brien's peers (for example, any audit data / data gathered in relation to other urology consultants) in relation to patients who may have been mis-triaged	The Trust does not have formal data on the triage comparison between Mr O'Brien and his peers. All incidents have been identified by exception; no other triaging related incidents have been identified with any other Urology Consultant.
		The outcome (or a copy of) the independent review into the administrative procedures that is due to be concluded by September 2020 (when this becomes available)	The review of administrative procedures is underway and will be shared following completion in September 2020 at which point a copy will be shared with the GMC.
		Any guidance or protocols that were put in place for the urology department in terms of triaging incoming referrals using the three tier system and how this was shared with the urology consultants including Mr O'Brien	The Trust do not use the three tier system for triaging but follow the Northern Ireland Cancer Network (NICaN) referral guidance, which is based on NICE guidelines. Appendix 3 show the prostate and bladder guidance for triage (which is usually updated every year) and which is shared and used by all urology consultants in Northern Ireland.
		The relevant medical records for service user A and service user B as identified in the more recent concerns.	Copies of Service Users A and B redacted notes are attached as Appendix 4.
		The relevant medical records for the following patients as identified in the concerns originally sent to the GMC. • Patient 10 Personal Information redacted by the USI • Patient 14 • Patient 11 • Patient 13 • Patient 12	Copies of the patient will not be available until 24th August 2020 and will be forwarded following this.
		Please could you provide details of the circumstances of the cancellation of the meeting in September 2018 and the lack of senior management availability in December 2018 including details of any plans that were put in place for Mr O'Brien / other consultants to raise their concerns to senior management	The meeting that was scheduled to take place between Urology Consultants and management in September 2018 was cancelled following the unexpected sickness absence of the Head of Service for Surgery. The Consultant body agreed that in the absence of the head of service the meeting should not progress. The meeting scheduled for December 2018 did not progress as 3 of the 6 Consultant Urology staff were unable to attend.

I trust this provides the necessary detail required. Should you have any queries, please do not hesitate to contact me.

Yours sincerely

Personal information redacted by USI

Dr Maria O'Kane
Medical Director

24.08.2020	Email correspondence between Ms Donnelly and Dr O'Kane	Notes the Royal College have advised a 5 year look back/recall of Dr O'Brien's patients (potentially over 1000 patients) and that the DOH are to consider the Royal College's advice.	Doc File 5 Page 73 AOB-02645

25.08.2020	Email correspondence between Mr Wallace, Mr Brammall, Ms Donnelly and Dr O'Kane	Trust forward records for SUA and SUB (having previously forwarded the incorrect copies to both the GMC and Tughans).	Doc File 5 Page 76 AOB-02648
03.09.2020	Screening Template	Re Patient [redacted] CT renal report on 13/11/2019 unsigned on NIECR. No record of action taken recorded in NIECR. Case identified at urology MDM of 3/9/2020 following review of backlog undertaken by Locum Consultant Urologist	TRU-02887
09.09.2020	SHSCT Governance Team (IR2) Form [redacted]	SHSCT Governance Team (IR2) Form [redacted] Poor copy – need better copy.	Doc File 5 Pages 100 – 102 AOB-02672 - AOB-02674
11.09.2020	SHSCT Governance Team (IR2) Form [redacted]	Further IR2 Form. Again poor copy – need better copy.	Doc File 5 Pages 114 – 116 AOB-02686 - AOB-02688
06.10.2020	SHSCT Governance Team (IR2) Form [redacted]	SHSCT Governance Team (IR2) Form 125819. Further datix form completed. Again illegible copy.	Doc File 5 Pages 165 – 167 AOB-02737 - AOB-02739
06.10.2020	Screening Template	Re: Patient [redacted] Commenced on low dose (subtherapeutic) dose of bicalutamide for prostate cancer. Subsequently increased to full dose of bicalutamide but in the setting of localized disease not licensed and outside of guidelines. No documentary evidence of discussion of radical treatment for prostate cancer (as per MDM recommendation). Concerns: 1. Full discussion of MDM treatment recommendations not held with patient 2. Patient commenced on sub-therapeutic dose of treatment and concern this low dose long term may have an adverse impact on disease outcome 3. Patient commenced on bicalutamide monotherapy for localized prostate cancer which is outside of guidance and recognized as being less effective than standard treatment (and no indication for primary hormone treatment alone in the context of localized prostate cancer in a man fit for radical treatment)	TRU-02892
16.10.2020	Level 3 Serious Adverse Incident Review Urology Services (Datix Numbers [redacted]	Paper to set out the framework of the "*Level 3 Serious Adverse Incident Review*"	Doc File 5 Pages 173 – 178 AOB-02745

	Personal information redacted by USI	**PURPOSE OF PAPER** This paper seeks to provide a framework within which to conduct a Level 3 Serious Adverse Incident Review regarding the treatment and care provided by a Urology Consultant (Doctor 1) who is no longer employed by Health and Social Care Services (Northern Ireland). This paper will address the following: • Proposed draft terms of reference for the review • Confirmation of review panel • Proposed timeline for conducting the review • Outlining the process for engagement with families throughout the review **Purpose of Review** The purpose of the review is to consider the quality of treatment and the care provided by Doctor 1 and to understand if actual or potential harm occurred. The review findings will be used to promote learning, to understand system wide strengths and weaknesses and to improve the quality and safety of care and treatment provided. **Scope of Review** As part of an internal review of patients under the care of Doctor 1, a number of patients have been identified as possibly been exposed to increased or unnecessary risk. **Review Aims and Objectives** The aims and objectives of this review are to: • To carry out a systematic multidisciplinary review of the process used in the diagnosis, multidisciplinary team decision making and subsequent follow up and treatment provided for each patient identified, using a Root Cause Analysis (RCA) Methodology. • To review individually the quality of treatment and care provided to each patient identified and consider any factors that may have adversely influenced or contributed to subsequent clinical outcomes. • To engage with patients / families to ensure where possible questions presented to the review team or concerns are addressed within the review.	- AOB-02750

		• To develop recommendations to establish what lessons are to be learned and how c systems can be strengthened regarding the delivery of safe, high quality care. • Examine any areas of good practice and opportunities for sharing learning from the incident	
16.10. 2020	Alert Letter from Dr McBridge	Alert letter issued re Mr O'Brien by Department of Health.	Doc File 5 Pages 179 – 180 AOB-02751 - AOB-02752
23.10. 2020	Attendance note between Tughans and DLS	**Telephone Attendance between Tughans and DLS** DLS advised of possibility of Irish News story being published in relation to Mr OB. Trust concerned story does not cause alarm to a significant number of patients. Ongoing communications between Trust and Department in relation to the matter. Noted that there had been "some kind of leak". Indicated Royal college Lookback Review going on… AFA noted that aware of college being contacted through GMC communications but in the dark in relation to any lookback report. DLS unclear of stage of that review but indicated it led to concerns which were "extensive and significant" . Indicated that Trust were trying to "get to bottom of things" Department may make a statement in relation to recall process for patients…. Indicated there are definitely 9 SAIs but has been told that there may be up to 14. AFA noted only aware of 7 or at most 8 SAI. DLS indicated issues in relation to Bicalutamide… Appear to be plans for ministerial statement.	Doc File 5 Pages 182 – 183 AOB-02754 - AOB-02755
23.10. 2020	Email correspondence between Dr O'Kane and Ms Donnelly	**Email corrs between Ms Donnelly and Dr O'Kane** Confirmation of conversation: 1. Advised RCS had recommended a review of Mr OB's work going back 5 years. AT this stage, review going back to Jan 2019. Review currently looking at 160 stent removal, 352 elective, 168 pathology, 1028 radiology, 271 note of MDM, 236 oncology 2. An expert SAI panel has been established to investigate 9 SAI. Dr Hughes will be chairing panel. Panel expert has identified a possible further concern in relation to prescribing of Bicalutamide. Concern is that patients have been managed on Bicalutamide for extended periods.. which is associated with making prostate cancer worse and with variety of harmful side-effects. … 3. MHPS process has not been triggered in relation to new concerns; SAI process needs to complete and in any event Mr OB no longer employed by SHSCT and have received legal advise that MHPS cannot be	Doc File 5 Pages 186 – 187 AOB-02758 - AOB-02759

		used when doctor not employed 4. MHPS investigation report re concerns 2015/2016 that *"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 process with clarity on roles and responsibilities at all levels within Acute Directorate …."* You advised that the SHSCT Assistant Director of Support Services and SHSCT Associate Medical Director for Primary Care have been carrying out this review, that a draft report has been prepared. Advised not in position to send this report to GMC. GMC need to see relevance for considerations. 5. Since 10 Sept 2020 Trust had weekly meeting with NI DoH, PHA, HSCB and permanent secretary has not written to SHSCT to advise that handling is being moved into DoH oversight process **6.** Th NI Health Minister intends to issue public statement.. Irish news has contacted the Trust this afternoon advising that they have received anonymous information	
25.10.2020	Email correspondence between DLS and Tughans	Tughans request details of the independent review of systems within the urology department. June Turkington indicates she will take instructions on that matter.	Doc File 5 Page 189 – 190 AOB-02761 - AOB-02762
25.10.2020	News Release, Statement to the Irish News	**News Release – Statement to Irish News** The southern health and social care trust can confirm that clinical concerns in relation to the work of a Consultant urologist, who no longer works in the health service are currently being reviewed. At this stage a small number of patients have been contacted so that their care can be reviewed. The Department of Health is being kept updated on the progress of the review and the potential impact on patients If anyone is concerned and would like information please phone us on [number] between 10am and 3pm	Doc File 5 Page 199 AOB-02771
25.10.2020	Letter to Tughans from DLS	A more detailed look back of your client's patient cases is still ongoing for the period 1st Januar 2019 to 30th June 2020. Mr Haynes' letter to your client dated 11th July 2020 included a summar of concerns following initial review of patient records for this period. I can confirm that the potential Serious Adverse Incidents (SAI) identified in that summary, relating to Service User	Doc File 5 Pages 200 – 204 AOB-02772 - AOB-02776

		and Service User B, have since been screened, and having met the threshold, these are being addressed as SAI reviews. As a result of the detailed ongoing review, additional serious concerns relating to your clie practice have been identified, and these are summarised as follows: **Elective care –** the review has identified that your Client had operated on 334 patients, and ou these 120 patients were found to have undergone delays in dictation of their discharge wit further 36 patients having no record of their discharge on the Trust's electronic care rec (NIECR). **Of the 36 patients, there have been 2 incidents identified that meet the thresh for SAI reviews.** **Management of Pathology and Cytology Results** – the review has identified 50 out of patients that require review as a result of un-actioned Pathology or Cytology results. **Of the patients requiring review there have been 3 incidents identified that meet the threshold SAI reviews with a further 5 requiring a review follow-up to determine if these patients ha come to harm.** **Management of Radiology Results** – the review has identified 1536 radiology results wh require review to ascertain if appropriate action was taken. A review of the 1536 cases is ongoir **Actions required as a result of Multidisciplinary Team Meetings –** there were 271 patie under your client's care whose cases were discussed at Multidisciplinary Team Meetings. review of these patient records is being undertaken. To date there are currently **3 confirm SAI's and a further 1 needing a review follow-up** to determine if these patients have come harm. This exercise is ongoing. **Oncology Review Backlog** – 236 review oncology outpatients will be seen face to face by Urologist in the independent sector for review. To date there has been **one SAI confirmed** fr this backlog as the patient presented to Emergency Department and he has been followed up as result of this attendance.	

Patients on Drug "Bicalutamide" - There are concerns regarding your Client's prescribing of androgen deprivation therapy outside of established NICE guidance regarding the diagnosis and management of prostate cancer[1].

Bicalutamide is an Anti-androgen that has a number of recognised short term uses in the management of prostate cancer. In men with metastatic prostate cancer NICE Guidance states;

'1.5.9 For people with metastatic prostate cancer who are willing to accept the adverse impact on overall survival and gynaecomastia with the aim of retaining sexual function, offer anti-androgen monotherapy with bicalutamide[B] (150 mg). ***[2008]***

1.5.10 Begin androgen deprivation therapy and stop bicalutamide treatment in people with metastatic prostate cancer who are taking bicalutamide monotherapy and who do not maintain satisfactory sexual function. ***[2008]'***

All patients currently receiving this treatment are being identified by a number of parallel processes utilising Trust and HSC / Primary Care systems in order to facilitate a review to ascertain if the ongoing treatment with this agent is indicated or if an alternative treatment / management plan should be offered.

In the interests of immediate patient safety, the Trust is requesting details of your Client's prescribing practices regarding anti-androgen therapy and specifically with regard to Bicalutamide. This can be undertaken in the form of a video discussion, telephone call or written format. Given the severity of this concern and the potential implications for affected patients, my Client asks that this is provided as a matter of urgency.

Summary table of Serious Adverse Incidents (SAI) confirmed to date

The following table contains the summary details of the SAI reviews required to date. The SAI process will be led by an external independent Chair, commissioned by the Trust and the Public Health Agency.

Element of Concern
Elective Exercise ** had a follow up CT scan of chest abdomen and pelvis performed on 17 December 2019 which was reported on 11 January 2020. The indicate for this was restaging of current renal cell carcinoma. ** had a right radical nephrectomy March 2019.The report noted possible sclerotic metastasis in L1 vertebral body. Result was not actioned. Patient contacted with result on 28 July 2020 and further

[1] Prostate cancer: diagnosis and management. National Institute for Health and Care Excellence. NICE guideline 131. May 2019.

		assessment required **Elective Exercise** Patient underwent TURP on 29/1/20. Pathology reported incidental prostate cancer. No follow-up or action from pathology result until picked up from elective exercise **Pathology** Patient diagnosed with prostate cancer Gleason 7. MDM 08/08/19- Significant Lower urinary tract symptoms but declined investigations. On maximum androgen blockade - No onward oncology referral was made. **Pathology** Diagnosed with penile cancer, recommended by cancer MDM for CT scan of Chest, Pelvis and Abdomen to complete staging. Same delayed by 3 months. **Pathology** Patient diagnosed with a slow growing testicular cancer (Seminoma) had delayed referral to oncology and therefore delay in commencing chemotherapy. **MDM** CT renal report of 13/11/2019 unsigned on NIECR. No record of action taken recorded in NIECR. Case identified at urology MDM of 3/9/2020 following review of backlog **MDM *deceased** **(previously notified in Mr Haynes' letter (11.7.20) as potential SAI – Service User A)** ** was diagnosed with locally advanced prostate cancer in August 2019. An MDT discussion on 31 October 2019 recommended androgen deprivation therapy (ADT) and external beam radiation therapy (EBRT). ** was not referred for ERBT and his hormone treatment was not as per guidance. In March 2020 ** PSA was rising and when restaged in June 2020 ** had developed metastatic disease **MDM/ Bicalutamide *deceased** MDM outcome not followed and inadequate treatment given. MDM outcome = commence LHRHa. Started on low dose of bicalutamide (unlicensed and sub-therapeutic dosage), subsequently re-presented with local progression January 2020 and appropriate treatment (Degeralex) was given along with TUR and stent / nephrostomy. The evidence for LHRHa in context of metastatic disease is that it reduces the risk of local progression (renal failure and spinal cord compression). This man had inadequate treatment and experienced a complication likely as a result of this. **Review Op Backlog** **(previously notified in Mr Haynes' letter (11.7.20) as potential SAI – Service User B)** In May 2019 ** had an assessment which indicated he had a malignant prostrate. ** was commenced on androgen deprivation therapy (ADT). Reviewed in July 2019 in outpatients and planned for repeat PSA and further review. Patient lost to review and attended Emergency Department in May 2020. Rectal mass investigated and diagnosed as locally advanced prostate cancer	
26.10.2020	Letter to Mr O'Brien from Ms Young	**Letter to Mr OB from Ms Young** Re Stage 1 Grievance enclosing outcome of grievance heard on 30 July and 07 August 2020. .. Some general issues in correspondence to grievance panel (08 October 2020) 1. It is correct that all new documents not previously seen by you have been provided 2. There are no outstanding matters of factual dispute beyond those discussed. There are, as described in my letter of 17 September 2020, opinions and/or comments expressed by others and the grievance panel has considered these in its deliberations .. I would advise that you have the right to appeal against this decision.	Doc File 5 Page 206 AOB-02778

26.10.2020	Grievance Outcome	**Outcome of formal grievance** … Overall, do not fine Mr OB's grievance upheld	Doc File 5 Pages 209 – 271 AOB-02781 - AOB-02843
27.10.2020	Email correspondence between DLS and Tughans	Exchange of emails. AA noting that he will get back to DLS after he has instructions. June Turkington replies indicating that she understands there are clinics scheduled for next Monday and Tuesday "*for low dose Bicalutamide patients"* and asks for a response to the immediate clinical concerns.	Doc File 5 Pages 272 - 273 AOB-02844 - AOB-02845
27.10.2020	Letter to Tughans from Mr Pengelly	**Letter to Tughans from DoH** Writing to advise that Minister intends to make a short written statement on Tuesday 27 October 2020 concerning matters related to SHSCT review of clinical practice of your client Mr OB. Trust notified department of its concerns and advised that they were undertaking a scoping exercise to ascertain the numbers of patients whose care may need to be reviewed.	Doc File 5 Page 275 AOB-02847
27.10.2020	Written Statement to the Assembly by Health Minister	Minister's written Statement to Assembly	Doc File 5 Page 276 AOB-02848
28.10.2020	Report of Mr Dawson to GMC	**Report of Mr Dawson, Consultant Urological Surgeon for GMC re Mr OB Fitness to Practice** Patient A – Seriously below Patient B – Seriously Belo Patient Patient 14 – Unable to comment as unclear from notes if failure to triage was due to an omission on Mr OB.. Patient F – Unable to comments as unclear from notes if failure to triage was due to an omission on Mr OB … Patient Patient 13 – Unable to comment as unclear from the notes if failure to triage was due to an omission of Mr OB Patient Patient 11 – Unable to comment as unclear from notes that failure to triage was due to an omission of Mr OB Patient Patient 10 – Unable to comment as unclear from notes that the failure to triage was due to an omission by Mr O'Brien	Doc File 5 Pages 277 – 342 AOB-02849 - AOB-02914
29.10.2020	SHSCT Governance Team (IR2) Form Personal information redacted by and SHSCT Governance Team (IR2) Form Personal information redacted by	Datix SHSCT Governance Team IR2 Forms	Doc File 5 Pages 343 – 348 AOB-02915 - AOB-02920
29.10.2020	Letter from Tughans to DLS	**Letter to DLS from Tughans** Re Trust notified of media interest by the Irish News at a time before any pronouncement was made by the Minister. Query of Trust' steps to take in identifying whether information has been inappropriately provided to the press by anyone within the Trust and confirm how that occurred and what steps	Doc File 5 Pages 349 – 351 AOB-02921 - AOB-02923

		being taken in relation to it. Query of nature of meeting which Dr O'Kane wants to have with Mr OB. Highlighted that no documentation provided to Mr OB in order to comment on the Summary of concerns after Tughans' request from Mr Haynes. .. Since July 2016 other than provision of records of two patients, SUA & SUB no other information or documentation whatsoever has been provided to Mr OB until DLS letter of 25 October 2020. .. Request for clarification of whether suggested 9 SAI are stage 1,2, or 3 and also for SAI notification forms, timescale within which each SAI is anticipated to be completed and also any Terms of References which have been drafted. Also whether Mr OB will be asked to comment in relation to any of the SAIs and when this will be expected and what information will be disclosed to him in advance. .. Request for update on how the Royal College has been interacting with the Trust and provide all relevant documentation/ information/ communications referring to Mr OB in relation to same. … Clarification for whether expert evidence is within context of RCS review and request for all communication with comments and or reports provided by the expert. .. Request for following re Bicalutamide 1. When concerns first identified 2. Steps taken to investigate 3. By whom the concerns have been investigated 4. Whether any expert comment has been received in relation to those concerns 5. Provide expert comments 6. Provide information and or internal opinions upon which concerns are based 7. Number and type of patients that the concerns relate to Request access to relevant clinical records … Request on whether report due to complete in September 2020 is now available and if so, provide copy of. It not, advise when it is anticipated and the reason for the delay.	
02.11.2020	Letter to Ms Toal from Mr M O'Brien	Appeal of determination of the Grievance.	Doc File 5 Pages 358 - 359

09.11.2020	Letter to Mr Brammall (GMC) from Dr O'Kane enclosing summary of concerns	**Letter to Mr Brammall (GMC) from Dr O'Kane including summary of concerns** Re GMC request for further information regarding concerns raised in relation to Mr OB. 1. Copy correspondence issued via Trust's legal advisors to Mr OB's solicitor on 25th October 2020. Additional information includes: - Info regarding media interest - Details of additional concerns re Bicalutamide - Chief Medical Officer decision to issue a Professional Alert Answers to questions: 1. Update re lookback/patient recall: Trust continuing to progress with review of Mr OB's activity since Jan 2019 to identify additional issues with the quality of care delivered. Trust liaising with DoH, Health and Social Care Board and Public Health Agency to guide the review process. Trust also consulted with Royal College who have provided guidance on developing review criteria. To date further issues have been identified which have required screening as potential SAIs in total 9 of these have been deemed to meet criteria of SAI and patient's families have been contacted. Trust has been made aware of scale of Mr OB's "significant" private practice. Conducted from his home not under the auspices of a private hospital or clinic. Trust has made DoH, Health and Social Care Board and Public Health Agency aware of this area of activity. There may be pp issues re ROI patients GP colleagues have commented that on occasion they have referred patients to SHSCT to later received correspondence from Mr OB regarding the same patient documentation referring individual as private patient NI minister has issued written statement on 27 October 2020. The concerns have also received media coverage. The DOH has established an oversight group .. 2. Update on new MHPS investigation due to additional concerns: Trust sought advice from DoH re MHPS. Trust has been advised that as the formal MHPS had not commenced when Mr OB was still employee, the Trust no longer designated body and no longer responsible office and that formal MHPS investigation should not now be commenced after his termination. …	Doc File 5 Pages 365 – 369 AOB-02937 - AOB-02941

		3. Update concerning SAI review for SUA and SUB as identified in the new concerns that were recently sent to GMC : Trust has discussed identified SAI with DoH, Health and Social Care Board and Public Health Agency. As result, Trust have appointed independent chair person to conduct level 3 SAI reviews with subject matter expert support provided by an independent consultant.. Wider review panel to support this have been appointed and work is preparing to commence. Trust have identified a further 7 SAI relating to patients on Mr OB's caseload. During initial stages of SAI reviews, immediate patient safety concerns have been raised by chairperson in relation to prescribing of Bicalutamide… Concern relates to management on bicalutamide. Should be prescribed 150mg for maximum 8 to 10 weeks. Concern is patients on Bicalutamide in excess of 8 to 10 weeks without review at 50 mgs – associated with making prostate cancer worse. Associated with harmful side effects. Trust currently identifying those patients who are prescribed the medication and providing review appointments as a matter of urgency. 26 Patients have been identified as requiring review… Outcome of independent review into admin processes due to be completed in Sept 2020: Review commenced in August 2020 and have been initially reported on. Further details on standard operating processes for administration of patient information has been requested to complete this work. This will be shared with GMC on finalisation expect 14 December 2020	
10.11.2020	Letter to Dr McBride from Tughans	**Letter to DoH from Tughans** Advised on 25 October 2020 by DLS that *"chief medical office has deemed that it is appropriate to issue a professional alert letter…"* Unclear whether letter was issued and if so, whom it was sent to. Issuing such letter is significantly damaging to Mr OB's reputation. Outlines undertakings to GMC and SHSCT of undertakings and of no intention to work … In the above circumstances there is no possible "reason" to believe Mr OB would seek work elsewhere, and therefore no basis to make a decision under that limb of the criteria. In light of the above either: 1. Confirm that no alert letter has been issued and	Doc File 5 Pages 371 – 373 AOB-02943 - AOB-02945

		will not be issued on the basis of the reassurances provided herein or If an alert letter has been issued, provide a copy of the letter and list of recipients, in addition to confirming that you will take immediate steps to ensure the recall of the alert letter	
12.11.2020	SHSCT Governance Team (IR2) Form Personal information redacted by	SHSCT Governance Team (IR2) Form Personal information redacted by [**NB this was not included in the Datix numbers of 16 October 2020.**]	Doc File 5 Pages 374 – 376 AOB-02946 - AOB-02948
12.11.2020	GMC Assistant Registrar Decision Rule 4(4)	**GMC Assistant Registrar Decision Rule 4(4)** Decision: In my opinion, these issues are serious enough to need further review of the concerns that have been raised. Given the limitations of the provisional enquiry process, these issues cannot be resolved at this stage as they will need to be investigated further with additional information being obtained. Consequently, this Provisional Enquiry is being prompted to a GMC investigation so that these matters can be considered in further detail. I note that Mr OB has raised concerns about the administrative processes and it is clear from the documentation that this was a broader issue at the Trust for some time…. However, in light of the new information which has come to light and the ongoing reviews into patient care I consider that the allegations and possible concerns about Mr OB's work at the Trust now requires further review and assessment by the GMC. We now have a number of cases where the delays caused by the administrative procedures and other work completed by Mr OB is being reviewed in relation to potential harm that this may have caused to patients. This is ongoing and being reviewed by both the Trust and the Northern Ireland authorities themselves. I have also noted the initial expert opinion we have now obtained on these matters whereby two of the patients have been confirmed as being seriously below the required standards and therefore raising potential concerns about fitness to practise. The remaining issues require further evidence and records prior to the expert confirming their opinion but they will have confirmed that there are potential concerns in the five further issues as well.	Doc File 5 Pages 377 – 381 AOB-02949 - AOB-02953

		Whilst the Trust's own systems may form part of this review I am satisfied that the further enquires, which will be completed as a result of promoting this matter for full investigation, are required to ensure that any patient safety concerns are addressed appropriately. … Both of the concerns about Dr OB as well as the potential Public Interest Concerns information	
24.11.2020	Letter to Tughans from Dr O'Kane	**Letter to Tughans from Dr O'Kane** Writing to advise that it is the Trust's intent to name your client in our internal and external communications. The Trust has reached this decision based on the following key considerations: 1. The Minister's statement has already placed your client's name in the public domain 2. We must ensure that patients who are not under your client's care are not caused unnecessary distress or anxiety following the Minister's statement We consider we have a duty of care to the patients who were under your client's care privately to ensure they are aware of the circumstances relating to the concerns raise.	Doc File 5 Pages 394 – 395
24.11.2020	Letter from Department of Health Cancelling alert letter	Letter from Department of Health Cancelling alert letter	Doc File 5 Page 396 AOB-02968
24.11.2020	Letter to Tughans from DLS	**Letter to Tughans from DLS** Response from letter dated 29 October 2020. Understand Trust has shared with you correspondence that was issued to the GMC on 09 November 2020 which addressed some of the questions contained within your letter. In response to Mr OB's concerns re media interest.. unlikely that any investigation would be successful in determining	Doc File 5 Pages 398 – 399 AOB-02970 - AOB-02971

		who alerted the Irish News…Trust believes it is impossible to confirm any source Purpose of Dr O'Kane offering to speak to Mr OB was to allow Mr OB the opportunity to be informed in person of the imminent media coverage by way of a professional courtesy. Update on number, progress and level of SAI review is provided in correspondence to GMC. SAI review has commenced and updates will be provided in due course. To date, Trust liaised with Royal College to identify independent urology subject matter expertise to support the SAI process and ongoing review of patient records. The Trust also requested an initial discussion with Royal College regarding potential future review of urology service in the context of the identified concerns via their invited review mechanism … Trust requests that Mr OB provides details to the Trust of the number of patients who attended to see him privately over the period between 01 Jan 2019 to 31 August 2020 and that Mr OB seeks to preserve all patient records. DoH also requested that Mr OB provides a written assurance to the Trust that he will make arrangements for all patients who attended him privately between Jan 19 to August 20 to be assessed by an independent consultant urologist' provided with appropriate follow-up treatment and that progress and outcomes of such assessment and treatment are recorded and communicated to the Trust. Concerns re Bicalutamide – a review of prescribing is ongoing with further details provided in Trust correspondence to the GMC dated 09 November 2020. Trust requests Mr OB to urgently provide details of prescribing practices re anti-androgen therapy and specifically in regards to Bicalutamide. ..	
24.11.2020	Letter to Tughans from Mr O'Neill (DoH)	**Letter to Tughans from DoH** Confirm that under Departmental Guidance HSS, alert letter was issued on 16 October 2020 to Chief executives of HSC Board, HSC Trusts, Public Health Agency, Business Services Organisation, NHS Resolution, Practitioner Advice and the Chief Medical Officers in Scotland and Wales. Alert letter provided the consultant's name and GMC number and advised organisations to contact the Southern Trust's	Doc File 5 Page 400 AOB-02972

		Medical Director if application for permanent or temporary employment is made. Can advise that Department was not in receipt of your letter to Mr Brammall dated 31 July 2020 at the time alert letter was issued. Further advise that in response to assurances having now been received, the Department is in process of withdrawing the alert letter.	
24.11.2020	Oral Statement to the Assembly by Health Minister	Please see statement for full detail. Key passages include the following:- On 31st July 2020 the Southern Trust contacted my Department to report an Early Alert concern clinical practice of this consultant. The Trust informed my Department that on the 7th June became aware of potential concerns regarding delays of treatment of surgery patients who were the care of the consultant urologist employed by the Trust. The Trust became aware that 2 ou patients listed for surgery under the care of this consultant were not on the hospital's Administration System at that time. As a result of these potential patient safety concerns, an initial lookback exercise in relation consultant's work was conducted, to ascertain if there were other areas of potential concern. This lookback, which considered cases over a 18 month period of the consultant's work in the Southern (from 1st January 2019 – 30th June 2020), concentrated on whether patients had a stent inserted a particular procedure and if this stent had been removed within the clinically recommended time The initial lookback identified concerns with 46 cases within a total of 147 patients who had the par procedure and were listed as being under the care of the consultant during the period addressed initial lookback exercise. Whilst Mr O'Brien has worked in the Southern Trust for 28 years, in consultation with the Royal College of Surgeons, the Review Group has looked at the timeframe from 1 January 2019 until 30 June 2020 and during this time there were a total of 2,327 patients under his care. The Review Group identified the most vulnerable group of urology patients within this cohort and has concentrated on these patients initially. There are areas of concern relating to elective and emergency activity; radiology, pathology and cytology results; patients whose cases where considered in Multidisciplinary Team Meetings; oncology and in relation to the safe prescribing of an anti-androgen drug, outside of established NICE guidance in the management of prostate cancer. Across those areas, to date 1,159 patients' records have initially been reviewed and 271 patients or families have been contacted by the Trust and their work continues across those areas of concern. Further details of the various review strands are appended to this oral statement. So far 9 cases have been identified that meet the threshold for a Serious Adverse Incident (SAI) review and all 9 patients and / or their families have been contacted by the Trust to inform them of the position in relation to their respective cases. A further 6 cases are currently being reviewed in more detail to establish if those patients have come to harm. Mr Speaker I have therefore taken the following actions. Firstly, I have established a Urology Assurance Group, chaired by the Permanent Secretary of my Department, to provide external oversight of the various work streams arising from the initial look back exercise initiated by the Southern Trust. Specifically this group will review the progress of the initial look back exercise; it will consider emerging strategic issues; commission and direct further work as necessary; monitor the impact on urology and	Doc File 5 Pages 401 – 407 AOB-02973 - AOB-02979

related services in the Southern Trust; ensure coordination with other associated reviews or investigations;
and oversee communication across all stakeholder groups, with patient care being the central focus throughout. I have published the Terms of Reference for this group alongside this statement.

Secondly, the Royal College of Surgeons has been commissioned to carry out an independent review of a sample of the clinical cases included in the initial lookback exercise to determine whether a further, more extensive, lookback or patient recall by the Trust is required.

Thirdly, in relation to his private patients who are not known to the Southern Trust, I have requested that his solicitors outline how Mr O'Brien intends to provide a similar independent process to ensure that those private patients are alerted to issues arising and that their immediate healthcare needs are being met. Whilst the Department has no explicit duty to take this particular matter forward, as part of our wider healthcare responsibilities, I want to do all I can to safeguard patients who may have received care or treatment in a private capacity from this consultant.

FACTSHEET **ANNEX A**

The Trust's review has identified that the consultant had operated on 352 elective patients between 1 January 2019 and 30 June 2020 and, out of these, 120 patients were found to have undergone delays in dictation of their discharge information, with a further 36 patients having no record of their discharge information recorded on the Trust's electronic care record (NIECR). Of these 36 patients, 2 incidents have been identified that meet the threshold for a Serious Adverse Incident (SAI) review.

The Trust's clinical review has identified that 168 patients required pathology / cytology investigations and 50 of these patients' results were unactioned and require review. Of these 50 patients, 3 incidents have been identified that meet the threshold for an SAI review with a further 5 cases requiring further information to determine if these patients have come to harm.

The Trust's review has identified a total of 1536 radiology results which require further assessment to ascertain if the appropriate action was taken. One third of these assessments have been completed and no concerns have been identified to date. Reviews of the remaining radiology results are ongoing.

There were 271 patients under the consultant's care whose cases were discussed at Multidisciplinary Team Meetings. A review of these patients' records is being undertaken. To date there are 3 cases which meet the threshold for an SAI review and a further 1 case is being reviewed. This exercise is ongoing.

A total of 236 oncology patients were deemed to be part of a backlog relating to Oncology Reviews. The Trust is arranging for these patients to be reviewed by a Consultant Urologist in the Independent Sector. To date a total 191 oncology review patients transferred to the Independent Sector and clinics are fully booked for the month of November for these patients. To date 1 case from this group has been identified as meeting the threshold for an SAI review.

The exercise also identified concerns regarding the consultant's prescribing of Bicalutamide, an anti-androgen drug, outside of established NICE guidance in the management of prostate cancer. Out of 300 patients, 26 men receiving this treatment have being identified by the Trust as needing an clinical review and are being reviewed urgently by a Consultant Urologist and Pharmacist. All 26 were contacted and invited to review appointments. The Trust is now conducting a further review to establish if there are any further patients who may need their prescribed medication revised.

It is with deep regret that I am informing the House this morning of a further occurrence of serious concerns about the clinical practice of a hospital consultant notified to my Department by one of our Health and Social Care Trusts.

..

The initial lookback identified concerns with 46 cases within a total of 147 patients who has the particular procedure they were listed for…

I January 2019 until 30 June 2020 there were a total of 2327 patients under his care.

		Trust's review identified that consultant had operated on 352 elective patients between 1 Jan 2019 and 30 June 2020 and out of these, 120 patients were found to have undergone delays in dictation of their discharge information, with a further 36 patients having no record of their discharge information recorded on the Trust's electronic care records. Of these 36 Patients, 2 incidents have been identified as SAI. Clinical review identified 169 patients required pathology/cytology investigations and 50 of these patients results were unactioned and require review. Of these 50, 3 incidents have been identified as SAI with a further 5 requiring further information to determine whether come to harm Trust's review identified a total of 1536 radiology results which require further assessment to ascertain if appropriate action was taken. One third of these assessments have been completed and no concerns have been identified. There were 271 patients under consultants care whose cases were discussed at MDM. To date 3 cases which meet threshold for SAI with further 1 being reviewed. …. A total of 236 oncology patients were deemed to be part of backlog relation to oncology review.. to date 1 case from this group has been identified as meeting the threshold for an SAI review Exercise also identified concerns regarding prescribing of Bicalutamide. Out of 300 patients, 26 men receiving this treatment identified by Trust as needing clinical review…	
27.11.2020	Responding to Fitness to Practice Concerns completed by Dr O'Kane	**Prescribing of Bicalutamide** There are concerns regarding the prescribing of the anti-androgen drug Bicalutamide by Mr O'Brien which appears to be outside of liscensed dosage and established NICE guidance with respect to the diagnosis and management of prostate cancer. This drug has a number of recognised short term uses at different dosages in the management of prostate cancer. Details about any local actions and outcomes (e.g. local restrictions, investigations, audits, practice reviews, or HR/disciplinary processes) Mr O'Brien has now retired. All patients currently receiving this treatment have been identified by the Trust in order to ascertain if their ongoing treatment with this drug is indicated or if an alternative treatment management plan should be offered. To date 479 patients over 6 months have been identified across NI who have been prescribed a dosage of 50mg. 32 of these patients, all of whom were under the care of Mr O'Brien, have been identified as receiving a low dosage medication (outside of licensed indications) and who require an urgent review. All have been contacted and to date 10 have been reviewed, all 10 have had their treatment revised. The second stage of this Audit has identified there are 486 patients across NI who are prescribed a higher dosage of 150mg Bicalutamide. These patients records are being viewed and information is being collated as to how many of these patients will require review to amend medication. To date, of the 300 cases reviewed, 60 require further assessment to ascertain if they require a full case review in the context of their overall management, including radiotherapy.	Doc File 5 Pages 415 – 423 AOB-02987 - AOB-02995

Record Keeping - Patient Administration System

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

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

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

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

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

Delayed Dictation

Another scoping exercise looked at the patients that Mr O'Brien had operated on electively between 1 January 2019 and 30 June 2020. There were 352 patients operated on during this period:

- Of these 352 patients, 120 patients were found to have undergone delays in dictation of their discharge information. (one letter was completed 41 weeks after patient's procedure). These cases have not yet been fully reviewed.
- A further 36 patients have no record of their discharge information recorded on the Trust's electronic care record (NIECR) and is not untypical in this part of the service which relies on handwritten discharge.
- However, of these 36 patients, following full case review, 2 incidents have been identified that meet the threshold for a Serious Adverse Incident (SAI) review based on concerns about suboptimal management including non follow up of results.

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

Scoping exercise of 352 patients and follow-up on patients that had no dictation completed to ensure that there was no immediate patient safety concerns/ additional follow-up required

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		Delays in Referrals During the scoping exercise into the 352 elective patients who were taken to theatre during the 18 month timeframe there were patients who were identified who had a delays in their onward referral to oncology, pathology, cytology and radiology which in turn led to delays in staging and timely management. **No Actioning Multi-Disciplinary Meetings Outcomes** There were 271 patients of Mr O'Briens whose cases were discussed at the Oncology Multidisciplinary Team Meetings and it has come to light that recommendations/outcomes from these discussions may not all have been actioned by Mr O'Brien.	
27.11. 2020	Letter to Mr Brammall from Dr O'Kane	In this correspondence Dr O'Kane alleges breach of undertakings in relation to seeing private patients in the following terms:- It has since been brought to our attention that Mr O'Brien appears to be continuing to conduct his private practice. The following information has been provided to the Trust: • The Southern Trust urology patient information line received a call on Wednesday 25th November 2020. The patient stated that 3 weeks ago Mr O'Brien phoned him and offered him a private consultation. Mr O'Brien was due to call him back with details of an appointment. • A GP practice in the Southern Area has informed the Trust that they had received a recent request for bloods to be taken for a private patient of Mr O'Brien's. The practice noted that Mr O'Brien was no longer employed by Health and Social Care Services and the test request was for private purposes.	Doc File 5 Pages 424 – 426 AOB-02996 - AOB-02998
03.12. 2020	Email correspondence between Ms Watkins, Ms Kennedy, Mr Sedwell and Dr O'Kane	Email correspondence between Ms Watkins, Ms Kennedy, Mr Sedwell and Dr O'Kane states: *"You also advised that a complainant had come forward through the advice line to allege that Dr 0B had provided a medical report for a defendant in a sexual assault case (in which she was the victim), which she suggested had the effect of collapsing the case. The complainant alleges that Dr OB was a friend of the defendant. You are seeking information from the Court to substantiate whether his medical report was, in fact, material in securing a not guilty verdict."*	Doc File 6 Pages 23- 24 AOB-03028 - AOB-03029
11.12.	Email correspondence	First letter from Dr Hughes, Chair of SAI Panel, to AOB	Doc File 6

2020	between Tughans and DLS	seeking a meeting with him for the SAI process "*….we have been carrying out interviews with all relevant members of staff who have been involved in these patients' care…...* *We are seeking to complete the staff interviews before Christmas ……* *Keen to have your input …..”*	Pages 29 – 31 AOB-03034 - AOB-03036
23.12. 2020	Letter to DLS from Tughans dated 23 December 2020 [Intended attachment to email of 23 December. Not attached – subsequently sent to DLS on 05 February 2021	Letter to DLS from Tughans Possible leak – Trust predetermined outcome of potential leak. Should have been a very limited number of people in Trust aware of information which was published and should be possible for Trust to carry out analysis. Matter of concern that leaks of this nature have been made to press. Notable that trust is only too willing to investigate matter into Mr OB but refusing to investigate the significant matters when raised by him. Meeting with Dr O'Kane – Mr OB disappointed that at no time during his employment and did not meet to notify him of referral she made to GMC Royal College – Unclear what role they are undertaking. Please share correspondence between Trust and Royal College and also tell us whether Royal College recommended a review of Urology Service, if so, what will encompass and when take place. Request made to DoH re provision of information regarding number of patients Mr OB has seen privately – we are instructed that 93 patients attended privately.. all patients have either been discharged to ongoing care of GP or have been transferred to NHS waiting list. Patient review - Mr OB has received no complaint nor claim from any patients you have asked him to review. Mr OB to send letter to patients attended privately in light of publicity from minister's statement. Bicalutamide – request same info as we did in letter of 29 October Not appropriate for you to ask our client to participate in both SAI review and also separately deal with matters in correspondence directly with you. Lack of information provided by you and we will communicate with chair of SAI review group accordingly.	Doc File 6 Pages 85 – 88 AOB-03090 - AOB-03093
23.12. 2020	Letter to Dr Hughes from Tughans	Letter to Dr Hughes from Tughans If requesting information in relation to clinical care he has	Doc File 6 Pages 90-91

		provided to patients it will be necessary for him to be provided with 1. Terms of ref 2. Review methodology 3. Description of incident/case 4. Timeline drafted by SAI group 5. Threshold criteria for SAU 6. Specific issues which inviting Mr OB to address on case by case basis Complete photocopies of hard copy records and complete data available on NIECR for each patient	AOB-03095 - AOB-03096
11.01.2021	Letter to Tughans from Dr Hughes enclosing questions for Mr O'Brien	Letter to Tughans from Dr Hughes enclosing questions for Mr AOB Attaching questions for AOB re SAI process and says notes and records of patients to be sent. Attached terms of reference and review methodology. Brief description with questions. Cannot paginate but have them in order. I would ask you answer my questions by 29 Jan 2021.	Doc File 6 Pages 107 – 109 AOB-03112 - AOB-03114
15.01.2021	Email correspondence between Tughans and Ms Kingsnorth	Confirmation from Tughans that SAI records were received on 14 January 2021.	Doc File 6 Page 142 AOB-03147
22.01.2021	Letter to Dr Hughes from Tughans	Letter to Dr Hughes from Tughans Request for further information: 1. The datix forms 2. Terms of reference are "proposed draft" confirm the Terms of Ref are still in draft or have they been finalised? If not finalised, when will that occur? 3. Terms of ref amended "pending engagement with all affected patients and families". Has that engagement now occurred if not when will it occur? 4. Has any consideration been given to engagement with Mr OB in relation to terms of ref and in particular, to seek his views in relation to the system within which he was working 5. Review methodology is said to be "as per SAI framework (2016) please provide a copy of that framework 6. Let me know how Mr OB's confidentiality is to be preserved in this process? In relation to Questions, request for following: 1. Copy of NICAN guidance (2016) for SUA and particular para arising from that in relation to SUA 2. Copy of peer review and annual report documents in relation to Nurse Specialists referred to in SUA 3. In relation to SUB, copy of NICAN urological clinical guidance pathway. Clarify if same guidance as	Doc File 6 Pages 155 – 159 AOB-03160 - AOB-03164

		referred to above. Identify paragraphs it is said were not followed 4. SUB, reference to NICAN Regional Guidance regarding androgen deprivation therapy. Clarify whether this refers to 2016 guidance. If not, provide a copy of additional guidance and specific paragraphs suggested were not adhered to 5. SUD copy of protocol referred to in relation to prescription of ADT. Identify paragraphs suggested were not followed 6. SUG, refer to patient not being referred to the MDM in accordance with "guidance". Identify what guidance and provide a copy and identify paragraphs suggest were not followed 7. SUH clarify if referring to 2016 guidance. If not provide copy of guidance you refer to and paragraphs suggest not followed We were not provided with: 1. SUA information on NIECR from 22 June 2020 until death 2. SUB information on NIECR from 01 August 2020 to date 3. SUC information on NIECR from 12 August 2020 to date 4. SUD information on NIECR from 14 May 2020 to death 5. SUE information on NIECR from 25 Sept 2019 to date 6. SUF information on NIECR from 02 October 2020 to date 7. SUG information on NIECR from 27 November 2020 to date 8. SUH information on NIECR from 25 Feb 2020 to date 9. SHI information on NIECR from 29 Jan 2020 to date Highlight to Dr Hughes how his request for information should be set out.	
22.01.2021	Letter to Tughans from DLS	Letter to Tughans from DLS Refer to letter dated 23 December 2020 which does not include response to serious patient issues highlighted in Trust letter on 24 November 2020. Wholly inadequate and awaiting response to 1. Mr OB private practice 2. Prescribing of Bicalutamide	Doc File 6 Pages 160 – 161 AOB-03165 - AOB-03166
05.02.2021	Letter to DLS from Tughans	Letter to DLS from Tughans Explaining that letter was omitted dated 23 December causing confusion. Addressed 1. Private practice: Mr OB does not intend to take any further action re his private practice 2. Bicalutamide: appear that Trust taken steps to investigate this issue and provide advice and treatment to patients as it considers appropriate. We	Doc File 6 Pages 176 – 178 AOB-03181 - AOB-03183

		fail to see how in those circumstances it can be suggested there are “immediate” patient safety issues, you client already having taken steps to address its concerns, the details of which it has not been made known to Mr O’Brien ….	
09.02. 2021	Email correspondence between Tughans and Ms Kingsnorth	Tughans confirm receipt of NIECR records.	Doc File 6 Page 179 AOB-03184
10.02. 2021	Dr Hughes’ response to Tughans	Response from Dr Hughes to Tughans Questions: 1. The datix forms: 9 datix forms shared on 08 Feb 21 2. Terms of reference are “proposed draft” confirm the Terms of Ref are still in draft or have they been finalised? If not finalised, when will that occur? Approved TOR finalised 12 Dec 2020 shared with you on 08 Feb 21 3. Terms of ref amended “pending engagement with all affected patients and families”. Has that engagement now occurred if not when will it occur? Family engagement took place between 9,11,16 November TOR were discussed with them and agreed. 4. Has any consideration been given to engagement with Mr OB in relation to terms of ref and in particular, to seek his views in relation to the system within which he was working: It would not be part of processes to consult any person subject to review to be involved in the generation of the Terms of Ref. The Expert Opinion to SAI is external to NI was provided independently to BA of Urological Surgeons. Review will take account of NI context . 5. Review methodology is said to be “as per SAI framework (2016) please provide a copy of that framework: This was provided 04 Feb 2021 6. Let me know how Mr OB’s confidentiality is to be preserved in this process?: The SAI process is patient focused and all professionals delivering care in the timeframe of the reviews are anonymised. 1. Copy of NICAN guidance (2016) for SUA and particular para arising from that in relation to SUA: provided 04 Feb 21NICAN section 9.2 2. Copy of peer review and annual report documents in relation to Nurse Specialists referred to in SUA: Provided 04 Feb 21. 2017 peer review submission stating increase in resource and availability of specialist nurse to all patients 3. In relation to SUB, copy of NICAN urological clinical guidance pathway. Clarify if same guidance as referred to above. Identify paragraphs it is said were not followed: I can confirm this is same guidance. Section 9.2 page 45	Doc File 6 Pages 182 – 186 AOB-03187 - AOB-03191

		4. SUB, reference to NICAN Regional Guidance regarding androgen deprivation therapy. Clarify whether this refers to 2016 guidance. If not, provide a copy of additional guidance and specific paragraphs suggested were not adhered to: NICAN Urology Cancer Clinical Guidelines section 9.2 pg 58 5. SUD copy of protocol referred to in relation to prescription of ADT. Identify paragraphs suggested were not followed: NICAN urology cancer clinical guidelines section 9.2 page 58 6. SUG, refer to patient not being referred to the MDM in accordance with "guidance". Identify what guidance and provide a copy and identify paragraphs suggest were not followed: NICAN Urology Cancer Clinical Guidelines section 9.4 pg 84 7. SUH clarify if referring to 2016 guidance. If not provide copy of guidance you refer to and paragraphs suggest not followed: NICAN Urology Cancer Clinical Guidelines section 9.3 page 69 Also responses to Tughans letter dated 11 Jan re Mr OB's comments in relation to 9 separate cases.	
01.03.2021	Root Cause Analysis report on the review of a Serious Adverse Incident SUA – SU1	Drafts of the SAI Reports on SUA to SUI had been completed by this stage.	Doc File 6 Pages 227 – 340 AOB-03232 - AOB-03345
05.03.2021	Email correspondence between Tughans and DLS	Email correspondence between Tughans and DLS Rex10 draft SAI reports. Tughans to take urgent opinion from counsel in relation to steps Trust proposing to take on Monday. That may involve a court application. Drew this development to my attention at 4.30 Friday afternoon and provided a letter at 17.37. Urgently confirm that your client did not take any of the steps contemplated in your letter of today for a further 7 days to enable Mr OB to obtain advise and if required, issue application.	Doc File 6 Pages 341 – 342 AOB-03346 - AOB-03347
16.04.2021	Email correspondence between Tughans and DLS	Email corrs between Tughans and DLS Confirmation that Mr OB is prepared to send letter from Trust to private patients. Letter current form requires amendments. Enclosed attached draft for Dr O'Kane review. Objective of letter is that private patients need to know that issues have been identified with Mr OB's NHS practice and that they can ask for help if they feel they need to. Will issue to all patients seen during the subject period within 7 days of letter being received by Tughans.	Doc File 6 Pages 360 – 361 AOB-03365 - AOB-03366
27.04.2021	Letter to Health Minister, Robin Swann, from	Letter from Tughans to Health Minister Re confirming assisting Mr OB in public inquiry. Mr OB	Doc File 6 Pages 378 – 379

	Tughans	intends to cooperate with inquiry to ensure that it is fully appraised of facts surrounding matters referred to in various statements to assembly. Mr OB of view that you have not been provided with a fair or accurate account of the background to those matters… Criticisms of Mr OB practice should be viewed in context of the adequacy of the urological service provided by the SHSCT. Ask that following matters form part of inquiry's terms of reference: 1. The adequacy and safety of urology service provided by the Trust 2. How the urological service provided by the Trust compared with the service provided in other specialities, such as breast surgery and gynaecology 3. How the Trust's urological service compared to comparable services elsewhere in UK 4. The impact of the above on the ability of the Trust's clinicians to provide an optimal service and achieve optimal clinical outcomes for the Trust's urology patients 5. The adequacy and appropriateness of the Trust's response to concerns raised and criticisms made by Mr OB and others in relation to the matters referred to above 6. The circumstances leading to the Trust's investigation into Mr OB's practice in June and July 2020	AOB-03383 - AOB-03384
28.04.2021	Email correspondence between DLS and Tughans	Email corrs between DLS and Tughans Enclosing 2nd draft letter to be sent to all Mr OB private patients. Mr OB to confirm the number of patients to whom the letter has been issued and to retain records of the patients to whom the letter has been issued.	Doc File 6 Page 380 AOB-03385
May 2021	Screening Report	Re: Patient [Patient 15] Discussion re notification considering patient has deceased and the report did not find anything wrong with the patient's care. It is understood that a consensus was required form the group regarding notification. Ronan and Damian felt the family should be notified, however, Ronan stated that a consensus from the group was required. Patricia to lnk with Melanie and Mark. … Confirmed that Mr Haynes has telephoned Ms [Personal Information redacted] this morning and advised that her husband was part of the	TRU-02893 – TRU-02897

		original SAI into urology servies. He firstly apologised nad then advised her about the orginal review into the triage of GP referral letters. He advised her that the review looked at two aspects 1. What can be done about the process and the consultant? 2. What impact the delay in referral letters had on the patients overall care. He advised that we would follow up with the learning to the family. We will agree a letter for Melanie to send but I do believe all the patients invovled in tehse cases new and old urology reviews should have a formal apology from the Trust	
June 2021	Grievance Appeal Review	Terms of Ref: 1. We are concerned that no account has been taken of the failures of senior managers within the Trust in respect of discharging their responsibilities. 2. Re letter of March 2016 – letter was sufficiently explicit in respect of an action plan being required. No response or action plan was received. 3. Do not accept Mr O'Brien's response to return notes and write up letters. The panel did not agree with this from our perspective we are concerned that Mr O'Brien appears to focus on the perceived procedural weaknesses of the case and less on the seriousness of the issues raised 4. Disagree with panel and do not find that there was appropriate action taken to affirm the seriousness of this situation… the approach which Mr O'Brien had to his work was known for years. 5. Matter not referenced again until oversight committee in September 2016 – was not discussed with Mr O'Brien. No action taken after October 2016 as Mr O'Brien off for surgery. 6. Mr O'Brien had not been told about Oversight Committee discussions, some 5 months since they were first held…. The senior managers who did not bring these matters to Mr O'Brien's attention had a responsibility to do so and are accountable for their failures to act in accordance with their own professional codes. 7. Conclude that the failures to follow up from the March meeting, the reporting and development of the action plan in September and lack fo action on this and agreed deferral at the October meeting suggest that if the SAI had not arisen that the question of an MHPS investigation may have been delayed even further or not have arisen at all. 8. The review panel considered this aspect of the grievance, considering the full report produced and the range of options which were open to the Case Manager… had taken appropriate advice on foot on all this there was a finding of misconduct. This in our view was correct as the report clearly identifies the failings which Mr O'Brien demonstrated some of which he acknowledged in the document entitled response to the formal investigation.	Grievance appeal review Page 13 – 14 AOB-50031 - AOB-50032
June 2021	Grievance Appeal Review	Terms of reference 1. In looking at the decision of the Stage One panel there are elements of this that we feel are not justifiable.	Grievance Appeal Review

		2. Note particularly the summary of conclusions by the panel the following: a. *Overall we do not find Mr O'Brien's grievance upheld* It is notable that the panel use the term overall which suggests they have essentially weighed the issues identified against the evidence available but in the consideration of these there is more weight given to what is "against" than "in favour of" Mr O'Brien. 3. Accept there are several of the issues of grievance where we accept the findings that the Trust's actions have been reasonable and justified, we find that the conclusions reached have not addressed the failures on the part of the Trust Managers in addressing their concerns and responsibilities in a prompt and thorough manner… we hold the view that this a weakness in the outcome and is fundamentally unfair. 4. Meeting of March , no follow up – the inaction in relation to follow up while not excusing Mr O'Brien's interpretation in this regard does in our view suggest that the seriousness of this was not as was later argued and gives more weight to his inaction. ….. 5. Chance of resolution was avoided – we do not agree that this is a fair assessment. It relies on the March 2016 meeting with him and the subsequent letter as the evidence to support this and ignores the discussions that were held subsequently at which dialogue and discussion were held by other senior colleagues and which were not shared with him. The panel concluded that the events which unfolded may have had some opportunity for resolution is quite disturbing. To lay the responsibility for this completely at the door of Mr O'Brien is disproportionate… absence of concise and proper management of the concerns held about Mr O'Brien by Trust Management which was not just an issue at the time but appears to have been known for years. 6. … there is an absence of thorough and proper management of the concerns raised in respect of Mr O'Brien and of the management of Mr O'Brien himself… conclude that the stage one grievance has not judged the grievance fairly. We hold the opinion that there are several of Mr O'Brien's complaints that should have been upheld or partially upheld.	Page 15 – 18 AOB-50033 - AOB-50036
June 2021	Grievance Appeal Review	Terms of Reference: 1. We have accepted that there were problems with the administrative practices of Mr O'Brien which were known for years, within the Directorate and on a wider basis. While we accept that Mr O'Brien's approach to this being raised was to initially ignore it, the absence of timely follow up did not affirm the seriousness with which the Trust was viewing this but supported his casual approach to it. 2. The most troubling concern that we have in relation to this matter is that throughout this time there is little mention of patients and the degree to which the failure to triage and report and then subsequent ongoing delays in processes all served to	Grievance Appeal Review Page 19 – 20 AOB-50037 - AOB-50038

			compromise patient care. The case manager's report confirmed significant numbers of patients untriaged (783) and it was determined has this been done, 24 of these would have been to red flag status which impacted on the assessment and planning of their treatment and care. Of this 24, 5 have gone on to have a cancer diagnosis and their treatment delayed by the failure of triage….	