Urology Services Inquiry

AMENDED SCHEDULE

[No 1A of 2022]

Preamble

We refer to Notice 1 of 2022 and specifically question 9 of said Notice.

By way of correspondence to the Inquiry dated the 8th March 2022, the Directorate of Legal Services, on behalf of the Trust, sent the following:-

"Please see attached copy of the draft patient details spreadsheet. I would ask you to note the heading the Trust has added which details the patient names who, after clinical screening, have been removed from the SCRR patient list. The Trust has added column 'I' which outlines the reason for removal of the patients from the SCRR list. The names and designation of those personnel present at the screening meetings have also been included on the spreadsheet. (The actual screening notes will be submitted with the S.21 No 1 of 2022 witness statement which is due for submission on 18 March 2022 from Dr O'Kane).

There are 56 patients on this spreadsheet which includes the two patients who are query SCRR patient's Clinical screening for these two patients is ongoing."

Questions:-

Arising out of this update the Trust is now asked to address the following matters:-

1. Taking each patient in turn and by name, explain why each of the 10 patients identified on the spreadsheet were initially included within the SCRR process.

   In answering this question you are required to provide an account of all of the information and factors that were taken into account, the date each decision was made, and the identity of the person(s) who made the decision to include the patient within the SCRR process and their job title.

2. Explain whether the initial decisions in respect of these 10 patients, to include them within the SCRR process, were the subject of oversight and/or an approval mechanism? If so, describe how this mechanism worked in respect of each patient, its outcome in respect of each patient and identify who was responsible for its operation and their job title.

3. Without merely repeating the generic explanation contained on the spreadsheet (i.e. *"no longer felt the patient met the threshold criteria for an SCRR"*), and taking each patient in turn and by name, explain why each of the 10 patients was removed from the SCRR process.

   In answering this question you are required to provide an account of all of the information and factors that were taken into account when reaching the decision to remove the patient from SCRR, and to fully explain the process of clinical screening which led to these decisions. You should also provide the date each decision was made, and the identity of the person(s) who made the decision to remove the patient from the SCRR process and their job title.

4. Explain whether the decisions to remove the 10 patients from the SCRR process, were the subject of oversight and/or an approval mechanism? If so, describe how this mechanism worked in respect of each patient, and identify who was responsible for its operation and their job title.

5. Is the screening panel and/or an oversight panel (if applicable) with responsibility for decisions in respect of the SCRR process required to declare any conflicts of interest prior to deciding on whether to include or exclude a particular case from the SCRR process?

6. Were each of the 66 patients contacted by the Trust to confirm their initial inclusion within the SCRR process?

7. Were the 10, now excluded patients, informed of the Trusts decision to remove them from the SCRR process?

8. What opportunity, if any, was the patient given to make comments on the Trusts decision to exclude them?

9. Confirm that the precise number of patients captured within the SAI reviews which were triggered in 2020 concerning the practices of Mr O'Brien is 9.

10. Confirm that the precise number of patients captured within the initial SCRR process (prior to the latest reduction of 10) is 66, meaning collectively there are 75 patients within these combined categories.

11. Confirm whether [redacted] Patient 6 is within the SAI 2020 category or the SCRR category.

In addressing the questions raised within this Notice, the Trust is also required to disclose any documentation relevant to its answers, and to refer to the specific sections of any document which support the answer being provided.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

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USI Ref: S21 1a of 2022

Date of Notice: 10 March 2022

Witness Statement of:

I, Ellen Maria O'Kane, will say as follows:-

1. I am the Medical Director and Temporary Accounting Officer and Cover for the Chief Executive of the SHSCT ('the Trust'). I make this statement, in response to Section 21 Notice No.1A of 2022 on behalf of the Trust in my capacity as acting Accounting Officer and Covering for the Trust Chief Executive.

2. With the permission of the Inquiry, I have relied upon the assistance of other Trust personnel in compiling documents and information in response to this Section 21 Notice. In particular, I have relied upon the following persons:

Question No	Name
1.	Chris Wamsley, Acute Governance Coordinator Sarah Ward, Head of Urology Clinical Assurance Martina Corrigan, Assistant Director Public Inquiry and Trust Liaison
2.	Chris Wamsley, Acute Governance Coordinator Sarah Ward, Head of Urology Clinical Assurance
3.	Chris Wamsley, Acute Governance Coordinator
4.	Chris Wamsley, Acute Governance Coordinator
5.	Chris Wamsley, Acute Governance Coordinator
6.	Chris Wamsley, Acute Governance Coordinator
7.	Chris Wamsley, Acute Governance Coordinator
8.	Chris Wamsley, Acute Governance Coordinator

9.	Martina Corrigan, Assistant Director Public Inquiry and Trust Liaison
10	Chris Wamsley, Acute Governance Coordinator

3. Below, I set out in bold text each question asked in Section 21 Notice No.1A of 2022 followed by my answer to it. Any documents being provided are in the form of Appendices to this statement.

1. Taking each patient in turn and by name, explain why each of the 10 patients identified on the spreadsheet were initially included within the SCRR process.

In answering this question you are required to provide

a. an account of all of the information and factors that were taken into account,

b. the date each decision was made,

c. and the identity of the person(s) who made the decision to include the patient within the SCRR process and their job title.

4. Originally there were 77 patients identified as meeting the criteria for SAI and they came from the review work that Prof Sethia (March 2020 onwards), Mr Keane (2nd Nov 2020 to 22nd Dec 2020), and Mr Haynes (Nov 2020- March 2021) undertook. The process that led to these 77 patients being identified involved Mr Haynes (Consultant Urologist and Divisional Medical Director in Urology), assisted by Martina Corrigan (Assistant Director for Public Inquiry and Trust Liaison), considering the review forms / letters for each patient mentioned at paragraphs 4.1 to 4.5 below along with other records such as NIECR and asking whether the patient

was at potential risk of having come to harm. If Mr Haynes' opinion was 'yes' then the patient went on to be considered at a formal second stage by the Acute Governance Screening Team (described in more detail at paragraphs 5, 8 and 9 below). These 77 patients were identified from the following cohorts:

4.1 1028 Radiology results
4.2 215 Mr Keane urology clinic review
4.3 168 Histopathology results
4.4 271 MDM episodes
4.5 A total of 466 patients were identified from the Western, Northern and Southern Trust areas as having received a prescription for Bicalutamide 50mg. Of these 34 were identified as not meeting the recognised indications

5. These 77 patients were then subjected to formal SAI screening by the Acute Governance Screening Team (named below at paragraph 9) and were reduced to 53 patients with 6 under further discussions. Therefore, 18 of the patients who had been screened in at the first stage were screened out through the formal second stage process adopted by the Acute Governance Screening Team. A detailed summary of the decisions made regarding the screening in of the 53 and the screening out of the 18 can be found in the tables that follow, respectively, paragraphs 12 and 19 of this statement. I understand that this level of detail is available in respect of the second, but not the first, stage of the screening process because, at the second stage, urology screening outcome forms were completed to record the Team's decision-making.

6. In addition to the above patients, those additional 402 patients who were identified by Prof Sethia where there have been clinical queries but who on first discussion with Mr Haynes and Mrs Corrigan did not appear to meet the criteria for SAI, are now also being formally screened by the Acute Governance Screening Team. To date 8 have been identified as meeting the criteria for SAI.

7. As indicated above, the cases which highlighted potential concerns were progressed through the normal SAI screening process following the initial review completed by Mr Haynes and Martina Corrigan.

8. The normal SAI screening process within Acute Services is completed through screening meetings with each division holding their own meeting. The membership of the Screening meetings have a universal core membership of the Assistant Director of the Division, the Divisional Medical Directors of the Division, Clinical Governance Coordinator and Governance Managers. Incidents which reach the threshold are discussed with the group members to collectively decide if a further investigation is necessary to identify system and process learning for the organization using the HSCB SAI investigation criteria. For the Urology cases which reach the threshold for an SAI, these are being reviewed through the SCRR process.

9. The identity of the Urology Screening Team members (the second stage of the process described above) are highlighted below.

   - Ronan Carroll – Assistant Director for SEC and ATICs
   - Mr McNaboe – Divisional Medical Director for SEC
   - Dr McKee – Divisional Medical Director for ATICs
   - Mr Haynes – Divisional Medical Director of Urology
   - Dr Scullion – Deputy Medical Director Appraisal and Revalidation
   - Chris Wamsley – Acute Clinical Governance Coordinator
   - Sarah Ward - Head of Clinical Assurance for the Public Inquiry
   - Carly Connolly – Governance Manager

- David Cardwell – Governance Manager
- Dawn King – Governance Manager
- Roisin Farrell - Governance Officer

10. The screening of the highlighted Urology cases is an ongoing process in the Southern Trust. An overview of the dates and numbers of cases screened are provided in the table below.

Date	Cases Screened	No. for SCRR	No. excluded for SCRR	No. to return to screening.	Comments
15/11/2021	16	13	0	3	
22/11/2021	22	13	5	4	
29/11/2021	17	7	4	6	
6/12/2021	0– Screening cancelled	N/A	N/A	N/A	Mr Haynes Unavailable
13/12/2021	0– Screening cancelled	N/A	N/A	N/A	Mr Haynes Unavailable
20/12/2021	18	12	5 (1 x not original 77)	1	
10/01/2021	19	8	4 (1 X Duplication)	4	

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11. The attendance of Mr Haynes, who is a Consultant Urologist, at the Urology Screening meetings is mandatory as the specialist urological knowledge of NICE guidelines, standards and treatments is essential to inform the screening meeting members to ensure informed decisions surrounding the SCRR process are obtained.

12. A summary of the 53 SCRR Screened IN Patients is set out in the table below and includes their name and a summary of both the relevant patient information and discussions. Those screened out are dealt with in Question 3 from paragraph 19.

15/11/2021

No. Name H+C	Summary of Incident	Summary of Discussions
1. Patient 17 Personal Information redacted by the USI	Personal Information year old gentleman with known history of prostate adenocarcinoma, Gleason score 3+3= 6 March 2011. PMHx of hypertension, AAA, BCC and MI. Patient 17 is currently on Bicalutamide 50mg for his prostate cancer. For outpatient review to recommend stopping bicalutamide and management by surveillance with up to date MRI staging if his PSA is rising and consideration of management options at that point.	15.11.21 - MDT surveillance, 2012 PSA rising, hormone and radiotherapy. Not referred for radiotherapy. Were these patients ever brought back to MDT. No mechanism in MDT at present to check or follow up of recommendations. This is a weakness. Has been highlighted at a senior level. **Meets the criteria for review.**
2. Patient 19 Personal Information redacted by the USI	Personal Information year old gentleman who had organ confined, Gleason 7, prostatic carcinoma diagnosed in 2011 and managed entirely with androgen blockade	15.11.21 - MDT outcome at aged Personal Information - started on bicalutamide. Looks like hormones alone when treatment options should have been radical treatment or watchful waiting/surveillance. Now onto watchful waiting. Has had fractured neck of femur. ADT increases risk of

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	alone since then. He has continued to take Bicalutamide 150mg daily in addition to Tamoxifen 10mg daily. Patient 19 is on Bicalutamide 150mg for his non metastatic prostate cancer. Watchful waiting / intermittent ADT are the recommended treatments.	osteoporosis. **Meets the criteria for review.**
3. Patient 20 Personal Information redacted by the USI	Personal Information redacted year old gentleman diagnosed with high risk Gleason 4+3 prostate cancer in 2014 and was Started on androgen blockade. His on-going PSA monitoring has showed minimal change in PSA with his most recent PSA in July 2020 being 0.05ng/ml. From medication point of view he currently takes Tamoxifen 10mg once daily and Bicalutamide 150mg once daily	15.11.21 - Looks like hormones alone when treatment options should have been radical treatment or watchful waiting/surveillance. MDT May 2014. Started on 150 mg. Nothing to suggest he was offered radical treatment as MDT suggested. April 2021 consideration of radiotherapy. Has since had same. Due to finish ADT in January 2022. Delay of 7 years - this has resulted in unnecessary ADT. **Meets the criteria for review.**
4. Patient 23 Personal Information redacted by the USI	Mr Patient 23 is currently receiving no treatment for his Prostate cancer. For outpatients review and recommendation of management by active surveillance with an up to date MRI scan and consideration of surveillance biopsy on the basis of PSA dynamics and MRI findings. Structured Clinical Judgement Review to be performed	15.11.21 - This patient is on watchful waiting. Localised prostate cancer 2011. Initially had some discussions about treatment with hormones and radiotherapy. TURP 2013. Stopped ADT himself and switched to surveillance. Prescription of hormones was 50mg initially. Not a licensed dose**. Meets the criteria for review.**
5. Patient 37	Patient 37 is currently Bicalutamide 150mg for a high risk non metastatic prostate cancer. For outpatients review to	15.11.21 - Diagnosed with high risk locally advanced prostate cancer in Feb 2020. Not referred for radiotherapy. MDT consideration for radial treatment or watch and wait.

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Personal Information redacted by the USI	recommend the addition of EBRT and referral to oncology if fit for radiotherapy.	Commenced on hormones alone. Subsequently referred for radiotherapy. Meets the critera for review. Recurring trend that patients are started on adjuvent treatment and not being followed up. PRO7 study findings have been well known since 2015 - specifically relates to this case (hormones and radiotherapy should have been the management for this patient) **Meets the criteria for review.**
6. Patient 38 Personal Information redacted by the USI	Patient 38 has been managed with Bicalutamide 150mg for prostate cancer. Despite antiandrogens his current PSA is 11.6. For outpatients review to recommend stopping bicalutamide and monitoring of PSA with a view to watchful waiting / intermittent androgen deprivation and to consider staging with CT and bone scan. If hormones are required in the future it should be an LHRH analogue or LHRH antagonist. Following MDM discussion his Bicalutamide has now been discontinued.	15.11.21 - Was started on an unlicensed dose of 50mg. Should have been offered a radical treatment option. PSA was not controlled. Questions around whether he should have been switched to a standard treatment. Should have been offered long term watch and wait rather drug therapy. Three issues which require investigation. **Meets the criteria for review.**
8. Patient 51 Personal Information redacted by the USI	Personal Information year old gentleman diagnosed with Gleason 3+4 prostate cancer which is currently managed with androgen deprivation therapy. Patient 51 is currently receiving Bicalutamide for his prostate cancer. For outpatients review to arrange up to date staging with an MRI and to discuss options of EBRT vs	15.11.21 - Looks like hormones alone when treatment options should have been radical treatment or watchful waiting/surveillance. **Meets the criteria for review.**

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	surveillance/watchful waiting.	
10. Patient 61 Personal Information redacted by the USI	Personal Information redacted year old gentleman diagnosed with Gleason score 4+4=8 organ confined adenocarcinoma of his prostate gland, June 2012. Patient 61 is on an LHRHa for his prostate cancer. For outpatient review to discuss re-staging and referral to oncology if fit for radiotherapy and to refer for assessment of bone density	15.11.21 - Was not offered radial treatment at time of diagnosis - options were surveillance or watchful waiting. Has received a prolonged period of ADT which was not indicated. Diagnosis in 2012, MDT decided radiotherapy but this was not followed up. Was discussed at MDT on 8 April 2021 and opinion of group was that restaging and discuss. Not offered radical treatment at the time of diagnosis in 2012 as he should have been. Patient has not got the service that they should have got - **meets the criteria for an SJR** as he was not offered the primary treatment.
11. Patient 77 Personal Information redacted by the USI	Personal Information redacted year old gentleman was diagnosed with clinical and biochemical diagnosis of prostatic carcinoma in May 2018 when he was reported to have a prostatic volume was reported to be 88ml and his residual urine volume was reported to be 201ml. Patient commenced him on Bicalutamide and Tamoxifen 2018. Patient 77 is on Bicalutamide 150mg for a clinical diagnosis of prostate cancer. For outpatient review, to recommend stopping bicalutamide and management with surveillance with consideration of staging / investigation dependent upon PSA dynamics.	15.11.21 - Reluctance to manage patients without treatment. Breast growth with bicalutamide. Tamoxifen to reduce this. Was started on medication without evidence of metastatic disease. Now being managed with watchful waiting and PSA monitoring. No diagnosis of cancer. Suspect reduced dose was to reduce complications of treatment. **Meets the criteria for review.**
13. Patient 74	Patient 74 has a low risk non muscle invasive bladder cancer treated by TURBT. For review by Mr O'Brien to recommend flexible	15.11.21 - Patient who contacted the Trust re concerns about management. Helpline. Was seen in clinic by Mr Haynes. Prostate cancer treated with radiotherapy. Now incontinent managed with pads.

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Personal Information redacted by the USI	cystoscopy in 3 months. Complaint about his treatment under Mr O'Brien. Comment MDH - ?indications for why a TURP was performed in 2013	Issues are incontinence. Mr Haynes could not satisfy the decision to proceed to TURP - this is incontinence stems from. Continuous stress incontinence. Bladder cancer first and then TURP when he attended for bladder procedure. Prostate cancer diagnosed at this point. 2013 given botox, went into retention, subsequent TURP (10% risk of retention) not an indication for bladder outflow surgery. In absence of obstruction TURP can worsen obstruction. Stress incontinence relates to closure pressures. Concerns re bladder outflow surgery. **Meets the criteria for review**.
14. Patient 6 Personal Information redacted by the USI	Patient 6 has an intermediate risk organ confined prostate cancer. Initially treated with Bicalutamide 50mg, switched to 150mg in November 2019 and then Mr Patient 6 has discontinued Bicalutamide since his last prescription in February 2020 - Recent PSA 15	15.11.21 - Initially started on 50mg for stage of disease which options were radical treatment or surveillance. Neither has he been treated or monitored. **Meets the criteria for review**
15. Patient 66 Personal Information redacted by the USI	On review with Mr O'Brien he was commenced on a low dose of Bicalutamide and placed on the waiting list for a TURP with the intent that the TURP would improve his urinary symptoms and obtain tissue for pathology with regards to prostate cancer likely diagnosis	15.11.21 - 2019 Raised PSA. No evidence of metastsis. Commenced on 50mg and planned for a TURP. No diagnosis of prostate cancer. PSA 28.8. Standard investigation of a raised PSA would include consideration of MRI and prostate biopsy. Started on unlicensed dose and investigation plan was not standard for diagnosis. Received hormone treatment to December 2020. Still no tissue diagnosis. Now on watchful waiting. Personal Information year old. PSA dynamics do not trigger any indication for treatment. The only standard use for 50mg is for testestrone flair for patients being started on LHRHa. Difficult to

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		understand why this drug was used. **Meets the criteria for review**
16. Patient 60 [redacted] Personal Information redacted by the USI	High risk locally advanced prostate cancer diagnosed 2017 and treated with oral Bicalutamide to date	15.11.21 - 2017 MDT high risk locally advanced disease. Treatment with curative intent. Started on 150 mg in March 2017. For patients having ADT with radiotherapy will receive this drug from oncologist. **Meets the criteria for review.**

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No. Name **H+C**	**Summary of Incident**	**Summary of Discussions**
7. Patient 40 [redacted] Personal Information redacted by the USI	Personal Information redacted year old gentleman diagnosed in 2012 with an PSA of 9, Gleason 7 (4+3) T2 adenocarcinoma Of prostate gland. Treatment history: Completed radical radiotherapy January 2013. Various doses of hormone treatment over the years stopping in January. PMHx of Prostate Ca and Renal Stone disease. Patient 40 has been treated with radiotherapy for his prostate cancer. He had some concerns regarding the delay from diagnosis to having radiotherapy.	15.11.21 - Patient advised during consultation with Mr Haynes. Was not referred for radiotherapy on diagnosis. Diagnosis in 2008 (prostate cancer). Started on Bicalutamide 50mg. Also had Tamoxifen started. In 2012 started on LHRHa in addition to Bicalutamide - referred to oncology. In documentation regarding radiotherapy, it is noted patient found it difficult to travel but later raised concerns about a delay in radiotherapy from 2008 to 2012. Need to obtain MDT outcomes. Standard pathway MDT at point of diagnosis would not come back when switching treatments. 19/11/2021 There was no MDT at this time. 22.11.2021 there is documentation in letters about radiotherapy, but patient advised he had difficulty travelling for radiotherapy. 2008 no MDM on CaPPs system. The patient has raised the concern in consultation, reviewing this one comment. Not keen for surgery, would not travel to Belfast on daily basis for 7/52.

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		Adequate evidence, offered radio and patient choice not to get radiotherapy. Low dose Bicalutamide unlicensed treatment. **For SJR.**
18. Patient 31 [redacted] Personal Information redacted by the USI	Bicalutamide 2011 and then Radiotherapy 2014 for CaP had assessment of LUTS prior to RT but dose of bicalutamide 50mg and 3 years from diagnosis to RT incorrect dose of bicalutamide referral to oncology delayed	22.11.2021 Discussed at screening- 01.05.2021 tel consultant with Mr Haynes. Patient was on an unlicensed dose of Bicalutamide, Now on correct treatment, **For SJR.**
22. Patient 67 [redacted] Personal Information redacted by the USI	Colovesical fistula, Haematuria / ?TCC bladder and raised PSA initial pathological interpretation of bladder lesion as G2Ta bladder cancer but review at MDM in keeping with inflammatory process. Raised PSA at time. MDM review January 2019 '... For review by Mr O'Brien to reassure and to repeat serum PSA.' Letter 16/1/19 discharged. No repeat PSA. Subsequently PSA has been found to remain elevated and is undergoing further investigations currently - Repeat PSA not checked despite MDM recommendation	22.11.2021 Discussed at screening. MDM Jan 2019 advised to repeat serum PSA- this was not done. Has had PSA repeated since and was elevated. Has since gone through prostate cancer diagnostic pathway and treated for prostate cancer. Patient aware. Would have had an earlier diagnosis had PSA done earlier. Patient has not come to harm. Earlier treatment small/ slight increase in cure. Patient inadvertently went onto watchful waiting. There is the potential of harm. MDM outcome not followed. **For SJR review.**
24. Patient 43 [redacted] Personal Information redacted by the USI	Admitted and catheterised for high pressure retention 2x TURPs CVA after 2nd TURP commenced on off license bicalutamide dizziness (SE of both tamsulosin and bicalutamide). Concerns;	22.11.2021 Discussed at screening-unlicensed use of Bicalutamide-bladder outflow surgery reasonable, TURP failed to establish voiding, 2nd TURP failed to establish voiding and pt had a stroke. Prostate volume 148cm3 at the time, NICE guidelines recommend Prostate volume >80 alternative treatment should be used, should have been offered alternative treatment and

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	1)no evidence of discussion of off license use or risks of bicalutamide 2)no offer of alternatives to TURP for large glands (NICE CG97 2010/15 recommendation 1.5.4) Bicalutamide off license use with no evidence discussion of this or risks prostate volume not assessed formally on initial admission and no discussion of alternatives to TURP as per NICE CG97 maybe had CVA after second GA. If he had been offered and opted for holmium enucleation (would have been ECR to England) would have only required 1 GA	avoided 2nd anaesthetic, which resulted in a stroke. Cardiovascular complications risk doubles after 1st anaesthetic- patient was Personal Information yrs at the time. Issues: 2 operation could have been avoided if offered alternative treatment; Bicalutamide off licensed dose. ADT given afterwards. NICE guidance offer alternative treatment, and maybe would have had a better outcome (no CVA). Unlicensed dose of medication, with side effects. **FOR SJR**
27. Patient 26 Personal Information redacted by the USI	Diagnosis: Intermediate risk localised prostate cancer diagnosed 2009 – on Bicalutamide 50mg since July 2010	22.11.2021 Discussed at screening- on a prolonged period of unlicensed dose of Bicalutamide. Mr Haynes reviewed patient 02.11.2020, patient aware. **FOR SJR**
28. Patient 33 Personal Information redacted by the USI	Diagnosis: T2 intermediate risk localised prostate cancer diagnosed in 2014 treated with low dose Bicalutamide since 2014	22.11.21 Mr Haynes reviewed patient on 3.11.2020. Personal Information at diagnosis. 2014 commenced on low dose Bicalutamide. Patient had a prolonged period of unlicensed dose of low Bicalutamide. Patient aware. Now switched to watchful waiting, **FOR SJR**
29. Patient 41 Personal Information redacted by the USI	Diagnosis: Prostate cancer diagnosed September 2014, gleason 3+5=8 in 2 of 6 cores with initial PSA of 8.02 initially commenced on Bicalutamide and Tamoxifen at a dose of 150/10. Discontinued due to hot flushes. He was then	22.11.21 Discussed at screening 02.11.20 reviewed by Mr Haynes, Patient had high-risk disease, no MRI was completed but had CT scan, commenced Bicalutamide and discontinued, then was restarted on Bicalutamide 50mg, treatment options should have been watchful

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	more recently started on Bicalutamide to 50mg	waiting or hormone/ radiotherapy. Discussed at 2014 MDT histology review, no evidence of subsequent MDM discussion. Patient informed. Patient is currently on watchful waiting pathway. **For SJR.**
30. Patient 45 Personal Information redacted by the USI	Diagnosis: intermediate risk prostate cancer diagnosed 2015 with initial PSA 13.25, gleason 4+3=7 prostate cancer in 5 of 10 cores and radiological evidence of no metastases and possible early T3a disease. on combined androgen blockade	22.11.21 Discussed at screening. Mr Haynes has reviewed patient - non-metastatic cancer standard treatment would be surveillance/ watchful waiting or radical treatment. Not offered referral to Radiotherapy. Patient was on unlicensed treatment. Patient now aware. **FOR SJR**
31. Patient 48 Personal Information redacted by the USI	Diagnosis: Locally prostate cancer diagnosed in 2010, on anti-androgen since diagnosis	22.11.2021 Clinical relevant index, diagnosed in 2010, PSA 15 prostate cancer, non-metastases prostate cancer 2010, pt was Personal Information, commenced on hormone treatment, AOB thought no need for radiotherapy, no evidence of benefits to treat with hormone treatment. Not offered opportunity for radiotherapy. Mr Haynes has reviewed patient and now on watchful waiting as this is the appropriate pathway. Patient could have had 10 yrs without hormone treatment on watchful waiting pathway. **For SJR**
32. Patient 49 Personal Information redacted by the USI	Diagnosis: Clinical/radiological suspicion of prostate cancer diagnosed in 2015 with PSA of 6.24 (on finasteride) and radiological suspicion of T2 (localised) prostate cancer - No prostate biopsy performed	Mr Haynes met and reviewed patient- Radiological suspicion of localised disease, Personal Information at time, not biopsied, started low dose Bicalutamide and continued on same. Personal Information redacted yrs old showed evidence PSA of 12 and evidence with localised disease, watchful waiting without biopsy, now on surveillance pathway as appropriate treatment. Unlicensed treatment dose of Bicalutamide, no sign of consent process, risks and benefits explained. **For SJR.**

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33. Patient 56 Personal Information redacted by the USI	Diagnosis: Low risk prostate cancer diagnosed 2003 treated with initially LH RH analogue for short period followed by low dose Bicalutamide treatment which he has remained on since diagnosis	22.11.2021- Personal Information yr old diagnosed in 2003 with low risk prostate cancer, placed on LHRH then Bicalutamide 50mg, treatment now discontinued current treatment on surveillance pathway. Can't find all details, should have been offered surveillance/ watchful waiting as most appropriate, patient had an unlicensed dose for 16 years before stopped Dec 2019. Patient is aware, NH patient won't actively follow up. **For SJR.**
34. Patient 68 Personal Information redacted by the USI	Diagnosed 2017 with an iPSA of 43, Gleason 7 (4+3), T2, N0, M0, adenocarcinoma of the prostate Gland – seen in Independent Sector and recommended that his case management is reviewed	22/11/2021 Discussed at screening diagnosed in 2011 prostate cancer, then treated with Bicalutamide at 150mg then sub LHRH, had non metastases disease at presentation, no discussion about radiotherapy until 3-4 years later, subs referral made to radiotherapy 2016/17. HIGH RISK localised cancer, MDMT outcome not followed, could have been off treatment if referred to radiotherapy earlier. Radiotherapy was recommended, no mechanism for tracking MDM outcomes. Responsibility lies with clinician to carryout MDT outcomes. Has been treated and currently on appropriate treatment. **For SJR review.**
36. Patient 80 Personal Information redacted by the USI	Personal Information year old gentleman diagnosed with Intermediate risk small volume localised prostate cancer in May 2012 with initial PSA of 7.36 and gleason 3+4=7 prostate cancer in 3 of 12 cores radiological stage T2 N0 M0. Treatment with low dose (50mg) Bicalutamide and tamoxifen since diagnosis.	22/11/2021 screening recurrent theme, unlicensed dose of bicalutamide, follow on from morning decision, seen by Mark Haynes on unlicensed treatment for prolonged period, without indication, should have been surveillance or radical treatment, now on surveillance. **For SJR**

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No. Name **H+C**	**Summary of Incident**	**Summary of Discussions**
37. Patient 82 Personal Information redacted by the USI Personal Information redacted by the USI	Personal Information redacted by the USI year old gentleman Personal Information redacted by the USI diagnosed with Localised intermediate risk prostate cancer initially in 2010 and commenced on low dose Bicalutamide 50mg and Tamoxifen 10mg February 2011.	29/11/2021 - Seen Mr Hayes recently -standard localised prostate cancer age Personal Information redacted by the USI - low dose Bicalutamide maintained, patient was never offered radical treatment, Mr Haynes took of treatment Nov 2020. **For SJR.**
38. Patient 42 [redacted] Personal Information redacted by the USI	Prostate cancer treated with radical radiotherapy – phoned Urology Inquiry Information line – wants his care under Mr O'Brien looked into (transferred to Mr Young on his wishes)	29/11/2021- Query timescales- seen in 2017 urinary symptoms raised PSA, clinical obs USS done March 2018; pt went on holiday bloods done Aug 2018. Letter March 2018 stated for blood test in June, if PSA was up to arrange MRI, pt tried to contact AOB with results and no action was taken. Despite contact with sec, no action taken, pt escalated to HOS and had an app with Mr Young. Patient was then diagnosed and had radiotherapy. Pt describes interaction he had with Mr AOB led to AOB not to take action for review. Patient contacted secretary and received no response. We do not know if sec shared info with AOB. Patient was investigated and assessed as intermediate risk prostate cancer. The patient's interaction was unsatisfactory and led to him not being followed up. Escalated following multiple contacts with secretary. Sec should add to doaro list and remain on list until PSA done, In August this should have been identified and flagged up. There was delay in diagnosis, no evidence harm

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		done.. There is potential harm, doaro list is a failsafe and should be used. **FOR SJR**.
40. Patient 36 Personal Information redacted by the USI	This Personal Information -year-old man attended Urology in 2017 and had Adenocarcinoma Prostate Gleason 3+4 diagnosed in April 2017. He was commenced on Bicalutamide and Tamoxifen on 05.05.17 and subsequently commenced on Fesoterodine 4mg daily in September 17.	29/11/2019 MDM outcome watchful waiting was started on hormone treatment, never referred for radiotherapy. Patient not aware DNA appointment. Not offered radio or watchful waiting, Quality impact on life on hormonal treatment. Evidence should have had hormone and radiotherapy, or watchful waiting. **FOR SJR**
42. Patient 55 Personal Information redacted by the USI	Diagnosis: Gleason 3+4=7 prostate adenocarcinoma diagnosed 2015 Radical radiotherapy completed July 2015 – IPSS =17 Subsequent treatment with Bicalutamide, Tamoxifen and medroxyprogesterone under Mr O'Brien	29/11/2021 Discussed at screening. Noted some clinicians rely on outpatient review to trigger a follow up, even with recognition they cannot provide review within recommended time scales due to backlog. Outpatient reviews. 3/12 No PSA, there was a delay in referral, then pt DNA appointment. There are complex letters query excuse for 8/12 delay in dictation. Definitely, there was a delay in action from clinic outcome, delayed referral to oncology. Patient DNA himself, although pt might have miss-understood urgency due to the delay in appointment. DNA are common for a variety of reasons. Delay in referral was too long. Reason provided in letter does not justify reason for delay and non-action from MDT recommendation. **FOR SJR**.
48. Patient 35 Personal Information redacted by the USI Personal Information redacted by the USI	Highlighted by professor Sethia Initial diagnosis in 2009 with a Gleason 7 T2 adenocarcinoma of the prostate gland. US guided biopsy in 2012 Gleason 7 was noted and a PSA of 3.9.	29/11/2021 Discussed at screening. Same as previous cases. Feb 2013 Bicalutamide 50mg, Off licence dose, later increased 150mg, no evidence offered surgery instead of hormone treatment, completed radiotherapy December 2014. FOR SJR Surgery should be a treatment option, no evidence choice offered, low dose of Bicalutamide . Treatment discussion in outpatient department should be in

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		notes. See attached notes.07/02/2022 Discussed at screening, Bicalutamide dose. **FOR SJR**
72. Patient 57 Personal Information redacted by the USI	Highlighted by Mr Keane at OPD clinic in Independent Sector SJR - Bicalutamide - medication unlicensed dose	28/11/2021 Discussed at screening. Off licence dose of Bicalutamide, prolonged period of ADT, subsequently referred to Oncology in 2014, completed radiotherapy 2015. Has had good outcome and done well. **FOR SJR**
74. Patient 18 Personal Information redacted by the USI	Highlighted by Mr Keane at OPD clinic in Independent Sector 'you may wish to review the hormone initial management of Patient 18'	29/11/2021 Discussed at screening. Initial hormone treatment with Bicalutamide 50mg. Discontinued himself because of side effects, then referred later for radiotherapy. Initial diagnosis was Sept 2011. Seen for discussion re surgery Nov 12, then referred to Radiotherapy. There was a delay in referral for radical treatment. Has now had treatment and has had a good outcome, patient unaware. **FOR SJR.**

20/12/2021

No. Name **H+C**	**Summary of Incident**	**Summary of Discussions**
59. Patient 63 Personal Information redacted by the USI	Highlighted by Professor Sethia Delayed diagnosis of Ca lung	Discussed at screening 20/12/2021 - Patient had CT scan Dec 2017- new lung nodule- follow up not done. CT 2018 Nodule bigger. There was a 9-month delay in lung cancer, CT report was not actioned. Patient attended as an emergency and only then was action taken, referred to oncology. **FOR SJR**, Patient not aware but may have some insight.

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62. Patient 34 Personal Information redacted by the USI	Highlighted by Mr Keane at OPD clinic in Independent Sector SJR no letters pt was on bicalutamide for a number of years before being offered radiotherapy	Discussed at screening 20/12/2021 - Patient commenced bicalutamide 2013. Off license dose, delay in referral to radiology, pt seen privately. **FOR SJR.**
64. Patient 72 Personal Information redacted by the USI	Highlighted by Mr Keane at OPD clinic in Independent Sector SJR - on bicalutamide for years before he had alternative treatment (2012-2014) and only started his LH/RHa in May 2014	Discussed at screening 20/12/2021- off license dose of bicalutamide. **FOR SJR**. Patient not aware. Sarah to follow up**.**
66. Patient 25 Personal Information redacted by the USI	Highlighted by Mr Keane at OPD clinic in Independent Sector Current management plan in place with MDH but needs an SJR for previous episodes	Discussed at screening 20/12/21. Off license dose of Bic 50mg, delay in referral for radiotherapy**. FOR SJR**. Sarah to inform patient.
67. Patient 32 Personal Information redacted by the USI	Highlighted by Mr Keane at OPD clinic in Independent Sector SJR as appears to have been on hormones for longer than should be and has FU planned	Discussed at screening 20/12/21- Intermediate risk -MDT- started Bicalultamide 50mg Feb 2014, switched to LHRHa May 2015, Radiotherapy Dec 2015. Issues off license dose of Nic and delay in referral for radiotherapy. Sarah to inform patient, PSA due March 2022. **For SJR**
68. Patient 24 Personal Information redacted by the USI	Highlighted by Mr Keane at OPD clinic in Independent Sector SJR for appropriateness of radical prostatectomy	Discussed at screening 20.12.21. Limited information 1998 PSA 26, High-grade prostate cancer, placed on hormone treatment before radiotherapy. PSA of 26 would not normally perform surgery, however query evidence base at the time, pt was not offered radical treatment, what was the standard practice in 1998. Mr

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		Haynes is unable to advise. 2 issues identified: pt should have had prosectomy for high-grade disease; should have had hormone treatment then radiotherapy; 29 years on hormone therapy. **FOR SJR**. Sarah to advise patient, nest PSA due March 2022, Sarah to arrange appointment with Mr Haynes before March 2022.
69. Patient 75 Personal Information redacted by the USI	Highlighted by Mr Keane at OPD clinic in Independent Sector This chap was diagnosed with Gleason 4+5 adenocarcinoma in 2011. He was then put on minimal androgen blockade using 50mg of bicalutamide and tamoxifen. There was no MDM discussion and he eventually ended up in the BCH system as he was referred on for radiotherapy on which he has done very well. obviously treating somebody with Gleason 9 adenocarcinoma of the prostate with 50mg of bicalutamide would need to be looked into	Discussed at screening 20.12.21. Personal Information redacted by the USI yr old at the time, PSA 10.9, Gleason 9 on biopsy, locally advanced on MRI. 2011 Commenced bicalutamide 50mg, 2014 referred for radiotherapy, Unsure if missed at MDM in 2010/2011. Patient has since deceased Personal Information redacted by the USI, unsure of cause of death, Sarah to follow up. **FOR SJR**
70. Patient 78 Personal Information redacted by the USI	Highlighted by Mr Keane at OPD clinic in Independent Sector He was last seen in 2017 and hasn't been seen since nor his PSA checked. He is still fit and well and the issue of radiation therapy might still arise or intermittent androgen therapy with delayed radiation treatment but this still needs discussed	Discussed at screening 10.01.2022. Mr Haynes unable to see MDT notes. Personal Information redacted by the USI yr old male, appears started hormone alone, intermediate risk for prostate cancer, and should have been offered radical treatment. Commenced off license dose of bicalutamide 50mg increasing to 150mg. Did not refer for radiotherapy. **FOR SJR**. Pt is awaiting clinic appt with Mr Haynes.

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	with the oncology and the surgeons	
71. Patient 70 Personal Information redacted by the USI	Highlighted by Mr Keane at OPD clinic in Independent Sector SJR (bicalutamide - medication unlicenced dose)	2013 Bicalultamide 50mg, switch LHRh 2016, discussion had about radiotherapy, felt best to proceed with drug therapy, who made decision? Letter 2019 documented declined radical radiotherapy. Off license dose of androgen dep therapy. **For SJR**. Sarah to follow up with patient letter to advise of SJR, patient is on Mr Haynes waiting list to be reviewed.
73. Patient 39 Personal Information redacted by the USI	Highlighted by Mr Keane at OPD clinic in Independent Sector SJR started on Bicalutamide 50mg and never offered radiotherapy	SCREENED 20.12.21. 2008 Patient prescribed off license dose of Bicalutamide 50mg, no referral made to oncology at the until January2021, pt developed metastic disease. Patient was not offered appropriate treatment **FOR SJR**. Sarah to book into Mr Haynes clinic.
75. Patient 81 Personal Information redacted by the USI	Highlighted by Mr Keane at OPD clinic in Independent Sector He is entering a hormone refractory period and his management and follow up will need to be reviewed at MDT at Craigavon	2012 intermediate risk prostate cancer. Patient was commenced on Bicalutamide 50mg, not referred to Radiology at the time. Patient had rectal bleeding and was referred to surgery. Unlicensed dose of Bicalutamide, failure to referral to oncology. **FOR SJR**. Patient not aware, Sarah to book into clinic, due PSA check January 2021.
77. Patient 76 Personal Information redacted by the USI	Highlighted by Professor Sethia This Personal Information redacted year old man was placed on a waiting list in August 2014 for elective admission for prostatic resection to relieve bladder outlet obstruction. His prostate gland was resected on 19 December 2019. Histopathological examination of resected tissue found Gleason 3+3 adenocarcinoma involving	Urodynamic study – 2012 no evidence of bladder issues. 2014 added to waiting list for TURP. Question was consent acquired, where risks and benefits explained- complication incontinence. Decision making odd. There is no record for indication/justification for procedure in notes, investigations showed no obstruction. Cancer was an incidental finding.. Sarah to book patient an apt with Mr Haynes clinic. **FOR SJR review**

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	approximately 7% of tissue. There was no perineural or lymphovascular infiltration. He has had severe urinary incontinence since surgery.	

10/01/2022

No. Name **H+C**	**Summary of Incident**	**Summary of Discussions**
41. Patient 46 Personal Information redacted by the USI	SJR on bicalutamide for years before going on an LA analogue and started on non-recommended treatment	Discussed at screening 10/01/2022: off license dose of bicalutamide **FOR SJR**
43. Patient 28 Personal Information redacted by the USI	Diagnosis: T3b N1 prostate cancer at diagnosis 2017 treated with oral Bicalutamide	Discussed at screening 10/01/2022. Metastases prostate cancer, Personal Information yr old commenced Bicalutamide , MDT recommended LHRHa, carried on Bicalutamide, no documentation of consultation about inferior outcomes of treatment, no referral to oncology **for SJR**
44. Patient 27 Personal Information redacted by the USI	Diagnosis: 4.5cm left renal mass Prostate cancer on androgen deprivation therapy On Bicalutamide and Tamoxifen for gleason 3+4 prostate cancer since 2014, stage T2 N0 M0	Discussed at screening 10/01/2022 - Kidney cancer was incidental finding, pt was restaged and this was identified, 2014 Initially commenced on low dose Bicalutamide then increased to 150mg, pt should have been offered radical treatment in 2014. Mr Haynes has referred pt for radiotherapy. 2 issues off license dose Bicalutamide and surveillance or radical treatment. **FOR SJR,**

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		recent clinical letter documents pt informed of options
45. Patient 62 Personal Information redacted by the USI	Patient request and highlighted by professor Sethia: I would like to have my care reviewed I was operated on by Mr Hagan in the City Hospital but the diagnosis and original procedure were carried out by Mr OBrien. As a result I had bladder cancer and prostate cancer I also had a kidney removed and as a result I had a stent inserted and now wear a colostomy bag.	Discussed at screening 10/01/2022 - 2017 pt had stroke, renal impairment right hydronephrosis, 2018 CT urogram 2018, which showed thick bladder wall, TURP July 2018. There was some delay in diagnosis management, flexible cystoscopy should have been considered based on urogram result. CT showed hydronephrosis, no stone evident, pt had a thick bladder wall. Flexible cystoscopy would not have required GI anaesthetic therefore low risk post stroke **FOR SJR** patient need to be informed.
51. Patient 64 Personal Information redacted by the USI	Highlighted by professor Sethia Diagnosis: T2, N0, M0 Gleason 4+3 iPSA 27NGS/ML (on 5ARI) prostate cancer. 9 out of 14 cores recent TURP.	Discussed at screening . Patient was on bicalutamide 150mg. Pt seen with raised PSA in Jan 2017, no correspondence from consultant, planned PSA + USS, both were completed. There is no evidence the results were actioned until patient attended clinic appt August 2018. There is no evidence patient was reviewed. Concerns raised in relation to initial management Jan 2017, high risk prostate cancer, was diagnostic investigation TURP standard practice at the time, patient now has pelvic node. Had patient had earlier management for same in 2017 would be in a different position. PSA raised significantly and no documentation action was taken. **FOR SJR.** Unsure if patient is aware.
53. Patient 58 Personal Information redacted by the USI	Highlighted by professor Sethia DIAGNOSIS: Adenocarcinoma of prostate - He has been diagnosed with prostate cancer in 2008	Discussed at screening 10/01/2021. Localised prostate cancer 2008, commenced low dose Bicalutamide then therapeutic dose 159mg, patient should have been referred for radiotherapy, **FOR SJR** patient aware

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	and has been kept on active surveillance since then.	Mr Haynes informed, pt does not recall offer of radiotherapy.
55. Patient 47 [redacted] Personal Information redacted by the USI	Highlighted by Professor Sethia incorrect management of Ca prostate in 2010 - possible harm	Discussed at screening 10/01/2021. Patient seen privately, no letters on NIECR, patient had non-metastases disease in 2010, should have been offered radical treatment, did patient decline? Patient was seen privately but getting scans done on NHS. Patient commenced primary hormone treatment as stated on Radiology request forms. Sarah to inform patient **FOR SJR**, need to acquire private consultation notes from the GP if not already obtained.
57. Patient 59 [redacted] Personal Information redacted by the USI	Diagnosis: Low risk prostate cancer diagnosed 2006 - Upgrade to intermediate risk prostate cancer on surveillance biopsies 2012 commenced Bicalutamide 50mg daily September 2019	Discussed at screening 10/01/2021. Commenced off license dose of Bicalutamide, should have had radical treatment or watchful wait. Mr Haynes has spoken with pt, telephone consultation and discussed treatments. Discussed at MDT. On appropriate treatment now, surveillance. **FOR SJR**

The above information contained within these tables can be located in S21 No 1a of 2022, Outcome Screening Sheets Excluded from SCRR and Screening Outcome Sheets for Confirmed SCRR Patients.

2. Explain whether the initial decisions in respect of these 10 patients, to include them within the SCRR process, were the subject of oversight and/or an approval mechanism? If so, describe how this mechanism worked in respect of each patient, its outcome in respect of each patient and identify who was responsible for its operation and their job title.

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13. The process outlined at Question 1 above describes how the index 77 patients were identified initially by Mr Haynes and Mrs Corrigan and how the Acute Governance Screening Team acts as an oversight mechanism for their initial decisions.
14. As at 3rd December 2021, there were 10 patients screened 'out' of the SAI process by the Acute Governance SAI Screening Team leaving 67 still to be screened.
15. In the period since then more work has been done and we now have all of the initial 77 screened by the Team, resulting in 53 which will now be subjected to the SCRR process, and 6 others that require further information to decide on status, and which therefore remain undecided.

16. As the Urology cases identified by Prof Sethia progress through the normal screening process the total number of SCRRs will change. . There are a further 247 cases highlighted by Prof Sethia (8 identified as SAI) which will progress through the screening meetings and therefore the potential total number of SCRRs will increase following completion of this process.

17. As highlighted in the table below, the screening process has confirmed and excluded SCRRs from the initial review following assessment within the standardised screening processes within Acute Services.

18. In respect of the limb of the question that asks for identification of the responsible individual and their job title, the screening meetings are designed so that the final decisions are collective, the sum of all its members, and therefore the membership highlighted within question one identifies the collective group undertaking the decision making process.

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3. Without merely repeating the generic explanation contained on the spreadsheet (i.e. "*no longer felt the patient met the threshold criteria for an SCRR*"), and taking each patient in turn and by name, explain why each of the 10 patients was removed from the SCRR process.

In answering this question you are required to provide an account of all of the information and factors that were taken into account when reaching the decision to remove the patient from SCRR, and to fully explain the process of clinical screening which led to these decisions. You should also provide the date each decision was made, and the identity of the person(s) who made the decision to remove the patient from the SCRR process and their job title.

19. I have attempted to answer this question by presenting in the table below a summary of each patient screened out at each relevant meeting (taken in sequence, between 15 November 2021 and 7 February 2022). After the table I have included a glossary of some of the acronyms and terms used.

15/11/2021 - No cases were screened out at this session.

22/11/2021 – detail of cases screened out

No. Initials **H+C**	**Summary of Incident**	**Summary of Discussions**
35. Personal Information redacted by the USI **3279585708**	Seen in Independent Sector – has 2 urological issues – he was seen with a complex cyst in 2016 and the kidney was asymptomatic. There had been various / many investigations done but this needs to be formally reviewed as there has yet to	22.11.2021 Patrick Keane letter – As outlined in the query opposite, the patient had complex conditions and the SJR review was requested because he had not been reviewed to establish a definitive diagnosis and prognosis. Mr Keane reviewed him and deemed that clinically his tumour was non cancerous and his psa not

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	be an MDM discussion and if there is a raise he may be better advised to have either cryotherapy or microwave ablation of the lesion. His other urological issue is that his PSA has remained between 4 and under 5 for last 4 years. His case needs reviewed.	raised and that he did not have clinical concerns. (minimum complex benign cyst marginalised, elevated PSA, patient ok) - **Not SJR.**
25. Personal Information redacted by the USI Personal Information redacted by the USI	Haematuria - Antibiotics recommended for finding of pyuria on MSU with no positive culture, and no documented symptoms of infection	22.11.2021 Discussed at screening Telephone cons 17.4.2021 with Mr Haynes. Not sure if patient aware, referred for investigation of haematuria and was commenced on long-term low dose antibiotic for pyuria without infection, question raised re long term dose of antibiotic. Not clinically UTI, abx prescribed for Pyuria. Prescribing antibiotic without indication would not normally be a SAI, therefore would not amount to SJR. **NOT SJR.**
19. Personal Information redacted by the USI Personal Information redacted by the USI	Initially seen privately so no letter for initial assessment. OP review June 2016 and then OP and UDS July 2016 - OP review / UDS / cystoscopy in July 2016 happened in an expedited timescale compared with	22.11.2021 Discussed at screening - re-occurring theme treatment expedited following private appt. Topical oestrogen should have used as first line treatment. Antibiotic treatment now discontinued. Patient came to no harm- **NOT SJR**

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	NHS patients - Topical vaginal oestrogens are an alternative option to low dose antibiotics for managing recurrent UTIs in post-menopausal patients. Managed with low dose antibiotics (no longer taking).	
21. Personal Information redacted by the USI Personal Information redacted by the USI	Storage LUTS initially assessed by gynaecology and referred to urology for cystoscopy and had urodynamic 2018 prior to trial of medical treatment - could have had a trial of anticholinergics before urodynamic as these have improved symptoms and would have avoided the investigation.	22.11.2021- discussed at screening- part of review Dr Sythia completed, series of questions asked, concerns highlighted in this case. 1.5.2021 Mr Haynes has reviewed patient, initially should be offered lifestyle changes, and instead went straight to invasive investigation. NICE guidelines pathway advised first line of treatment lifestyle changes, bladder retraining; then offer anti-cholergenic medication; then offer invasive investigations. Has patient come to harm? No. Treatment pathway could have been different patient has not come to harm, could have avoided invasive investigation Potential harm from urodynamic studies UTI. **Does not meet criteria for SAI/ SJR.**
12.	With regards to his large post void residual patient and I discussed at length	15.11.21 - Has a patient review form been filled in by Professor Sethia. Will need to come back to him.

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Personal Information redacted by the USI Personal Information redacted by the USI	his treatment options and explained more fully his anatomy and what has been happening to him as he has described dissatisfaction with his care in these last couple of years feeling that he has been "neglected.	Wendy Clarke asked for information, patient review form. Martina Corrigan advised patient came through Laura McCauley, who asked for patients care to be reviewed. Did not come from Prof Sethia, Laura McCauley raised concerns, patient not happy with care. Relates to waiting times. Seen in 2017 added to waiting list for surgery, referred in retention, was catheterised, had trial removal. Which failed, listed for TURP 2017, since then come off meds and has had catheter removal. Feels he has being neglected. Agreed is the Trusts waiting times due to demand and capacity issues. Appropriately managed at the time, trail removal, highlighted TURP, WAITING TIMES rather than clinician. **NOT SJR.**

29/11/2021– detail of cases screened out

No. Initials **H+C**	**Summary of Incident**	**Summary of Discussions**
49.	Highlighted by professor Sethia	29.11.2021 Discussed at screening. Management : Was seen when pandemic hit, consultants did not

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Personal Information redacted by the USI Personal Information redacted by the USI Personal Information redacted by the USI	Prostatic adenocarcinoma of Gleason score 3+4 = 7 is present in 6 out of 6 cores with a maximum length of 13 mm. Tumour occupies approximately 70% of the total tissue volume. Rip Personal Information redacted by the USI Has not been seen since AOB Aug 19	know what was happening, MDM results were awaited, report not available, died very soon after he was seen, cause of death not related to urology, upper GI bleed. AOB tried to make contact and realised patient had died. No harm had come. MDT 27/02, seen on 09/03 then died Personal Information redacted by the USI. There was a delay in correspondence. This is a theme; delay in actions from outpatient clinic 09/03/2020 correspondence. 27/04/2020. In this patient did not make a difference. Discussed at MDT commenced on treatment, reviewed in appropriate timescale. Pandemic hit, Came to no harm. General letter to be sent to family. **NOT FOR SJR.**
54. Personal Information redacted by the USI Personal Information redacted by the USI	Highlighted by professor Sethia Post prostatectomy incontinence - why wait until 2019 to treat?	29/11/2021 Discussed at screening. Patient was seen 2011 UDS treatment, outpatient review back log, not offered another apt. In Feb 2015 patient was discharged without been seen, asked for re-referral if required. GP re referred and patient seen AOB in 2019. There was no delay by Mr AOB, there was system review back log and patient was discharged by someone else without a review, this was a Board driven process at the

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		time, review on waiting list was beyond 3 years, **NOT SJR**
50. Patient 69 [redacted] Personal Information redacted by the USI	Recurrent intermediate risk TCC bladder. Last resection 13th February 2021. pTa grade 2 (high) urothelial cancer of right ureter treated by right laparoscopic nephron-urethrectomy 31st July 2020.	29/11/2021 Discussed at screening. Mr Haynes has reviewed care and unsure of concerns raised from NIECR notes. Sarah forwarded review by Dr Sethia. Initial presentation haematuria, first resection grade 2 Ta , renogram 2020 result right kidney non-functioning , there was delay in surgery, however that year there was industrial strikes. Patient had check of bladder, further re-occurrence was resected, Covid Pandemic 2020 , all surgery was moved to DHH. Delays due to industrial action and Covid. Sarah Ward to review wording on form 'right Nephron-ureterostomy' MDM outcomes, makes no sense, typo error. Brought back to MDT 3/52 and outcome essential corrected for ureterostomy 6/52. No concerns raised. Low risk, if kidney is well-functioning then potentially look at distal ureterostomy to confirm disease. Renogram was not performed until Jan 2020, plan was reasonable , Post op Feb 2020 rechecked bladder, **External issues affected provision of service, MDT was reasonable. NOT SJR** Sarah

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		Ward to arrange comment from MDT and feedback to group.
47. Personal Information redacted by the USI Personal Information redacted by the USI Personal Information redacted by the USI	Highlighted by professor Sethia August 2018 diagnosed metastatic prostate cancer PSA>400 Started on degarelix MDM 16.08.18 to continue ADT PSA rise to 9.2 in February 2019. Started on bicalutamide 50mg. March 2019 PSA 15 Started on dexamethasone MDM recommended referral to oncology Died Personal Information redacted by the USI – comment from Prof Sethia - Enzalutamide might have improved survival for 4-6 months?	Discussed at screening 10/01/2021. Personal Information redacted year old gentleman, performance status poor, care package, had multiple emergency admission pneumonia, would not have been suitable for other treatments due to poor performance status, palliative care. **NOT SJR**

20/12/2021– detail of cases screened out

No. Initials **H+C**	**Summary of Incident**	**Summary of Discussions**
76.	Came via phone inquiry to Urology CNS – passed to	GP appropriately red flagged urology referral. Patient met criteria for red

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Patient 53 Personal Information redacted by the USI	Mr Haynes who advises. He needs an SCRR. He was referred as RF, downgraded (unclear if downgrade letter went) but met RF criteria at time	flag, non-visible haematuria, Personal Infor yrs. AOB inappropriately downgraded this referral to urgent. Investigations fortunately were all normal, patient came to no harm in this case. Discussed: agree this can happen in all departments, human error, other department would not generally produce a letter to the GP to advise as this would be a massive workload. Booking centre would send letter? Ultrasound was not reviewed until patient attended appointment. **Not for SJR as patient came to no harm.**
65. Patient 22 Personal Information redacted by the USI	Highlighted by Mr Keane at OPD clinic in Independent Sector under on-going oncology FU SJR into previous care	Discussed at screening 20/12/21- no issues identified patient care managed appropriately. **NOT SJR.**
63. Patient 44 Personal Information redacted by the USI	Highlighted by Mr Keane at OPD clinic in Independent Sector currently on combined Androgen Blockade - SJR for bicalutamide 50mg	Discussed at screening 20/12/2021- treatment was reasonable, on both treatments maximum blockade and LHRHa- no issues -treatment was appropriate- **NOT SJR**
60.	Diagnosis: Circumcision June 2019 for lichens	Discussed at screening information line contact. No clinical issue .Mr

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Patient 21 Personal Information redacted by the USI	sclerosus (balanitis xerotica obliterans) Lower urinary tract symptoms	Haynes has wrote detailed letter, **NOT SJR**

10/01/2022– detail of cases screened out

No. Initials **H+C**	**Summary of Incident**	**Summary of Discussions**
54. Personal Information redacted by the USI Personal Information redacted by the USI **(not removed from screening list, on two review lists)**	Highlighted by professor Sethia Post prostatectomy incontinence - why wait until 2019 to treat?	29/11/2021 Discussed at screening. Patient was seen 2011 UDS treatment, outpatient review back log, not offered another apt. In Feb 2015 patient was discharged without been seen, asked for re- referral if required. GP re referred and patient seen AOB in 2019. There was no delay by Mr AOB, there was system review back log and patient was discharged by someone else without a review, this was a Board driven process at the time, review on waiting list was beyond 3 years, **NOT SJR**
39. Patient 73 **3630357652**	Telephone clinic on 15 May 2021: comment on PRF Although would likely have been recommended to proceed to orchidectomy,	Discussed at screening 10/01/2021- USS reported abnormal right testes, orchiectomy completed- result - benign disease, Given the report would have completed orchiectomy,

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	the US was not reviewed at urology MDM prior to surgery, and subsequent pathology was benign. The US report had raised a number of differentials so I feel best practice would have been review at MDM	however best practice would be to present at MDT for peer review. USS reported definite abnormalities and raised concerns, probably would have had orchiectomy. **NOT SJR**
23. Patient 29 Personal Information redacted by the USI	LUTS - assessed with UDS >> BNI and botox No improvement >> UDS >> TURP >>improved but ongoing symptoms and ED. Advised in consultation was not made aware that ED / retrograde ejaculation were risks of TURP although he would have gone ahead with the surgery even if he had known this risk Seen privately 30/4/16>>UDS 27/5/16>>TURP 27/7/16 likely shorter waits than other patents seen in NHS	22.11.2021 Discussed at screening- at consultation patient brought up concerns - not consented for risk of erectile dysfunction, retrograde ejaculation. Mr Haynes to review and bring back next week. 20/01/2022 Discussed at screening , notes reviewed, AOB did not perform procedure, question about consent, were all risks explained, difficult to read consent form and what risks were identified. No concerns raised in relation to treatment and care. Patient advised he still would have gone ahead had he known the risks. **NOT SJR.**
58. Patient 65 Personal Information redacted by the USI	Was TURP necessary? Now incontinent	29/11/2021 Discussed at screening. Decision for TURP not always taken to MDT. Mr Haynes unable to provide information from NIECR. Require full notes to review. Post op retention following hernia repair, TURP and now incontinent. 80-90% retention

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		after hernia repair resolves after 3-4 months. Should offer trial removal of catheter in 3 months, anaesthesia can also cause bladder voiding problems. 10% risk in hernia repair in men over 65 yrs. Mr Haynes advised need notes to review. Notes attached 10.01.2022 discussed at screening, patient already had a catheter in place 2005, did not relate to hernia repair. Generally urodynamic studies would be completed initially, is there sufficient documented evidence for bladder obstructions and decision to proceed to TURP. Patient had catheter inserted in 2015 due to urinary retention, blocked catheter in Nov 2015, AOB seen patient privately in February 2016, noted in NIECR, had TURP completed in March 2016. It was agreed the plan was reasonable, patient was not suitable for urodynamic studies due to [redacted] Personal Information redacted by the USI, patient probably not able to complete investigation. Sarah to follow up in relation to treatment times, seen privately and then procedure expedited on NHS waiting list. **NOT SJR**

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7/2/2022– detail of cases screened out

No. Initials **H+C**	**Summary of Incident**	**Summary of Discussions**
52. Patient 52 Personal Information redacted by the USI	1. Previous transitional cell carcinoma of bladder 2. Bladder outlet obstruction 3. Urinary infection Potentially incorrect management	29/11/2019 Discussed at screening. June 2018 TURPT, resection Aug 2018 - standard management, pt was Personal Information yrs at the time recommended for BCG treatment, completed this treatment, he had a check of bladder. Had a TURP, appears to have continued on surveillance pathway, had a MRI, patient had PE. Right hydronephrosis nephrostomy was completed. Unsure of the concerns raised in this case. Sarah Ward to contact Mr Sethia for more information in relation to concerns he had raised and feedback. 07/02/2022 Discussed at screening Questions raised why urethra not stented earlier. Mr Haynes advised there is good documentation in relation to decision-making, AOB justified decision in his letters, patients has had multiple reviews since, justification for not stenting. Had USS in Feb which identified hydronephrosis, march -April there was a shift in service due to

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		pandemic out of AOB hands. Decision for stenting documented and reasonable. **NOT SAI.**
17. Patient 50 Personal Information redacted by the USI	Report from Mr Haynes review letter - Varicocele currently asymptomatic: I reviewed Patient 50 following his contact with the Trust Information line. He had seen Mr O'Brien in 2014 and 2015 having been referred initially with azoospermia and a varicocele. The reason behind this referral was whether management of the varicocele would impact on fertility issues him and his wife were experiencing. His semen analysis as stated at the time had shown azoospermia however subsequent analysis did improve with lifestyle change. At the time that [redacted] Patient 50 saw Mr O'Brien he also had some testicular pain which would fit with pain being related to the varicocele however this has since resolved. Ultimately Patient 50 did not have his	For screening, clinical notes and MDM attached. Mr Haynes has reviewed case, patient not happy with care not offered surgery. Mr Haynes advised patient had a low sperm count and low quality sperm, embolization surgery unfortunately would not have improved fertility chances. No urological treatments would improve fertility. AOB decision therefore reasonable. However, service was of a poor standard, pt unable to make contact with AOB, received no response to his letter. communication was poor. No harm to patient, communication could have been better. Treatment in this case was appropriate, **NOT SJR**

Urology Services Inquiry

	varicocele treated and him and his wife had three cycles of treatment for infertility which were unfortunately unsuccessful.	

22/11/2021 – detail of cases screened out

No. Initials **H+C**	**Summary of Incident**	**Summary of Discussions**
35. Personal Information redacted by the USI Personal Information redacted by the USI	Seen in Independent Sector – has 2 urological issues – he was seen with a complex cyst in 2016 and the kidney was asymptomatic. There had been various many investigations done but this needs to be formally reviewed as there has yet to be an MDM discussion and if there is a reis he may be better advised to have either cryotherapy or microwave ablation of the lesion. His other urological issue is that his PSA has remained	22.11.2021 Patrick Kean letter - minimum complex benign cyst marginalised elevated PSA, patient ok - **Not SJR.**

Urology Services Inquiry

	between 4 and under 5 for last 4 years. His case needs reviewed.	
25. Personal Information redacted by the USI Personal Information redacted by the USI	Haematuria - Antibiotics recommended for finding of pyuria on MSU with no positive culture, and no documented symptoms of infection	22.11.2021 Discussed at screening Telephone cons 17.4.2021 with Mr Haynes. Not sure if patient aware, referred for investigation of haematuria and was commenced on long-term low dose antibiotic for pyuria without infection, question raised re long term dose of antibiotic. Not clinically UTI, abx prescribed for Pyuria. Prescribing antibiotic without indication would not normally be a SAI, therefore would not amount to SJR. **NOT SJR.**
19. Personal Information redacted by the USI Personal Information redacted by the USI	Initially seen privately so no letter for initial assessment. OP review June 2016 and then OP and UDS July 2016 - OP review / UDS / cystoscopy in July 2016 happened in an expedited timescale compared with NHS patients - Topical vaginal oestrogens are an alternative option to low dose antibiotics for managing recurrent UTIs in post-menopausal patients. Managed with low dose	22.11.2021 Discussed at screening - re-occurring theme treatment expedited following private appt. Topical oestrogen should have used as first line treatment. Antibiotic treatment now discontinued. Patient came to no harm- **NOT SJR**

Urology Services Inquiry

	antibiotics (no longer taking).	
21. Personal Information redacted by the USI Personal Information redacted by the USI	Storage LUTS initially assessed by gynaecology and referred to urology for cystoscopy and had urodynamic 2018 prior to trial of medical treatment - could have had a trial of anticholinergics before urodynamic as these have improved symptoms and would have avoided the investigation.	22.11.2021- discussed at screening- part of review Dr Sythia completed, series of questions asked, concerns highlighted in this case. 1.5.2021 Mr Haynes has reviewed patient, initially should be offered lifestyle changes, and instead went straight to invasive investigation. NICE guidelines pathway advised first line of treatment lifestyle changes, bladder retraining; then offer anti-cholergenic medication; then offer invasive investigations. Has patient come to harm? No. Treatment pathway could have been different patient has not come to harm, could have avoided invasive investigation Potential harm from urodynamic studies UTI. **Does not meet criteria for SAI/ SJR.**
12. Personal Information redacted by the USI Personal Information redacted by the USI	With regards to his large post void residual patient and I discussed at length his treatment options and explained more fully his anatomy and what has been happening to him as he has described dissatisfaction with his care in these last	15.11.21 - Has a patient review form been filled in by Professor Sethia. Will need to come back to him. Wendy Clarke asked for information, patient review form. Martina Corrigan advised patient came through Laura McCauley, who asked for patients care to be reviewed. Did not come from Prof Sethia, Laura McCauley raised concerns, patient not happy

Urology Services Inquiry

	couple of years feeling that he has been “neglected.	with care. Relates to waiting times. Seen in 2017 added to waiting list for surgery, referred in retention, was catheterised, had trial removal. Which failed, listed for TURP 2017, since then come off meds and has had catheter removal. Feels he has being neglected. Agreed is the Trusts waiting times due to demand and capacity issues. Appropriately managed at the time, trail removal, highlighted TURP, WAITING TIMES rather than clinician. **NOT SJR.**

29/11/2021– detail of cases screened out

No. Initials **H+C**	**Summary of Incident**	**Summary of Discussions**
49. Personal Information redacted by the USI Personal Information redacted by the USI Personal Information redacted by the USI	Highlighted by professor Sethia Prostatic adenocarcinoma of Gleason score 3+4 = 7 is present in 6 out of 6 cores with a maximum length of 13 mm. Tumour occupies	29.11.2021 Discussed at screening. Management : Was seen when pandemic hit, consultants did not know what was happening, MDM results were awaited, report not available, died very soon after he was seen, cause of death not related to urology, upper GI bleed. AOB tried to make contact and realised patient had died. No harm had come. MDT

Urology Services Inquiry

	approximately 70% of the total tissue volume. Rip [redacted] Has not been seen since AOB Aug 19	27/02, seen on 09/03 then died [redacted]. There was a delay in correspondence. This is a theme; delay in actions from outpatient clinic 09/03/2020 correspondence. 27/04/2020. In this patient did not make a difference. Discussed at MDT commenced on treatment, reviewed in appropriate timescale. Pandemic hit, Came to no harm. General letter to be sent to family. **NOT FOR SJR.**
54. [redacted] [redacted]	Highlighted by professor Sethia Post prostatectomy incontinence - why wait until 2019 to treat?	29/11/2021 Discussed at screening. Patient was seen 2011 UDS treatment, outpatient review back log, not offered another apt. In Feb 2015 patient was discharged without been seen, asked for re-referral if required. GP re referred and patient seen AOB in 2019. There was no delay by Mr AOB, there was system review back log and patient was discharged by someone else without a review, this was a Board driven process at the time, review on waiting list was beyond 3 years, **NOT SJR**
50. Patient 69 [redacted]	Recurrent intermediate risk TCC bladder. Last resection 13th February 2021. pTa grade 2 (high) urothelial cancer of right ureter treated by right laparoscopic	29/11/2021 Discussed at screening. Mr Haynes has reviewed care and unsure of concerns raised from NIECR notes. Sarah forwarded review by Dr Sethia. Initial presentation haematuria, first

Urology Services Inquiry

	nephron-urethrectomy 31st July 2020.	resection grade 2 Ta , renogram 2020 result right kidney non-functioning , there was delay in surgery, however that year there was industrial strikes. Patient had check of bladder, further re-occurrence was resected, Covid Pandemic 2020 , all surgery was moved to DHH. Delays due to industrial action and Covid. Sarah Ward to review wording on form 'right Nephron-ureterostomy' MDM outcomes, makes no sense, typo error. Brought back to MDT 3/52 and outcome essential corrected for ureterostomy 6/52. No concerns raised. Low risk, if kidney is well-functioning then potentially look at distal ureterostomy to confirm disease. Renogram was not performed until Jan 2020, plan was reasonable , Post op Feb 2020 rechecked bladder, **External issues affected provision of service, MDT was reasonable. NOT SJR** Sarah to arrange comment from MDT and feedback to group.
47. Personal Information redacted by the USI Personal Information redacted by the USI	Highlighted by professor Sethia August 2018 diagnosed metastatic prostate cancer PSA>400 Started on degarelix MDM 16.08.18 to	Discussed at screening 10/01/2021. Personal Information redacted year old gentleman, performance status poor, care package, had multiple emergency admission pneumonia, would not have been suitable for other treatments due to

Urology Services Inquiry

Personal Information redacted by the USI	continue ADT PSA rise to 9.2 in February 2019. Started on bicalutamide 50mg. March 2019 PSA 15 Started on dexamethasone MDM recommended referral to oncology Died Personal Information redacted by the USI – comment from Prof Sethia - Enzalutamide might have improved survival for 4-6 months?	poor performance status, palliative care. **NOT SJR**

20/12/2021– detail of cases screened out

No. Initials **H+C**	**Summary of Incident**	**Summary of Discussions**
76. Patient 53 Personal Information redacted by the USI	Came via phone inquiry to Urology CNS – passed to Mr Haynes who advises. He needs an SCRR. He was referred as RF, downgraded (unclear if downgrade letter went) but met RF criteria at time	GP appropriately red flagged urology referral. Patient met criteria for red flag, non-visbale haematuria, Personal Infor yrs. AOB inappropriately downgraded this referral to urgent. Investigations fortunately were all normal, patient came to no harm in this case. Discussed: agree this can happen in all departments, human error, other department would not generally produce a letter to the GP to advise as this would be a massive workload.

Urology Services Inquiry

		Booking centre would send letter? Ultrasound was not reviewed until patient attended appointment. **Not for SJR as patient came to no harm.**
65. Patient 22 Personal Information redacted by the USI	Highlighted by Mr Keane at OPD clinic in Independent Sector under on-going oncology FU SJR into previous care	Discussed at screening 20/12/21- no issues identified patient care managed appropriately. **NOT SJR.**
63. Patient 44 Personal Information redacted by the USI	Highlighted by Mr Keane at OPD clinic in Independent Sector currently on combined Androgen Blockade - SJR for bicalutamide 50mg	Discussed at screening 20/12/2021- treatment was reasonable, on both treatments maximum blockade and LHRHa- no issues -treatment was appropriate- **NOT SJR**
60. Patient 21 Personal Information redacted by the USI	Diagnosis: Circumcision June 2019 for lichens sclerosus (balanitis xerotica obliterans) Lower urinary tract symptoms	Discussed at screening information line contact. No clinical issue .Mr Haynes has wrote detailed letter, **NOT SJR**

10/01/2022– detail of cases screened out

Urology Services Inquiry

No. Initials **H+C**	**Summary of Incident**	**Summary of Discussions**
54. Personal Information redacted by the USI Personal Information redacted by the USI **(not removed from screening list, on two review lists)**	Highlighted by professor Sethia Post prostatectomy incontinence - why wait until 2019 to treat?	29/11/2021 Discussed at screening. Patient was seen 2011 UDS treatment, outpatient review back log, not offered another apt. In Feb 2015 patient was discharged without been seen, asked for re- referral if required. GP re referred and patient seen AOB in 2019. There was no delay by Mr AOB, there was system review back log and patient was discharged by someone else without a review, this was a Board driven process at the time, review on waiting list was beyond 3 years, **NOT SJR**
39. Patient 73 Personal Information redacted by the USI	Telephone clinic on 15 May 2021: comment on PRF Although would likely have been recommended to proceed to orchidectomy, the US was not reviewed at urology MDM prior to surgery, and subsequent pathology was benign. The US report had raised a number of differentials so I feel best practice would have been review at MDM	Discussed at screening 10/01/2021- USS reported abnormal right testes, orchiectomy completed- result - benign disease, Given the report would have completed orchiectomy, however best practice would be to present at MDT for peer review. USS reported definite abnormalities and raised concerns, probably would have had orchiectomy. **NOT SJR**

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23. Patient 29 Personal Information redacted by the USI	LUTS - assessed with UDS >> BNI and botox No improvement >> UDS >> TURP >>improved but ongoing symptoms and ED. Advised in consultation was not made aware that ED / retrograde ejaculation were risks of TURP although he would have gone ahead with the surgery even if he had known this risk Seen privately 30/4/16>>UDS 27/5/16>>TURP 27/7/16 likely shorter waits than other patents seen in NHS	22.11.2021 Discussed at screening- at consultation patient brought up concerns - not consented for risk of erectile dysfunction, retrograde ejaculation. Mr Haynes to review and bring back next week. 20/01/2022 Discussed at screening , notes reviewed, AOB did not perform procedure, question about consent, were all risks explained, difficult to read consent form and what risks were identified. No concerns raised in relation to treatment and care. Patient advised he still would have gone ahead had he known the risks. **NOT SJR.**
58. Patient 65 Personal Information redacted by the USI	Was TURP necessary? Now incontinent	29/11/2021 Discussed at screening. Decision for TURP not always taken to MDT. Mr Haynes unable to provide information from NIECR. Require full notes to review. Post op retention following hernia repair, TURP and now incontinent. 80-90% retention after hernia repair resolves after 3-4 months. Should offer trial removal of catheter in 3 months, anaesthesia can also cause bladder voiding problems. 10% risk in hernia repair in men over 65 yrs. Mr Haynes advised need notes to review. Notes attached

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		10.01.2022 discussed at screening, patient already had a catheter in place 2005, did not relate to hernia repair. Generally urodynamic studies would be completed initially, is there sufficient documented evidence for bladder obstructions and decision to proceed to TURP. Patient had catheter inserted in 2015 due to urinary retention, blocked catheter in Nov 2015, AOB seen patient privately in February 2016, noted in NIECR, had TURP completed in March 2016. It was agreed the plan was reasonable, patient was not suitable for urodynamic studies due to Bipolar depression/ nursing home resident, patient probably not able to complete investigation. Sarah to follow up in relation to treatment times, seen privately and then procedure expedited on NHS waiting list. **NOT SJR**

7/2/2022– detail of cases screened out

No. Initials **H+C**	**Summary of Incident**	**Summary of Discussions**

Urology Services Inquiry

52. Patient 52 Personal Information redacted by the USI	1. Previous transitional cell carcinoma of bladder 2. Bladder outlet obstruction 3. Urinary infection Potentially incorrect management	29/11/2019 Discussed at screening. June 2018 TURPT, resection Aug 2018 - standard management, pt was Personal Infor yrs at the time recommended for BCG treatment, completed this treatment, he had a check of bladder. Had a TURP, appears to have continued on surveillance pathway, had a MRI, patient had PE. Right hydronephrosis nephrostomy was completed. Unsure of the concerns raised in this case. Sarah Ward to contact Mr Sethia for more information in relation to concerns he had raised and feedback. 07/02/2022 Discussed at screening Questions raised why urethra not stented earlier. Mr Haynes advised there is good documentation in relation to decision-making, AOB justified decision in his letters, patients has had multiple reviews since, justification for not stenting. Had USS in Feb which identified hydronephrosis, march -April there was a shift in service due to pandemic out of AOB hands. Decision for stenting documented and reasonable. **NOT SAI.**
17. Patient 50	Report from Mr Haynes review letter - Varicocele currently asymptomatic: I	For screening, clinical notes and MDM attached. Mr Haynes has reviewed case, patient not happy with

Urology Services Inquiry

Personal Information redacted by the USI	reviewed Patient 50 following his contact with the Trust Information line. He had seen Mr O'Brien in 2014 and 2015 having been referred initially with azoospermia and a varicocele. The reason behind this referral was whether management of the varicocele would impact on fertility issues him and his wife were experiencing. His semen analysis as stated at the time had shown azoospermia however subsequent analysis did improve with lifestyle change. At the time that [redacted] Patient 50 saw Mr O'Brien he also had some testicular pain which would fit with pain being related to the varicocele however this has since resolved. Ultimately Patient 50 did not have his varicocele treated and him and his wife had three cycles of treatment for infertility which were unfortunately unsuccessful.	care not offered surgery. Mr Haynes advised patient had a low sperm count and low quality sperm, embolization surgery unfortunately would not have improved fertility chances. No urological treatments would improve fertility. AOB decision therefore reasonable. However, service was of a poor standard, pt unable to make contact with AOB, received no response to his letter. communication was poor. No harm to patient, communication could have been better. Treatment in this case was appropriate, **NOT SJR**

Urology Services Inquiry

Glossary of Terms used in SCRR process

Term	Definition
AAA	Abdominal aortic aneurysm
abx	antibiotics
ADT	Androgen deprivation therapy
AOB	Mr Aiden O'Brien
appt/ apt	Appointment
BCC	Basal Cell Carcinoma
BCG	Bacillus Calmette-Guerin
BCH	Belfast City Hospital
Bic	Bicalutamide
Ca	Cancer
CAH	Craigavon Area Hospital
CaPPs	Cancer Patient Pathway System
CaP	prostate cancer
cons	Consultant
CT	computerised tomography
DHH	Daisy Hill Hospital

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DNA	Did not attend
EBRT	External Beam Radiation Therapy
ED	Emergency Department
FU	Follow up
G*Ta	Grade (*) non-invasive papillary carcinoma
GI	Gastrointestinal
GP	General Practitioner
HOS	Head of Service
LA analogue	Luteinizing hormone-releasing hormone agonists
LHRH / LHRHa	Luteinizing hormone-releasing hormone agonists
LUTS	Lower Urinary Tract Symptons
MDM	Multidisciplinary Meeting
MDT	Multidisciplinary Team
MI	Mycardial Infarction
MRI	Magnetic resonance imaging
MSU / MSSU	Mid Stream Sample of Urine
NICE	The National Institute for Health and Care Excellence
NIECR	Northern Ireland Electronic Care Record
obs	observation
op	Out Patients

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op	operative
OPD	Out Patients Department
PMH/ PMHx	Past Medical History
PSA	Prostate-Specific Antigen Test
pt	Patient
pTa (grade X	pTa tumours are those neoplasms that are confined to the epithelia layer of the bladder ('noninvasive papillary carcinoma')
RF	Red Flag
RIP	Rest in Peace / Death
RT	radiotherapy
SAI	Serious Adverse Advent
SCRR	Structure Care Record Review
sec	secretary
SJR	Structured Judgement Review
TCC	Transitional cell cancer
TURP	Transurethral resection of the prostate
UDS	Urodynamic studies
US	Ultrasound
UTI	Urinary Tract Infection

4. Explain whether the decisions to remove the 10 patients from the SCRR process, were the subject of oversight and/or an approval mechanism? If so,

describe how this mechanism worked in respect of each patient, and identify who was responsible for its operation and their job title.

20. The process and rationale for each case is provided in the table at Question 3 above. The decision was that of the group identified at Question 1, reviewing the initial screening decisions of Mr Haynes and Mrs Corrigan.
21. The composite data emanating from the SCRR meetings is reported to the internal (the Southern Co-ordination Group) and external oversight groups (the HSCB Group and the Urology Assurance Group).

22. An audit of the SCRR process is being undertaken by RQIA at the request of the Trust

5. Is the screening panel and/or an oversight panel (if applicable) with responsibility for decisions in respect of the SCRR process required to declare any conflicts of interest prior to deciding on whether to include or exclude a particular case from the SCRR process?

23. The panel was not directly asked surrounding conflicts of interest. However, members are expected to declare any conflict. In this regard, one member of the panel declared that one of the 77 cases was a relative and excluded themselves for the discussion surrounding their relative's case.

6. Were each of the 66 patients contacted by the Trust to confirm their initial inclusion within the SCRR process?

24. In keeping with the usual SAI process within the NHS, it is usual custom and practice not to inform patients of inclusion until their cases have been screened in as in this situation.
25. The patients included in the screening process were not made aware that their case was being screened until a clear decision was made as to whether or not their care

merited inclusion or exclusion using the regional SAI criteria for further SCRR. This decision was made in discussion with the HSCB and the DOH and was based on the premise of not causing unnecessary alarm or suffering to patients in the absence of definitive decision making which in the context of the complexity of the review we realised would take a considerable time to work through. These patients have been made aware by the Trust of their inclusion of the SCRR process.

7. Were the 10, now excluded patients, informed of the Trusts decision to remove them from the SCRR process?

26. In keeping with the usual SAI process within the NHS, it is usual custom and practice not to inform patients if they have been screened for SAI and if these have been excluded.
27. The patients included screened out of the screening process were not made aware that their case was being screened or that it had been screened out using the regional SAI criteria for further SCRR. This decision was made in discussion with the HSCB and the DOH and was based on the premise of not causing unnecessary alarm or suffering to patients in the absence of definitive decision making which in the context of the complexity of the review we realised would take a considerable time to work through. These patients have been made aware by the Trust of their exclusion of the SCRR process.

Urology Services Inquiry

8. What opportunity, if any, were the patients given to make comments on the Trust's decision to exclude them?

28. In keeping with the usual SAI process within the NHS, it is usual custom and practice not to inform patients of inclusion until their cases have been screened in as in this situation.
29. The patients included in the screening process were not made aware that their case was being screened until a clear decision was made as to whether or not their care merited inclusion or exclusion using the regional SAI criteria for further SCRR. This decision was made in discussion with the HSCB and the DOH and was based on the premise of not causing unnecessary alarm or suffering to patients in the absence of definitive decision making which in the context of the complexity of the review we realised would take a considerable time to work through. Patients were advised by letter of the information line should they have any concerns or queries. These letters can be located in S21 1 of 2022, SCRR Letters.

9. Confirm that the precise number of patients captured within the SAI reviews which were triggered in 2020 concerning the practices of Mr O'Brien is 9.

30. There were 9.

10. Confirm that the precise number of patients captured within the initial SCRR process (prior to the latest reduction of 10) is 66, meaning collectively there are 75 patients within these combined categories.

31. The process of identifying patients for SCRR is ongoing. Other than the case of [redacted] Patient 6 (at Question 11 below), the remaining 76 cases of the original 77 identified as SCRR have not been part of the previous 9 person SAI process,

32. The process of reviewing patients using the SCRR is also ongoing. Given that this is a highly specialised and intricate speciality relying on a variety of information from various sources, this is by definition a complex process for each patient and takes time.

33. As indicated above, the initial screening undertaken by Mr Haynes and Mrs Corrigan yielded 77 patients from the last 18 months of Mr O'Brien's NHS work. These have subsequently been subjected to second screening by the Acute Governance Screening Team (membership included above) which in turn has identified these now as 53 patients with 6 patients yet to be decided. 18 patients have been identified as not requiring SCRR out of the original 77.

34. In addition to this, as part of the Quality Assurance measures on the screening being undertaken, screening using the same SAI criteria to identify patients for the SCRR process is being undertaken on 402 patients who were identified by Professor Sethia and the other consultant urologists involved as having queries in relation to their care but not reaching caseness previously in relation to SAI criteria. The initial SAI screening of these patients for SCRR has yielded 8 further patients to date. This is an ongoing process and may yield further patients.

11. Confirm whether Patient 6 is within the SAI 2020 category or the SCRR category.

35. Patient 6 was on both lists. Patient 6 was identified as part of the original cohort of 9 patients contained in the 2020 SAI process, as result of delays in responding adequately to histopathology results with adequate radiological screening. What was also noted in the SAI was the need for the review of Bicalutamide.

Urology Services Inquiry

36. Patient 6 was also placed on Prof Sethia's list for review and he identified similar difficulties and was screened in for SAI screening by the Acute Governance Screening Team.

37. Patient 6 then was identified by 2 independent consultants working separately as requiring an SAI process.

Statement of Truth

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

Signed: _____ Personal Information redacted by the USI _____

Date: 29th March 2022

Section 21 Number 1a of 2022

Table of Attachments

Attachment Number	Document Name
1	S21 1**a** of 2022, Outcome screening sheets excluded from SCRR, Screening outcome sheets for confirmed SCRR patients.

RECORD OF SCREENING

Personal Information redacted by the USI

HNC: Personal Information redacted by the USI

Datix :

Directorate:	Acute Services
Reporting Division:	SEC/ Urology
Date of Incident:	17/11/21
Date of Screening	23/11/21
Incident (IR1) ID:	Personal Information redacted by the USI
Grade of Incident:	moderate
Screening Team:	Dr Ted McNaboe Dr Damian Scullion Dr Raymond McKee Mr Mark Haynes Mrs Wendy Clayton Mrs Sarah Ward Mr Chris Wamsley Mrs Carly Connolly
Summary of Incident	With regards to his large post void residual patient and I discussed at length his treatment options and explained more fully his anatomy and what has been happening to him as he has described dissatisfaction with his care in these last couple of years feeling that he has been “neglected.
Summary of Discussions	15.11.21 - Has a patient review form been filled in by Professor Sethia. Will need to come back to him. Wendy Clarke asked for information, patient review form. Martina Corrigan advised patient came through Laura McCauley, who asked for patients care to be reviewed. Did not come from Prof Sethia, Laura McCauley raised concerns, patient not happy with care. Relates to waiting times. Seen in 2017 added to waiting list for surgery, referred in retention, was catheterised, had trial removal. Which failed, listed for TURP 2017, since then come off meds and has had catheter removal. Feels he has being neglected. Agreed is the Trusts waiting times due to demand and capacity issues. Appropriately managed at the time , trail removal, highlighted TURP, WAITING TIMES rather than clinician. **NOT SJR**.
Level and Type of Review	
Review Team	

RECORD OF SCREENING

Patient 50

hnc: Personal Information redacted by the USI

Datix: Personal Information redacted by the

Directorate:	Acute Services
Reporting Division:	SEC/ Urology
Date of Incident:	17/11/2021
Date of Screening	07/02/2022
Incident (IR1) ID:	Personal Information redacted by the USI
Grade of Incident:	moderate
Screening Team:	Dr Ted McNaboe Dr Damian Scullion Dr Raymond McKee Mr Mark Haynes Mr Ronan Carroll Mrs Sarah Ward Mrs Carly Connolly
Summary of Incident	Report from Mr Haynes review letter - Varicocele currently asymptomatic: I reviewed Patient 50 following his contact with the Trust Information line. He had seen Mr O'Brien in 2014 and 2015 having been referred initially with azoospermia and a varicocele. The reason behind this referral was whether management of the varicocele would impact on fertility issues him and his wife were experiencing. His semen analysis as stated at the time had shown azoospermia however subsequent analysis did improve with lifestyle change. At the time that Patient 50 saw Mr O'Brien he also had some testicular pain which would fit with pain being related to the varicocele however this has since resolved. Ultimately [redacted] Patient 50 did not have his varicocele treated and him and his wife had three cycles of treatment for infertility which were unfortunately unsuccessful.
Summary of Discussions	For screening, clincal notes and mdm attached. Mr Haynes has reviewed case, patient not happy with care not offered surgery. Mr Haynes advised pt had a low sperm count and low quality sperm, embolisation surgery unfortunately would not have improved fertility chances. No urological treatments would improve feritility.AOB decision therefore reasonable. However service was of a poor standard, pt unable to make contact with AOB, received no response to his letter. communication was poor. No harm to patient, communication could have been better. Treatment in this case was appropriate, **NOT SJR**
Level and Type of Review	
Review Team	

RECORD OF SCREENING

Personal Information redacted by the USI

HNC : Personal Information redacted by the USI

Datix : Personal Information redacted by the USI

Directorate:	Acute Services
Reporting Division:	SEC/ Urology
Date of Incident:	17/11/21
Date of Screening	23/11/21
Incident (IR1) ID:	Personal Information redacted by the USI
Grade of Incident:	moderate
Screening Team:	Dr Ted McNaboe Dr Damian Scullion Dr Raymond McKee Mr Mark Haynes Mrs Wendy Clayton Mrs Sarah Ward Mr Chris Wamsley Mrs Carly Connolly
Summary of Incident	Initially seen privately so no letter for initial assessment. OP review June 2016 and then OP and UDS July 2016 - OP review / UDS / cystoscopy in July 2016 happened in an expedited timescale compared with NHS patients - Topical vaginal oestrogens are an alternative option to low dose antibiotics for managing recurrent UTIs in post-menopausal patients. Managed with low dose antibiotics (no longer taking).
Summary of Discussions	22.11.2021 Discussed at screening - re-occurring theme treatment expedited following private appt. topical oestrogen should have used as first line treatment. Abx treatment now discontinued. Patient came to no harm- **NOT SJR**
Level and Type of Review	
Review Team	

RECORD OF SCREENING

Personal Information redacted by the USI

HNC: Personal Information redacted by the USI

Datix : Personal Information redacted by the USI

Directorate:	Acute Services
Reporting Division:	SEC/ Urology
Date of Incident:	17/11/21
Date of Screening	23/11/21
Incident (IR1) ID:	Personal Information redacted by the USI
Grade of Incident:	moderate
Screening Team:	Dr Ted McNaboe Dr Damian Scullion Dr Raymond McKee Mr Mark Haynes Mrs Wendy Clayton Mrs Sarah Ward Mr Chris Wamsley Mrs Carly Connolly
Summary of Incident	Storage LUTS initially assessed by gynaecology and referred to urology for cystoscopy and had urodynamic 2018 prior to trial of medical treatment - could have had a trial of anticholinergics before urodynamic as these have improved symptoms and would have avoided the investigation.
Summary of Discussions	22.11.2021- discussed at screening- part of review Dr Sythia completed, series of questions asked, concerns highlighted in this case. 1.5.2021 Mr Haynes has reviewed patient, initially should be offered lifestyle changes, instead went straight to invasive investigation. NICE guidelines pathway advised first line of treatment lifestyle changes, bladder retraining; then offer anti-cholergenic medication ;then offer invasive investigations. Has patient come to harm? No. Treatment pathway could have been different patient has not come to harm, could have avoided invasive investigation Potential harm from urodynamic studies UTI. **Does not meet criteria for SAI/ SJR.**
Level and Type of Review	
Review Team	

UROLOGY RECORD OF SCREENING

Patient 29

HNC: Personal Information redacted by the USI

Datix: Personal Information redacted by the USI

Directorate:	Acute Services
Reporting Division:	SEC
Date of Incident:	17/11/21
Date of Screening	22/11/21
Incident (IR1) ID:	Personal Information redacted by the USI
Grade of Incident:	moderate
Screening Team:	Mr Mark Haynes Dr Damian Scullion Dr Ted McNaboe Ms Sarah Ward Head of Service Mr Chris Wamsley Mrs Carly Connolly
Summary of Incident	LUTS - assessed with UDS >> BNI and botox No improvement >> UDS >> TURP >>improved but ongoing symptoms and ED. Advised in consultation was not made aware that ED / retrograde ejaculation were risks of TURP although he would have gone ahead with the surgery even if he had known this risk Seen privately 30/4/16>>UDS 27/5/16>>TURP 27/7/16 likely shorter waits than other patents seen in NHS
Summary of Discussions	22.11.2021 Discussed at screening- at consultation patient brought up concerns - not consented for risk of erectile dysfunction, retrograde ejaculation. Mr Haynes to review and bring back next week. 20/01/2022 Discussed at screening , notes reviewed, AOB did not perform procedure, question about consent, were all risks explained, difficult to read consent form and what risks were identified. No concerns raised in relation to treatment and care. Patient advised he still would have gone ahead had he known the risks. **NOT SJR.**
Level and Type of Review	
Review Team	

RECORD OF SCREENING

Personal Information redacted by the USI

HNC: Personal Information redacted by the USI

Directorate:	Acute Services
Reporting Division:	SEC/ Urology
Date of Incident:	
Date of Screening	23/11/21
Incident (IR1) ID:	
Grade of Incident:	moderate
Screening Team:	Dr Ted McNaboe Dr Damian Scullion Dr Raymond McKee Mr Mark Haynes Mrs Wendy Clayton Mrs Sarah Ward Mr Chris Wamsley Mrs Carly Connolly
Summary of Incident	Haematuria - Antibiotics recommended for finding of pyuria on MSU with no positive culture, and no documented symptoms of infection
Summary of Discussions	22.11.2021 Discussed at screening Telephone cons 17.4.2021 with Mr Haynes. Not sure if patient aware, referred for investigation of haematuria and was commenced on long term low dose abx for pyuria without infection, question raised re long term dose of antibiotic. Not clinically UTI, abx prescribed for Pyuria. Prescribing abx without indication would not normally be a SAI, therefore would not amount to SJR. **NOT SJR.**
Level and Type of Review	
Review Team	

RECORD OF SCREENING

HNC: Personal Information redacted by the USI

Datix: Personal Information redacted by the USI

Directorate:	Acute Services
Reporting Division:	SEC/ Urology
Date of Incident:	13/12/2021
Date of Screening	23/11/21
Incident (IR1) ID:	Personal Information redacted by the USI
Grade of Incident:	moderate
Screening Team:	Dr Ted McNaboe Dr Damian Scullion Dr Raymond McKee Mr Mark Haynes Mrs Wendy Clayton Mrs Sarah Ward Mr Chris Wamsley Mrs Carly Connolly
Summary of Incident	Seen in Independent Sector – has 2 urological issues – he was seen with a complex cyst in 2016 and the kidney was asymptomatic. There had been various many investigations done but this needs to be formally reviewed as there has yet to be an MDM discussion and if there is a reis he may be better advised to have either cryotherapy or microwave ablation of the lesion. His other urological issue is that his PSA has remained between 4 and under 5 for last 4 years. His case needs reviewed.
Summary of Discussions	22.11.2021 Patrick Kean letter - minimum complex benign cyst marginalised elevated PSA, patient ok - Not SJR.
Level and Type of Review	SJR
Review Team	

RECORD OF SCREENING

Patient 73

HNC: Personal Information redacted by the USI

Datix : Personal Information redacted by the USI

Directorate:	Acute Services
Reporting Division:	SEC/ Urology
Date of Incident:	01/12/2021
Date of Screening	10/01/2021
Incident (IR1) ID:	Personal Information redacted by the USI
Grade of Incident:	moderate
Screening Team:	Dr Ted McNaboe Dr Damian Scullion Mr Mark Haynes Mr Chris Wamsley Mrs Carly Connolly Mrs Dawn King
Summary of Incident	Telephone clinic on 15 May 2021: comment on PRF Although would likely have been recommended to proceed to orchidectomy, the US was not reviewed at urology MDM prior to surgery, and subsequent pathology was benign. The US report had raised a number of differentials so I feel best practice would have been review at MDM
Summary of Discussions	Discussed at screening 10/01/2021- USS reported abnormal right testes, orchiectomy completed- result - benign disease, Given the report would have completed orchiectomy, however best practice would be to present at MDT for peer review. USS reported definite abnormalities and raised concerns, probably would have had orchiectomy. **NOT SJR**
Level and Type of Review	
Review Team	

RECORD OF SCREENING

Personal Information redacted by the USI

HNC: Personal Information redacted by the USI

Datix: Personal Information redacted by the

Directorate:	Acute Services
Reporting Division:	SEC/ Urology
Date of Incident:	23/11/2021
Date of Screening	10/01/2021
Incident (IR1) ID:	Personal Information redacted by the USI
Grade of Incident:	moderate
Screening Team:	Dr Ted McNaboe Dr Damian Scullion Mr Mark Haynes Mr Chris Wamsley Mrs Carly Connolly Mrs Dawn King
Summary of Incident	Highlighted by professor Sethia August 2018 diagnosed metastatic prostate cancer PSA>400 Started on degarelix MDM 16.08.18 to continue ADT PSA rise to 9.2 in February 2019. Started on bicalutamide 50mg. March 2019 PSA 15 Started on dexamethasone MDM recommended referral to oncology Died Personal Information redacted by the USI – comment from Prof Sethia - Enzalutamide might have improved survival for 4-6 months?
Summary of Discussions	Discussed at screening 10/01/2021. Personal Information yr old gentleman, performance status poor, care package, had multiple emergency admission pnuemonia, would not have been suitable for other treatments due to poor performance status, palliative care. NOT SJR
Level and Type of Review	
Review Team	

RECORD OF SCREENING

Personal Information redacted by the USI

HNC: Personal Information redacted by the USI

Datix : Personal Information redacted by the USI

Directorate:	Acute Services
Reporting Division:	SEC/ Urology
Date of Incident:	23/11/2021
Date of Screening	29/11/21
Incident (IR1) ID:	Personal Information redacted by the USI
Grade of Incident:	moderate
Screening Team:	Dr Ted McNaboe Dr Raymond McKee Mr Mark Haynes Mr Ronan Carroll Mrs Sarah Ward Mr Chris Wamsley Mrs Carly Connolly
Summary of Incident	Highlighted by professor Sethia Prostatic adenocarcinoma of Gleason score 3+4 = 7 is present in 6 out of 6 cores with a maximum length of 13 mm. Tumour occupies approximately 70% of the total tissue volume. Rip Personal Information redacted by the USI Has not been seen since AOB Aug 19
Summary of Discussions	29.11.2021 Discussed at screening. Management : Was seen when pandemic hit, consultants did not know what was happening, MDM results were awaited, report not available, died very soon after he was seen, cause of death not related to urology, upper GI bleed. AOB tried to make contact and realised pt died. No harm had come. MDT 27/02, seen on 09/03 then died Personal Information redacted by the USI. There was a delay in correspondence. This is a theme; delay in actions from outpatient clinic 09/03/2020 correspondence. 27/04/2020. In this patient did not make a difference. Discussed at MDT commenced on treatment, reviewed in appropriate timescale. Pandemic hit, Came to no harm. General letter to be sent to family. NOT FOR SJR.
Level and Type of Review	datix
Review Team	

RECORD OF SCREENING

Patient 69

HNC: Personal Information redacted by the USI

Datix: Personal Information redacted by the USI

Directorate:	Acute Services
Reporting Division:	SEC/ Urology
Date of Incident:	23/11/21
Date of Screening	29/11/21
Incident (IR1) ID:	Personal Information redacted by the USI
Grade of Incident:	moderate
Screening Team:	Dr Ted McNaboe Dr Raymond McKee Mr Mark Haynes Mr Ronan Carroll Mrs Sarah Ward Mr Chris Wamsley Mrs Carly Connolly
Summary of Incident	Recurrent intermediate risk TCC bladder. Last resection 13th February 2021. pTa grade 2 (high) urothelial cancer of right ureter treated by right laparoscopic nephron-urethrectomy 31st July 2020.
Summary of Discussions	29/11/2021 Discussed at screening. Mr Haynes has reviewed care and unsure of concerns raised from NIECR notes. Sarah forwarded review by Dr Sethia. Initial presentation haematuria, first resection grade 2 Ta , renogram 2020 result right kidney non-functioning , there was delay in surgery, however that year there was industrial strikes. Patient had check of bladder, further re-occurrence was resected, Covid Pandemic 2020 , all surgery was moved to DHH. Delays due to industrial action and Covid. Sarah Ward to review wording on form 'right Nephron-ureterostomy' MDM outcomes, makes no sense, typo error. Brought back to MDT 3/52 and outcome essential corrected for ureterostomy 6/52. No concerns raised. Low risk, if kidney is well-functioning then potentially look at distal ureterostomy to confirm disease. Renogram was not performed until Jan 2020, plan was reasonable , Post op Feb 2020 rechecked bladder, **External issues affected provision of service, MDT was reasonable. NOT SJR** Sarah to arrange comment from MDT and feedback to group.
Level and Type of Review	Datix revierw
Review Team	

RECORD OF SCREENING

Patient 52

HNC: Personal Information redacted by the USI

Datix : Personal Information redacted by the USI

Directorate:	Acute Services
Reporting Division:	SEC/ Urology
Date of Incident:	23/11/21
Date of Screening	29/11/21
Incident (IR1) ID:	Personal Information redacted by the USI
Grade of Incident:	moderate
Screening Team:	Dr Ted McNaboe Dr Raymond McKee Mr Mark Haynes Mr Ronan Carroll Mrs Sarah Ward Mr Chris Wamsley Mrs Carly Connolly
Summary of Incident	1. Previous transitional cell carcinoma of bladder 2. Bladder outlet obstruction 3. Urinary infection Potentially incorrect management
Summary of Discussions	29/11/2019 Discussed at screening. June 2018 TURPT, resection Aug 2018 - standard management, pt was Personal Information yrs at the time recommended for BCG treatment, completed this treatment, he had a check of bladder. Had a TURP, appears to have continued on surveillance pathway, had a MRI , pt had PE. Right hydronephrosis nephrostomy was completed. Unsure of the concerns raised in this case. Sarah Ward to contact Mr Sethia for more information in relation to concerns he had raised and feedback. 07/02/2022 Discussed at screening Questions raised why urethra not stented earlier. Mr Haynes advised there is good documentation in relation to decision making, AOB justified decision in his letters, pts has had multiple reviews since, justification for not stenting. Had USS in Feb which identified hydronephrosis, march -April there was a shift in service due to pandemic out of AOB hands. Decision for stenting documented and reasonable. **NOT SAI.**
Level and Type of Review	
Review Team	

RECORD OF SCREENING

HNC: Personal Information redacted by the USI Personal Information redacted by the USI

Datix : Personal Information redacted by the USI

Directorate:	Acute Services
Reporting Division:	SEC/ Urology
Date of Incident:	23/11/21
Date of Screening	29/11/21
Incident (IR1) ID:	Personal Information redacted by the USI
Grade of Incident:	moderate
Screening Team:	Dr Ted McNaboe Dr Raymond McKee Mr Mark Haynes Mr Ronan Carroll Mrs Sarah Ward Mr Chris Wamsley Mrs Carly Connolly
Summary of Incident	Highlighted by professor Sethia Post prostatectomy incontinence - why wait until 2019 to treat?
Summary of Discussions	29/11/2021 Discussed at screening. Pat was seen 2011 UDS treatment, outpatient review back log, not offered another apt. In Feb 2015 pt was discharged without been seen, asked for re-referral if required. GP re referred and pt seen AOB in 2019. There was no delay by Mr AOB, there was system review back log and pt was discharged by someone else without a review, this was a Board driven process at the time, review on waiting list was beyond 3 yrs, **NOT SJR**
Level and Type of Review	Datix review
Review Team	

RECORD OF SCREENING

Patient 65

HNC: Personal Information redacted by the USI

Datix : Personal Information redacted by the USI

Directorate:	Acute Services
Reporting Division:	SEC/ Urology
Date of Incident:	22/11/2021
Date of Screening	10/01/2021
Incident (IR1) ID:	Personal Information redacted by the USI
Grade of Incident:	moderate
Screening Team:	Dr Ted McNaboe Dr Damian Scullion Mr Mark Haynes Mr Chris Wamsley Mrs Carly Connolly Mrs Dawn King
Summary of Incident	Was TURP necessary? Now incontinent
Summary of Discussions	29/11/2021 Discussed at screening. Decision for TURP not always taken to MDT. Mr Haynes unable to provide information from NIECR. Require full notes to review. Post op retention following hernia repair, TURP and now incontinent. 80-90% retention after hernia repair resolves after 3-4 months. Should offer trial removal of catheter in 3 months, anaesthesia can also cause bladder voiding problems. 10% risk in hernia repair in men over 65 yrs. Mr Haynes advised need notes to review. Notes attached 10.01.2022 discussed at screening, pt already had a catheter in place 2005, did not relate to hernia repair. Generally urodynamic studies would be completed initially, is there sufficient documented evidence for bladder obstructions and decision to proceed to TURP. Patient had catheter inserted in 2015 due to urinary retention, blocked catheter in Nov 2015, AOB seen pt privately in February 2016, noted in NIECR, had TURP completed in March 2016. It was agreed the plan was reasonable, pt was not suitable for urodynamic studies due to Personal Information redacted by the USI, pt probably not able to complete investigation. Sarah to follow up in relation to treatment times, seen privately and then procedure expedited on NHS waiting list. NOT SJR
Level and Type of Review	
Review Team	

UROLOGY RECORD OF SCREENING

Patient 21

HNC: Personal Information redacted by the USI

Datix: Personal Information redacted by the USI

Directorate:	Acute Services
Reporting Division:	SEC
Date of Incident:	13/12/2021
Date of Screening	20/12/21
Incident (IR1) ID:	Personal Information redacted by the USI
Grade of Incident:	moderate
Screening Team:	Mr Mark Haynes Dr Damian Scullion Dr Ted McNaboe Mr Ronan Carroll Dr Raymond McKee Mr Chris Wamsley Mrs Sarah Ward Mrs Carly Connolly
Summary of Incident	Diagnosis: Circumcision June 2019 for lichens sclerosus (balanitis xerotica obliterans) Lower urinary tract symptoms
Summary of Discussions	Discussed at screening information line contact. No clinical issue .Mr Haynes has wrote detailed letter, NOT SJR
Level and Type of Review	
Review Team	

UROLOGY RECORD OF SCREENING

Patient 44

HNC: Personal Information redacted by the USI

Datix : Personal Information redacted by the USI

Directorate:	Acute Services
Reporting Division:	SEC
Date of Incident:	13/12/2021
Date of Screening	20/12/21
Incident (IR1) ID:	Personal Information redacted by the USI
Grade of Incident:	moderate
Screening Team:	Mr Mark Haynes Dr Damian Scullion Dr Ted McNaboe Mr Ronan Carroll Dr Raymond McKee Mr Chris Wamsley Mrs Sarah Ward Mrs Carly Connolly
Summary of Incident	Highlighted by Mr Keane at OPD clinic in Independent Sector currently on combined Androgen Blockade - SJR for bicalutamide 50mg
Summary of Discussions	Discussed at screening 20/12/2021- treatment was reasonable, on both treatments maximum blockade and LHRHa- no issues - treatment was appropriate- NOT SJR
Level and Type of Review	
Review Team	

UROLOGY RECORD OF SCREENING

Patient 22

HNC: Personal Information redacted by the USI

Datix :

Directorate:	Acute Services
Reporting Division:	SEC
Date of Incident:	
Date of Screening	20/12/21
Incident (IR1) ID:	
Grade of Incident:	
Screening Team:	Mr Mark Haynes Dr Damian Scullion Dr Ted McNaboe Mr Ronan Carroll Dr Raymond McKee Mr Chris Wamsley Mrs Sarah Ward Mrs Carly Connolly
Summary of Incident	Highlighted by Mr Keane at OPD clinic in Independent Sector under on-going oncology FU SJR into previous care
Summary of Discussions	Discussed at screening 20/12/21- no issues identified pt care managed appropriately. **NOT SJR.**
Level and Type of Review	
Review Team	

UROLOGY RECORD OF SCREENING

Patient 53

HNC: Personal Information redacted by the USI

Datix: Personal Information redacted by the USI

Directorate:	Acute Services
Reporting Division:	SEC
Date of Incident:	
Date of Screening	20/12/21
Incident (IR1) ID:	Personal Information redacted by the USI
Grade of Incident:	01/12/2021
Screening Team:	Mr Mark Haynes Dr Raymond McKee Dr Damian Scullion Dr Ted McNaboe Mr Ronan Carroll Ms Sarah Ward Head of Service Mr Chris Wamsley Mrs Carly Connolly
Summary of Incident	. Came via phone inquiry to Urology CNS – passed to Mr Haynes who advises. He needs an SCRR. He was referred as RF, downgraded (unclear if downgrade letter went) but met RF criteria at time
Summary of Discussions	GP appropriately red flagged urology referral. Patient met criteria for red flag, non visbale haematuria, Personal Inform ation yrs. AOB inappropriately downgraded this referral to urgent. Investigations fortunately were all normal, pt came to no harm in this case. Discussed: agree this can happen in all departments, human error, other department would not generally produce a letter to the GP to advise as this would be a massive workload. Booking centre would send letter? Ultrasound was not reviewed until pt attended appointment. **Not for SJR as patient came to no harm.**
Level and Type of Review	
Review Team	

UROLOGY RECORD OF SCREENING

Patient 17

HNC: Personal Information redacted by the USI

Datix : Personal Information redacted by the USI

Directorate:	Acute Services
Reporting Division:	SEC
Date of Incident:	11/11/21
Date of Screening	15/11/21
Incident (IR1) ID:	Personal Information redacted by the USI
Grade of Incident:	Moderate
Screening Team:	Mr Mark Haynes Dr Damian Scullion Dr Ted McNaboe Mr Ronan CarrolL Mr Matthew McAlinden Mr Chris Wamsley Mr David Cardwell Mrs Carly Connolly
Summary of Incident	Personal Information year old man with known history of prostate adenocarcinoma, Gleeson Score 3+3=6 March 2011. PMHX of Hypertension, AAA, BCC, and MI. Patient is currently on Bicalutamide 50mg for his Prostate Cancer. For outpatient review to recommend stopping Bicalutamide and management of surveillance with up to date MRI staging if his PSA is rising and consideration of management options at that point.
Summary of Discussions	15.11.21 - MDT surveillance, 2012 PSA rising, hormone and radiotherapy. Not referred for radiotherapy. Were these patients ever brought back to MDT. No mechanism in MDT at present to check or follow up of recommendations. This is a weakness. Has been highlighted at a senior level. Meets the criteria for review.
Level and Type of Review	SJR
Review Team	

UROLOGY RECORD OF SCREENING

Patient 19

HNC: Personal Information redacted by the USI

Datix : Personal Information redacted by the USI

Directorate:	Acute Services
Reporting Division:	SEC
Date of Incident:	08/11/21
Date of Screening	
Incident (IR1) ID:	Personal Information redacted by the USI
Grade of Incident:	moderate
Screening Team:	Mr Mark Haynes Dr Damian Scullion Dr Ted McNaboe Mr Ronan Carroll Mr Matthew McAlindan Mr Chris Wamsley Mr David Cardwell Mrs Carly Connolly
Summary of Incident	Personal Inform Year old gentleman who had organ confirmed, Gleason 7 Prostatic Carcinoma diagnosed in 2011 and managed entirely with androgen blockade alone since then. He has continued to take Bicalutamide 150mg daily in addition to Tamoxifen 10mg daily. [redacted] Patient 19 is on Bicalutamide 150mg for his non metastatic prostate cancer. Watchful waiting/ Intermittent ADT are recommended treatments
Summary of Discussions	15.11.21 - MDT outcome at aged Personal Infor - started on bicalutamide. Looks like hormones alone when treatment options should have been radical treatment or watchful waiting/surveillance. Now onto watchful waiting. Has had fractured neck of femur. ADT increases risk of osteoporosis. Meets the criteria for review.
Level and Type of Review	SJR
Review Team	

UROLOGY RECORD OF SCREENING

Patient 61

HNC: Personal Information redacted by the USI

Directorate:	Acute Services
Reporting Division:	SEC
Date of Incident:	11/11/21
Date of Screening	08/11/21
Incident (IR1) ID:	Personal Information redacted by the USI
Grade of Incident:	Moderate
Screening Team:	Mr Mark Haynes Dr Damian Scullion Dr Ted McNaboe Mr Ronan Carroll Mr Matthew McAlinden Mr Chris Wamsley Mr David Cardwell Mrs Carly Connolly
Summary of Incident	Personal Information redacted year old gentleman diagnosed with Gleason score 4+4=8 organ confined adenocarcinoma of his prostate gland. June 2012. [redacted] Patient 61 is on a LHRHa for his prostate cancer. For outpatient review to discuss re-staging and referral to oncology if fit for radiotherapy and to refer for assessment of bone density.
Summary of Discussions	15.11.21 - Was not offered radial treatment at time of diagnosis - options were surveillance or watchful waiting. Has received a prolonged period of ADT which was not indicated. Diagnosis in 2012, MDT decided radiotherapy but this was not followed up. Was discussed at MDT on 8 April 2021 and opinion of group was that restaging and discuss. Not offered radical treatment at the time of diagnosis in 2012 as he should have been. Patient has not got the service that they should have got - meets the criteria for an SJR as he was not offered the primary treatment.
Level and Type of Review	SJR
Review Team	

UROLOGY RECORD OF SCREENING

Patient 77

HNC: Personal Information redacted by the USI

Datix : Personal Information redacted by the USI

Directorate:	Acute Services
Reporting Division:	SEC
Date of Incident:	11/11/21
Date of Screening	15/11/21
Incident (IR1) ID:	Personal Information redacted by the USI
Grade of Incident:	Moderate
Screening Team:	Mr Mark Haynes Dr Damian Scullion Dr Ted McNaboe Mr Ronan Carroll Mr Matthew McAlinden Mr Chris Wamsley Mr David Cardwell Mrs Carly Connolly
Summary of Incident	Personal Information redacted year old gentleman was diagnosed with clinical and biochemical diagnosis of prostatic carcinoma in May 2018 when he was reported to have a prostatic volume was reported to be 88ml and his residual urine volume was reported to be 201ml. Patient commenced him on Bicalutamide and Tamoxifen 2018. Patient is on Bicalutamide 150mg for a clinical diagnosis of prostate cancer. For outpatient review, to recommend stopping bicalutamide and management with surveillance with consideration of staging / investigation dependent upon PSA dynamics
Summary of Discussions	15.11.21 - Reluctance to manage patients without treatment. Breast growth with bicalutamide. Tamoxifen to reduce this. Was started on medication without evidence of metastatic disease. Now being managed with watchful waiting and PSA monitoring. No diagnosis of cancer. Suspect reduced dose was to reduce complications of treatment. Meets the criteria for review.
Level and Type of Review	SJR
Review Team	

UROLOGY RECORD OF SCREENING

Patient 74

HNC: Personal Information redacted by the USI

Datix : Personal Information redacted by the USI

Directorate:	Acute Services
Reporting Division:	SEC
Date of Incident:	11/11/21
Date of Screening	15/11/21
Incident (IR1) ID:	Personal Information redacted by the USI
Grade of Incident:	Moderate
Screening Team:	Mr Mark Haynes Dr Damian Scullion Dr Ted McNaboe Mr Ronan Carroll Mr Matthew McAlinden Mr Chris Wamsley Mr David Cardwell Mrs Carly Connolly
Summary of Incident	patient has a low risk non muscle invasive bladder cancer treated by TURBT. For review by AOB to recommend flexible cystoscopy in 3 months. Complaint about his treatment under AOB Comment MDH - ?indications for why a TURP was performed in 2013
Summary of Discussions	15.11.21 - Patient who contacted the Trust re concerns about management. Helpline. Was seen in clinic by Mr Haynes. Prostate cancer treated with radiotherapy. Now incontinent managed with pads. Issues are incontinence. Mr Haynes could not satisfy the decision to proceed to TURP - this is incontinence stems from. Continuous stress incontinence. Bladder cancer first and then TURP when he attended for bladder procedure. Prostate cancer diagnosed at this point. 2013 given botox, went into retention, subsequent TURP (10% risk of retention) not an indication for bladder outflow surgery. In absence of obstruction TURP can worsen obstruction. Stress incontinence relates to closure pressures. Concerns re bladder outflow surgery. Meets the criteria for review.
Level and Type of Review	SJR
Review Team	

UROLOGY RECORD OF SCREENING

Patient 6

HNC: Personal Information redacted by the USI

Datix : Personal Information redacted by the USI

Directorate:	Acute Services
Reporting Division:	SEC
Date of Incident:	11/11/21
Date of Screening	15/11/21
Incident (IR1) ID:	Personal Information redacted by the USI
Grade of Incident:	Moderate
Screening Team:	Mr Mark Haynes Dr Damian Scullion Dr Ted McNaboe Mr Ronan Carroll Mr Matthew McAlinden Mr Chris Wamsley Mr David Cardwell Mrs Carly Connolly
Summary of Incident	Patient has an intermediate risk organ confined prostate cancer. Initially treated with Bicalutamide 50mg, switched to 150mg in November 2019 and then patient has discontinued Bicalutamide since his last prescription in February 2020 - Recent PSA 15
Summary of Discussions	15.11.21 - Initially started on 50mg for stage of disease which options were radical treatment or surveillance. Neither has he been treated or monitored. Meets the criteria for review
Level and Type of Review	SJR
Review Team	

UROLOGY RECORD OF SCREENING

Patient 66
HNC: Personal Information redacted by the USI
Datix : Personal Information redacted by the USI

Directorate:	Acute Services
Reporting Division:	SEC
Date of Incident:	11/11/21
Date of Screening	15/11/21
Incident (IR1) ID:	Personal Information redacted by the USI
Grade of Incident:	Moderate
Screening Team:	Mr Mark Haynes Dr Damian Scullion Dr Ted McNaboe Mr Ronan CarrolL Mr Matthew McAlinden Mr Chris Wamsley Mr David Cardwell Mrs Carly Connolly
Summary of Incident	On review with AOB he was commenced on a low dose of Bicalutamide and placed on the waiting list for a TURP with the intent that the TURP would improve his urinary symptoms and obtain tissue for pathology with regards to prostate cancer likely diagnosis
Summary of Discussions	15.11.21 - 2019 Raised PSA. No evidence of metastsis. Commenced on 50mg and planned for a TURP. No diagnosis of prostate cancer. PSA 28.8. Standard investigation of a raised PSA would include consideration of MRI and prostate biopsy. Started on unlicensed dose and investigation plan was not standard for diagnosis. Received hormone treatment to December 2020. Still no tissue diagnosis. Now on watchful waiting. Personal Information redacted year old. PSA dynamics do not trigger any indication for treatment. The only standard use for 50mg is for testestrone flair for patients being started on LHRHa. Difficult to understand why this drug was used. Meets the criteria for review
Level and Type of Review	SJR
Review Team	

UROLOGY RECORD OF SCREENING

Patient 60

HNC: Personal Information redacted by the USI

Datix : Personal Information redacted by the USI

Directorate:	Acute Services
Reporting Division:	SEC
Date of Incident:	11/11/21
Date of Screening	15/11/21
Incident (IR1) ID:	Personal Information redacted by the USI
Grade of Incident:	Moderate
Screening Team:	Mr Mark Haynes Dr Damian Scullion Dr Ted McNaboe Mr Ronan Carroll Mr Matthew McAlinden Mr Chris Wamsley Mr David Cardwell Mrs Carly Connolly
Summary of Incident	High risk locally advanced prostate cancer diagnosed 2017 and treated with oral Bicalutamide to date
Summary of Discussions	15.11.21 - 2017 MDT high risk locally advanced disease. Treatment with curative intent. Started on 150 mg in March 2017. For patients having ADT with radiotherapy will receive this drug from oncologist. Meets the criteria for review.
Level and Type of Review	SJR
Review Team	

RECORD OF SCREENING

Patient 31
HNC : Personal Information redacted by the USI
Datix : Personal Information redacted by the USI

Directorate:	Acute Services
Reporting Division:	SEC/ Urology
Date of Incident:	
Date of Screening	23/11/21
Incident (IR1) ID:	
Grade of Incident:	moderate
Screening Team:	Dr Ted McNaboe Dr Damian Scullion Dr Raymond McKee Mr Mark Haynes Mrs Wendy Clayton Mrs Sarah Ward Mr Chris Wamsley Mrs Carly Connolly
Summary of Incident	Bicalutamide 2011 and then Radiotherapy 2014 for CaP had assessment of LUTS prior to RT but dose of bicalutamide 50mg and 3 years from diagnosis to RT incorrect dose of bicalutamide referral to oncology delayed
Summary of Discussions	22.11.2021 Discussed at screening- 01.05.2021 tel consultant with Mr Haynes. Patient was on an unlicensed dose of Bicalutamide, Now on correct treatment, For SJR.
Level and Type of Review	SJR
Review Team	

Urology screening 06/12/21 No screening Mrs Sarah Ward, Dr Damian Scullion Dr Ted McNaboe; Mr David Cardwell; Mrs Carly Connolly. Apologies: Raymond McKee Ronan Carroll.Mr Haynes Urologist of the week.						
Department		**Type**	**Name and H&C**	**Background**	**Screening update**	**Attachments**
SEC/urology	25	screening	Patient 25 HNC: Personal Information redacted by the USI 1	Highlighted by Mr Keane at OPD clinic in Independent Sector Current management plan in place with MDH but needs an SJR for previous episodes	06/12/2021 Discussed at screening,	
SEC/urology	24	screening	Patient 22 HNC: Personal Information redacted by the USI	Highlighted by Mr Keane at OPD clinic in Independent Sector under on-going oncology FU SJR into previous care		
SEC/urology	23	screening	Patient 72 HNC: Personal Information redacted by the USI	Highlighted by Mr Keane at OPD clinic in Independent Sector SJR - on bicalutamide for years before he had alternative treatment (2012-2014) and only started his LH/RHa in May 2014		
SEC/urology	22	screening	Patient 44 HNC: Personal Information redacted by the USI	Highlighted by Mr Keane at OPD clinic in Independent Sector currently on combined Androgen Blockade - SJR for bicalutamide 50mg		
SEC/urology	21	screening	Patient 34 HNC: Personal Information redacted by the USI	Highlighted by Mr Keane at OPD clinic in Independent Sector SJR no letters pt was on bicalutamide for a number of years before being offered radiotherapy		
SEC/urology	20	Screening	Patient 71 HNC: Personal Information redacted by the USI	Diagnosis: Initial urological issue of chronic urinary retention requiring intermittent catheterisation Abdominal hysterectomy 2008 complicated with small bowel obstruction requiring emergency laparotomy. Colostomy for chronic constipation 2010 Cystectomy, salpingo-oopherectomy and ileal conduit urinary diversion 2011		
SEC/urology	19	Screening	Patient 21 HNC: Personal Information redacted by the USI	Diagnosis: Circumcision June 2019 for lichens sclerosus (balanitis xerotica obliterans) Lower urinary tract symptoms		
SEC/urology	18	screening	Patient 63 HNC: Personal Information redacted by the USI	Highlighted by Professor Sethia Delayed diagnosis of Ca lung		
SEC/urology	17	Screening	Patient 59 HNC: Personal Information redacted by the USI	Diagnosis: Low risk prostate cancer diagnosed 2006 - Upgrade to intermediate risk prostate cancer on surveillance biopsies 2012 commenced Bicalutamide 50mg daily September 2019		
SEC/urology	16	Screening	Patient 47 HNC : Personal Information redacted by the USI	Highlighted by Professor Sethia incorrect management of Ca prostate in 2010 - possible harm		

Received from Dr Maria O'Kane on 29/03/22. Annotated by the Urology Services Inquiry.

SEC/urology	15	Screening	Patient 58 HNC: Personal Information redacted by the USI	Highlighted by professor Sethia DIAGNOSIS: Adenocarcinoma of prostate - He has been diagnosed with prostate cancer in 2008 and has been kept on active surveillance since then.		
SEC/urology	14	screening	Patient 64 HNC: Personal Information redacted by the USI	Highlighted by professor Sethia Diagnosis: T2, N0, M0 Gleason 4+3 iPSA 27NGS/ML (on 5ARI) prostate cancer. 9 out of 14 cores recent TURP.		
SEC/urology	13	Screening	Personal Information redacted by the USI HNC: Personal Information redacted by the USI *Deceased	Highlighted by professor Sethia August 2018 diagnosed metastatic prostate cancer PSA>400 Started on degarelix MDM 16.08.18 to continue ADT PSA rise to 9.2 in February 2019. Started on bicalutamide 50mg. March 2019 PSA 15 Started on dexamethasone MDM recommended referral to oncology Died Personal Information redacted by the – comment from Prof Sethia - Enzalutamide might have improved survival for 4-6 months?		
SEC/urology	12	Screening	Patient 30 HNC : Personal Information redacted by the USI	Highlighted by professor Sethia Diagnosis: Prostate cancer Gleason score 3+3=6 in 2018 – no evidence of follow-up		
SEC/urology	11	Screening	Patient 62 HNC: Personal Information redacted by the USI	Patient request and highlighted by professor Sethia: I would like to have my care reviewed I was operated on by Mr Hagan in the City Hospital but the diagnosis and original procedure were carried out by Mr OBrien. As a result I had bladder cancer and prostate cancer I also had a kidney removed and as a result I had a stent inserted and now wear a colostomy bag.		
SEC/urology	10	screening	Patient 27 HNC: Personal Information redacted by the USI	Diagnosis: 4.5cm left renal mass Prostate cancer on androgen deprivation therapy On Bicalutamide and Tamoxifen for gleason 3+4 prostate cancer since 2014, stage T2 N0 M0		
SEC/urology	9	screening	Patient 65 HNC: Personal Information redacted by the USI Datix : Personal Information redacted by the	Was TURP necessary? Now incontinent	29/11/2021 Discussed at screening. Decision for TURP not always taken to MDT. Mr Haynes unable to provide information from NIECR. Require full notes to review. Post op retention following hernia repair, TURP and now incontinent. 80-90% retention after hernia repair resolves after 3-4 months. Should offer trial removal of catheter in 3 months, anaesthesia can also cause bladder voiding problems. 10% risk in hernia repair in men over 65 yrs. Mr Haynes advised need notes to review. Notes attached	Adobe Acrobat Document
SEC/urology	8	screening	Personal Information redacted by the USI HNC: Personal Information redacted by the USI Datix : Personal Information redacted by the	Incorrect management of Ca prostate - complicated case- may have suffered harm	29/11/2021 Discussed at screening.- Sarah Ward to ask Chris for update on concerns, Mark reviewed notes, unable to identify concerns raised.	
SEC/urology	7	screening	Patient 52 HNC: Personal Information redacted by the USI Datix : Personal Information redacted by the	1. Previous transitional cell carcinoma of bladder 2. Bladder outlet obstruction 3. Urinary infection Potentially incorrect management	29/11/2019 Discussed at screening. June 2018 TURPT, resection Aug 2018 - standard management, pt was Personal Information rs at the time recommended for BCG treatment, completed this treatment, he had a check of bladder. Had a TURP, appears to have continued on surveillance pathway, had a MRI , pt had PE. Right hydronephrosis nephrostomy was completed. Unsure of the concerns raised in this case. Sarah Ward to contact Mr Sethia for more information in relation to concerns he had raised and feedback.	
SEC/urology	6	Screening	Patient 73 HNC: Personal Information redacted by the USI	Telephone clinic on 15 May 2021: comment on PRF Although would likely have been recommended to proceed to orchidectomy, the US was not reviewed at urology MDM prior to surgery, and subsequent pathology was benign. The US report had raised a number of differentials so I feel best practice would have been review at MDM		

SEC/urology	**5**	**screening**	Patient 46 **HNC:** Personal Information redacted by the USI	**SJR on bicalutamide for years before going on an LA analogue and started on non-recommended treatment**		
SEC/urology	**4**	**screening**	Patient 28 **HNC:** Personal Information redacted by the USI	**Diagnosis: T3b N1 prostate cancer at diagnosis 2017 treated with oral Bicalutamide**		
SEC/urology	3	screening	Patient 79 hnc: Personal Information redacted by the USI	See progress notes on NIECR - Long history of urology attendances / interventions states 19 procedures in total although limited documentation on NIECR	22.11.2021 Discussed at screening- Mr Haynes has reviewed patient – Patient had a significant number of treatments due to chronic pelvic pain syndrome without evidence. 19 Procedures, timing for waiting lists and getting treatment were expedited, seen privately and added to list. Currently on appropriate management pathway. Patient 79 contacted Trust, Mr Haynes reviewed care and would appreciate an external review of his management and care. Need external reviewer to review case.	
SEC/urology	2	Screening	Patient 29 HNC: Personal Information redacted by the USI Datix : Personal Information redacted by the	LUTS - assessed with UDS >> BNI and botox No improvement >> UDS >> TURP >>improved but ongoing symptoms and ED. Advised in consultation was not made aware that ED / retrograde ejaculation were risks of TURP although he would have gone ahead with the surgery even if he had known this risk. Seen privately 30/4/16>>UDS 27/5/16>>TURP 27/7/16 likely shorter waits than other patents seen in NHS	22.11.2021 Discussed at screening- at consultation patient brought up concerns - not consented for risk of erectile dysfunction, retrograde ejaculation. Mr Haynes to review and bring back next week.	Adobe Acrobat Document Adobe Acrobat Document
SEC/urology	1	Screening	Patient 54 HNC : Personal Information redacted by the USI Datix : Personal Information redacted by the	Personal Information year old gentleman diagnosed 2010 with an IPSA of Gleason 7 (3+4) pT1 RT3 N0 M0 adenocarcinoma prostate gland. Treatment history: radiotherapy not given due to other comorbidities. Commenced on Zoladex 2010 and remains on this to date. patient is currently on an LHRHa for his non metastatic prostate cancer. For outpatient review to recommend stopping this LHRHa and ongoing management with watching waiting/ intermittent ADT	15.11.21 - in 2010 the clinical thinking that radiotherapy was the primary treatment of choice. Radiotherapy discussion was had but MDT discussion felt patient was not fit for same. Reason given for not progressing to radical radiotherapy. At time of diagnosis localised prostate cancer - was referred for radio but on LHRH analogue for a prolonged time. Was discussed at MDT and view was that if he was not fit for treatment consideration should have been for watchful waiting rather than androgen depravation therapy (Zoladex) which was commenced in 2010. All patients will be started on androgen depravation therapy before radiotherapy. Unclear as to who made the decision to start androgen depravation therapy - Governance to obtain MDT outcome from 2010.19/11/2020 Wendy has advised there was no MDT at this time. Nothing on CaPPS Should have had watchful /waiting. What did MDT recommend at the time. There is comment not fit for radiotherapy, should have had watchful waiting. Were MDM running routinely for prostate cancer at that time. If not there is no MDM discussion with recommended treatment, would hormone treatment be used at the time. Wendy to ask Robert McCormick and feedback next week.	

HCN Personal Information redacted by the USI
AE Number Personal Information redacted by the USI
GP Personal Information redacted by the USI
GP TEL Personal Information redacted by the USI

Surname Patient 65 Forename Patient 65 Dob Personal Information redacted by the USI
Personal Information redacted by the USI
Personal Information redacted by the USI

Diagnosis Investigations and Results

1. Personal Information redacted by the USI
2.
3.

ED Discharge Plan Patient to attend GP re:

Referred to Specialty Time

Admission Agreed By: DTA Time

Grade of Doctor Patient to make appt with GP

Prescription (Medicines on discharge) Supply

Medicine	Dose	Route	Frequency	Duration	Signature	Supply required	Checked by	Given by	Quantity

98
15/4/15
3 SENT
To:

FINAL PLACEMENT

Admit to ward	GP		other hospital OPD
CDU	ED Review		Did not wait/refuses Rx
TNF to OH	Fracture Clinic		Died in ED
Home	CBYL	Psych. Assess	CTMA
OPD	ED Physio		Absconded

Sign
Grade
Breach Time 17:32
Exam Finish Time
Departure Time

Discharge OBS

P	BP	RESP	TEMP	SPO2	GCS	CR	BM
70	102/62	19	37.5	95%	14/15		

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

Breach Time 17:32

Time left department 23:35 Signature Nurse Personal Information redacted by the USI

CRAIGAVON HOSPITAL EMERGENCY DEPARTMENT

Lurgan Road, Craigavon, BT6 35QQ
Tel: 028 38334444 Fax: 028 38351276

Personal Information redacted by the USI

AE Number Personal Information redacted by the USI HCN Personal Information redacted by the USI Priority Code 3
Surname Patient 65 GP Personal Information redacted by the USI
Forename Personal Information redacted by the USI
Dob Personal Information redacted by the USI Age Personal Information
Sex M MS S
Occ. Personal Information redacted by the USI Tel Personal Information redacted by the USI
Casenote Personal Information redacted by the USI Mobile/Other NONE

Arrival Date/Time 11/11/2015 13:32
Arrival Mode PR Incident Type NT
Source of Referral Gp Request
Accompanied By OTHER NON-RELATIVE
Patient at risk of leaving Yes/No

Prev Episodes 02 / 02
Triage Date/Time 11/11/2015 13:39
Breach Time 17:32
Nurse: SBRU SHANNON BRUSH
Tetanus Status:
Booster Given Yes/No

Adult Safeguarding Concerns Yes/No
Child Protection Concerns Yes/No
Special Needs

Presenting Complaint BLOCKED CATHETER
Presentation URINARY PROBLEMS
Discriminator MODERATE PAIN
Triage Text NH PATIENT, DISCHARGE FROM PENIS, ONLY 50 ML DRAIN AGE, SRC BYPASSING, TUMMY PAIN. H/O DEMENTIA.
Medication

Allergies NKDA

Signature Personal Information redacted by the USI

Pulse	B/P	RR	PFR	Temp	SaO2	GCS	CRT	BM	PERL	AVPU
	173/77	22		36.3	99					A

Visual Acuity Right Eye Left Eye
Urine
Pregnancy Test
Weight

ECG required yes/no (< 10 minutes cardiac)
History MRSA CDIFF
Patient Location MINOR AREA
Pain Score 5
Time 13:39
Category 3 Infection

Commenced on NEWS/CNS/PEWS chart Yes No Signature Personal Information redacted by the USI

Nursing Assessment

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

HCN Personal Information redacted by the USI Surname Patient 65 Forename Patient 65 Dob Personal Information redacted by the USI

AE Number Personal Information redacted by the USI

Assessment Seen By Personal Information redacted by the USI Time 1623

Personal Information redacted by the USI

HCN Personal Information redacted by the USI Surname Patient 65 Forenam Patient 65 Dob Personal Information redacted by the USI

AE Number Personal Information redacted by the USI

Prescription (Medicines in Department)

Medicine	Dose	Route	Time to be	Signature	Administration Given by	Time
Personal Information redacted by the USI						

Nursing/care delivered in ED

Personal Information redacted by the USI

Fluid Balance	☐	Relevant performa	☐
Copy of NIAS notes stroke PTs	☐	Own Drugs	☐

IV Cannula Form ☑

C diff completed ☑

Relatives aware admission ☑

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

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

If yes to any of above refer to agreed guidance.

Southern Health and Social Care Trust

Quality Care - for you, with you

Urinary Catheter Insertion and Monitoring Form

NOTE: ***Keep this form at the patient's bed*** and file in the medical notes when appropriate.
If catheter needs reinserted please use new form and file the old form in patient's notes.

PATIENT DETAILS (use Addressograph label)

Patient 65 [redacted]
Name
Healthcare No. Personal Information redacted by the USI
Date of birth Personal Information redacted by the USI
Address Personal Information redacted by the USI

Consultant
Hospital ALE.
Ward
General Practitioner Dr Personal Information redacted by the USI
Health Care facility/Home

INDICATION FOR CATHETERIZATION

- **Urinary Retention** ☑
  Result of Bladder scan (if available)
  Painful ☐ Painless ☐ Failed TROC ☐
- **To maintain skin integrity** ☐
- **Urinary Input/output monitoring** ☐
- **Other** _____ ☐

CATHETER INSERTION

Patient consent obtained (Yes) / No
Date 11/11/15 **Time**

Operator name **Grade/designation** WOC REG.

INSERTION BUNDLE

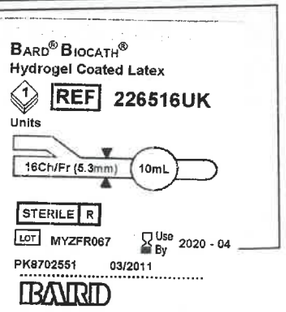
1. **Disinfect hands before insertion** ☑
2. **Sterile Catheter pack used** (Yes) / No
3. **Sterile gloves used** ☑
4. **Sterile items used** ☑
5. **Single use sterile water/saline/antiseptic** ☑
6. **Aseptic non-touch technique maintained** ☑
7. **Disinfect hands after insertion** ☑

Easy insertion? Yes/No. **If No, why** (indicate no. of attempts)
Description of urine Clear. **Residual volume after 30 minutes**
CSU collected? Yes / (No) **If Yes, why**
Closed Drainage system Yes / No.
PPE appropriately used Yes / No.

CATHETER INFORMATION (use label from catheter)

Catheter type Standard ☑ Female ☐ Short-term ☐ Long-term ☐
Make
Lot number **Size** **Expiry date**
Amount of water used to inflate balloon
Type of Gel used Lignocaine ☐ Sterile lubricant Gel ☐

ATTA



Received from Dr Maria O'Kane on 29/03/22. Annotated by the Urology Services Inquiry.

Daily Review of Catheterization

DAY/DATE	NAME, DESIGNATION	INDICATION TO REMAIN	PLAN (REMOVE, FURTHER REVIEW)
1 12/11/15	Lynn Harrison	monitor output	Longterm SRC
2 13.11.15	P. Patterson SN	monitor output	longterm src.
3 14.11.15	R Montgomery SN	"	"
4 16/11/15	Lynn Harrison SN	Monitor output	Longterm SRC
5 17/11/15	Lynn Harrison SN	monitor output	Longterm SRC
6			
7			
8			
9			
10			
11			
12			
13			
14			

Date catheter removed_____

If failed trial removal of catheter (TROC) use new form documenting clearly it is a repeat insertion of catheter.

If the patient is going home with a new catheter inform the following:

	Date	Signature
General Practitioner		
District nurse if housebound		
Continence team if not housebound		

This information is documented on the patient's e-discharge letter? Yes / No

Patient given a urinary catheter patient information leaflet? Yes / No

NOTE: Please send a photocopy of this form to the GP/District nurse/Continence Team/ Nursing home

Quality Care - for you, with you

INFECTION PREVENTION & CONTROL RISK ASSESSMENT TOOL AND PATIENT PLACEMENT

Patient Name	Date of Birth	Health & Care Number
Patient 65 [redacted]	Personal Information redacted by the USI [redacted]	Personal Information redacted by the USI [redacted]

Does the patient have a history of:	Circle as appropriate	
Carbapenemase Producing Enterobacteriaceae (**CPE**)	Yes	No
Has the patient been in previous contact with a CPE /CPO case?	Yes	No
Meticillin-resistant Staphylococcus aureus (**MRSA**)	Yes	No
Vancomycin-resistant Enterococcus (**VRE**)	Yes	No
Clostridium difficile	Yes	No
Extended Spectrum Beta-Lactamase (**ESBL**)	Yes	No
Glycopeptide-Resistant Enterococci (**GRE**)	Yes	No

Does the patient currently have: *Refer to Triage flowchart*	Circle as appropriate	
Meningitis	Yes	No
Diarrhoea or Vomiting	Yes	No
A rash thought to be due to an infection	Yes	No
Flu-like illness	Yes	No
Symptoms/signs suggestive of TB	Yes	No
Abscess or draining wound that cannot be covered	Yes	No
Traveller's fever	Yes	No

Has the patient been:	Circle as appropriate	
An inpatient in a hospital outside of Northern Ireland in the past 12 months	Yes	No
Has the patient been an inpatient in BHSCT in the past 12 Months	Yes	No
Inpatient in a Hospital within NI where there has been spread of CPE - HCAI Alerts ☐	HCAI Alerts ☐	No

Actions	Circle as appropriate	
Patient Flow have been informed re outcome of above assessment	Yes	No

Document location of in-patient placement as determined by Patient Flow

Name of Ward	Tick as appropriate			
	Open bay	Side room without en-suite	Side room with en-suite	Negative pressure room

Document assessor details and date and time of assessment:

Print Name	Signature:	
	Personal Information redacted by the USI [redacted]	

PLEASE FILE THIS ASSESSMENT TOOL WHEN COMPLETED WITH PATIENT'S NOTES

If any concerns re patient management, please refer to the relevant Trust infection prevention and control guidance documents available on the Trust intranet site and/or contact a member of the infection prevention and control team

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

Patient 65

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→		Personal Information redacted by the USI
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		

LPC 03/08/021

WPH000134

	Date
→	
Age	
URINE Protein	
Sugar	
Acetone	
WEIGHT	
kg.	
→	
Age	
URINE Protein	
Sugar	
Acetone	
WEIGHT	
Age	
URINE Protein	
Sugar	
Acetone	
WEIGHT	
kg.	

Personal Information redacted by the USI

Personal Information redacted by the USI

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78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

Patient 65

[redacted]

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→		
Age		Personal Information redacted by the USI
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		

LPC 03/08/021

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

Patient 65

t

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→		Personal Information redacted by the USI
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		

LPC 03/08/021

Received from Dr Maria O'Kane on 29/03/22. Annotated by the Urology Services Inquiry.

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters Full Name Date of Birth Unit No. Ward/Dept. Address Consultant

[redacted] Patient 65

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→		[redacted] Personal Information redacted by the USI
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT kg.		

James Hamilton & Co. (Surgical) Ltd.

	Date	Clinical Notes
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT kg.		
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT kg.		
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT kg.		
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT kg.		

Personal Information redacted by the USI

Received from Dr Maria O'Kane on 29/03/22. Annotated by the Urology Services Inquiry.

AIDAN O'BRIEN FRCSI
Consultant Urologist

Personal Information redacted by the USI

Tel: Personal Information redacted by the USI

4th March 2016

Personal Information redacted by the USI

Dear Personal Information redacted by the

Patient 65

Personal Information redacted by the USI

DOB Personal Information redacted by the USI

UN

Personal Information redacted by the USI

Yours sincerely

dictated but not signed by

Mr Aidan O'Brien
Consultant Urologist

Date dictated: 4th March 2016
Date typed: 4th March 2016/LH

HSS TRUST _____ | **GP PRACTICE** or other _____

Hospital Unit _____ | **Primary Care Provider** _____

FORM 1 -- CONSENT FOR EXAMINATION, TREATMENT OR CARE

Personal details (or pre-printed label)

Surname/family name .....

First names .....

Date of Birth .....

❑ Male ❑ Female H+C No. (or

Special requirements (language o

.....

[redacted] Patient 65

.....

.....

.....

.....

.....

.....

Statement of healthcare professional

Responsible healthcare professional .....Job Title.....

Name of proposed procedure or course of treatment *(include side of body or site and brief explanation if medical term not clear)*

.....

.....

I have explained the p

.....

.....

The intended benefits

.....

[redacted] Personal Information redacted by the USI

[redacted] Personal Information redacted by the USI

Contact details *(if patient wishes to discuss options later)* .....

Statement of interpreter (where appropriate)

I have interpreted the information above to the person giving consent to the best of my ability and in a way which I believe s/he can understand.

Signed .....Date .....

Name **(Print)** .....

Copy accepted by person giving consent Yes/No (please circle)

Statement of person giving consent

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask - we are here to help you. You have the right to change your mind at any time, including after you have signed the form.

I agree to the procedure or course of treatment described on this form. 3,

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia).

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about possible additional procedures which may become necessary during my treatment. I have listed below any procedures **which I do not wish to be carried out** without further discussion.

.....

.....

***I agree** that healthcare students, who will be supervised by healthcare professionals, may observe or assist in my care. * *You may remove this sentence without affecting your care.*

Signature [redacted] Personal Information redacted by the USI .....

Name **(Print)** .....

A witness should sign below if the person is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes)

Signature .....Date .....

Name **(Print)**.....

Confirmation of consent (to be completed by a healthcare professional when the person is admitted for the procedure, if s/he has signed the form in advance). I have confirmed that s/he has no further questions and wishes the procedure to go ahead.

Signature .....Date .....

Name **(Print)** .....Job Title .....

Important notes: (tick if applicable)

☐ **See also advance directive/living will (eg Jehovah's Witness form)**

☐ **Person has withdrawn consent** .....Date.....

(ask person to sign/date here)

LPC 03/08/031

Received from Dr Maria O'Kane on 29/03/22. Annotated by the Urology Services Inquiry.

PRESCRIPTION RECORD SHEET

Item	Date started	Medication name, type, strength	Dose	Admin method	9am	1pm	5pm	9pm	Nurse 1 sign	Nurse 2 sign	GP sign	Discontinued Date/initial
1	9/9/15	ASPIRIN 75MG	ONE	ORAL	√				Personal Information redacted by the USI			
2	9/9/15	LEVOTHYROXINE 50MCG	ONE	ORAL	√							
3	9/9/15	LEVOTHYROXINE 25MCG	ONE	ORAL	√							
4	9/9/15	FOLIC ACID 5MG	ONE	ORAL	√							
5	9/9/15	AMLODIPINE 10MG	ONE	ORAL	√							
6	9/9/15	LAXIDO POWDER	ONE	ORAL	√							
7	9/9/15	CALCIUM CARBONATE & COLECALCIFEROL (CALCEOS)	~~TWO~~ one	ORAL		√						
8	9/9/15	PARACETAMOL 500MG	TWO	ORAL	QID PRN							
9	9/9/15	ATORVASTATIN 10MG	ONE	ORAL				√				
10	9/10/15	SODIUM PICOSULPHATE 5MG/5MLS	5 - 10MLS	ORAL	AS REQUIRED							
11	21/11/15	CO-CODAMOL 15/500MG	1-2	ORAL	QID PRN							
12	~~13/02/16~~	~~TRIMETHOPRIM 100MG~~	~~ONE~~	~~ORAL~~	~~√~~			~~√~~				
13	29-2-16	Hyoscine Butylbromide	one	oral	✓			✓				
14												
15												
16												
17	27/01/16	BIOCATH BARD TRAY	1		AS	REQ						
18	20/11/15	INSTILLAGEL 2%/0.255	1	ECL	√	√	√	√				
19	12.3.16	Co-Amoxiclav One t.i.d	1		✓		✓	✓				
20												

Resident details: Personal Information redacted by the USI

NAME	Patient 65	KNOWN ALLERGIES 1:	
DOB	Personal Information redacted by the USI	2:	

WRITTEN BY: Personal Information redacted by the USI

CHECKED BY: Personal Information redacted by the USI

DATE: Personal Information redacted by the USI

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PREOPERATIVE ASSESSMENT

ASA status: 1 2 3 4 5 6 E

Patient 65 [redacted]

PERSONNEL

Anaesthetist (grade):

Surgeon: Mr. O'Brien

PROCEDURE DETAILS

Diagnosis:

Operation: TURP.

NCEPOD : Scheduled

Urgent

Emergency

Personal Information redacted by the USI [redacted]

L
H
P
N
K
U
C
X
E
C

Mg 45

TP NSV Code WPG201N

Patient 65 [redacted]

POSTOPERATIVE INSTRUCTIONS/ MONITORING

SURGICAL PROCEDURE:

Oxygen @ ..... L/min ..... % for ..... hrs/overnight/humidified

Target SpO_2 ≥ 94 %

ANALGESIA

Morphine IV (.....mg/ml) up to max ..... mls

Paracetamol .....mg IV/PO/NG/PR ..... hrly PRN/Regular

Other -

ANTIEMETICS

See Pantoon.

Routine Observations ☑

Discharge at Sister's advice ☑ Only after D/W anaesthetist ☐

Please see:

Drug Kardex ☑

Fluid balance chart ☑

PCA Form ☐

Epidural Form ☐

Intrathecal opiate Form ☐

CVC Audit sheet ☐

POSTOP INVESTIGATIONS

Full ICU .....

FBP, U& .....

ABG .....

CXR ....

Other : Patient 65 [redacted]

Personal Information redacted by the USI [redacted]

Patient Protection

AAGBI Equipment Check	□
WHO Safety Checklist	□
Eye Protection	□
Pressure Points Padded	□
Warming Mat	□
Forced Air Warmer	□
Blood Warmer	□
Calf compression	□

Procedure

Date:

Operation:

Consultant (Supervising):

Anaesthetist(s):

Surgical Team:

CAH □ DHH □ STH □ Theatre:

Monitoring

Machine ID .....

ECG	□	$ETCO_2$	□
SpO2	□	FIO_2	□
NIBP	□	Gas	□
ABP	□	Temp	□
CVP	□	NM	□
CO	□	BIS	□

Vascular Access

Peripheral:

1. C F
2. C F
3. C F

Arterial:

CVC: Audit Form □

Airway Management

$PreO_2$ □ IV induction □ RSI □

Facemask □ Guedel □ NGT □

SAD □ Type & Size ETT □ Type & Size Laryngoscopy Details

Ventilation/Positioning

Circle System □ Other .....

Position..... Arms <90° □

SR □ PSV □ PCV □ VCV □

.....cmH_2O

.....cmH_2O

D

R

U

G

S

N_2O / O_2 / Air % ET Agent:

CNB:

Spinal □ Epid □ CSE □

Detail:

PNB:

Site: L R

'STOP' before you block □

Awake □ Nerve Stim □

Sedated □ USG □

Asleep □

USG in plane □ OOP □

Needle.....mm .....make

Catheter □ ..... mm

LA :

Fluids Given: Times→

250

200

150

100

50

Blood Loss :

Urinary Output :

Notes:

FiO_2

SpO_2

$ETCO_2$

PAP

Temp

ABL825 Recovery
PATIENT REPORT Syringe - S 195uL 19:44 16/03/2016 Sample # 18137

Identifications

Patient ID	Patient 65
Patient Last Name	[redacted]
Patient First Name	
Sample type	Venous
FiO2	0 %
PEEP	cmH2O
T	37.0 °C
Operator	Linda Mcnally

Personal Information redacted by the USI

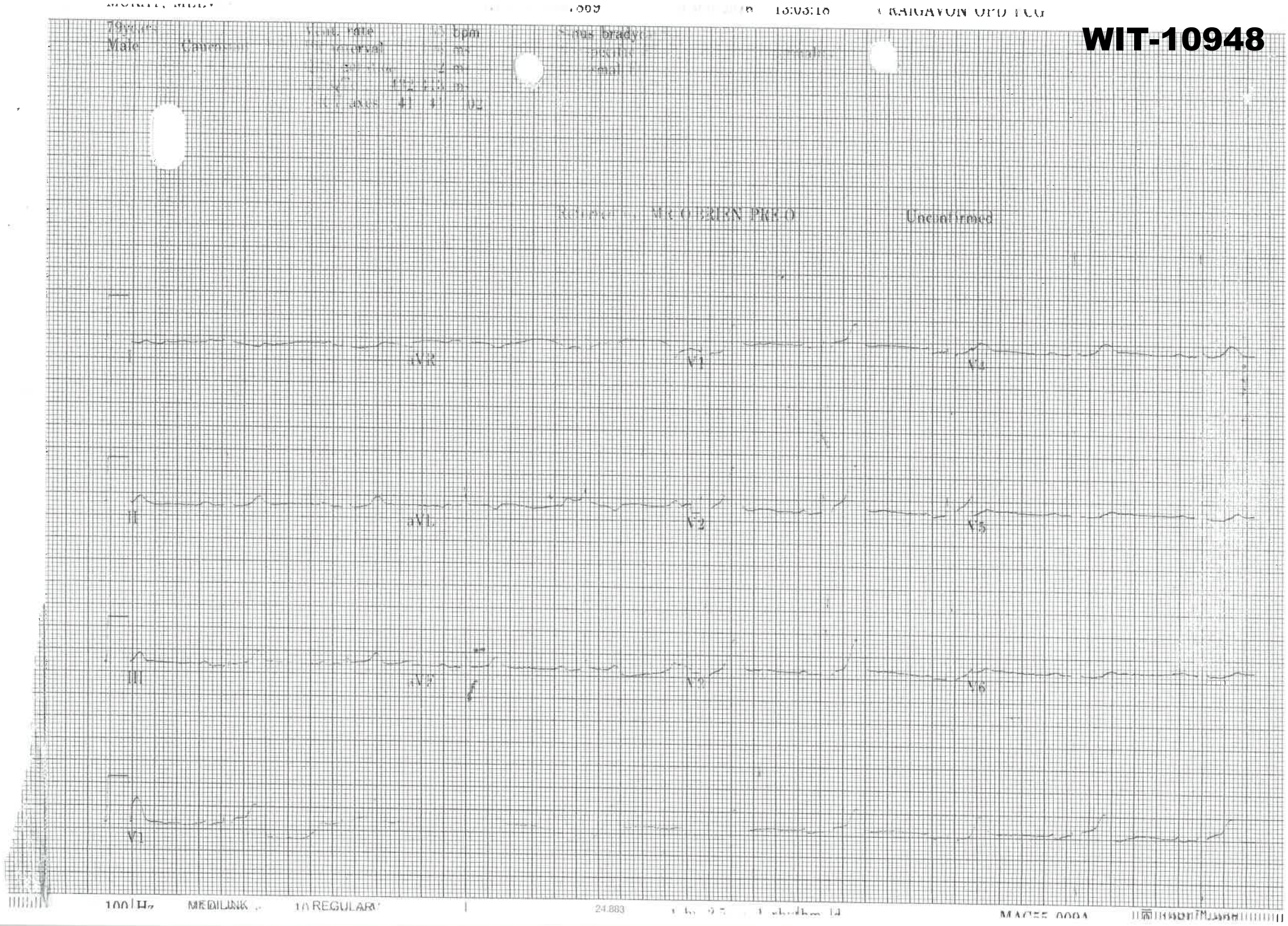
Notes

↑ Value(s) above reference range

↓ Value(s) below reference range

c Calculated value(s)

Printed 19:45:12 16/03/2016



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ANAESTHESIA RECORD

HSC SHSCT

Main Theatre

PROCEDURE DATE 16-03-2016

Patient 65

H&C [redacted]

DATE OF BIRTH [redacted]

PATIENT/CASE DATA (PLANNED PROCEDURE)

H&C Number	[redacted]	Height	ASA	3	Service	Urology
Age	[redacted]	Weight	Type of admission		Theatre Location	Theatre 4
Gender	Male	Body Mass Index	Visit ID	CAH THEA 4 1-7	Disharge to	
Blood group		[redacted]				

ALLERGIES

ANAESTHETIC TECHNIQUES

I Regional anaesthesia II Sedation

Induction Type: None

PERSONNEL

Anaesthetist: [redacted]

Surgeon: aidan.o'brien

LINES, TUBES AND DRAINS

[redacted]

AIRWAY MANAGEMENT

POSITIONING

[redacted]

PROTECTION

[redacted]

TIMES

19:50	Anaesthesia Record Start
19:59	Ready for surgery
20:00	Surgery start
20:23	Surgery end
20:30	Anaesthesia end

Surgery duration: 23 min

Anaesthesia duration: 40 min

EQUIPMENT

LOCAL AND REGIONAL

16/03/16 19:55, Spinal anaesthesia, Sitting, Full asepsis, L3 - L4, Spinal needle, 25g, Whitacre, Fluid return, Clear CSF, Aspirate, Clear CSF, Straightforward. Block >T8 B/L @5min

PROCEDURAL EVENTS

FLUID BALANCE

BLOOD OUT	TOTAL IN	509 mL
URINE OUT	TOTAL OUT	
OTHER OUT	BALANCE	509 mL

TOTALS OF GIVEN DRUGS AND FLUIDS

Gentamicin 160 mg

Bupivacaine 0.5% HYPER 13 mg

Ondansetron 4 mg

Paracetamol 1000 mg

Fentanyl IT 25 µg

NaCl 0.9%. 500 mL

NOTES

Pre-Op Notes

[redacted]

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HSC SHSCT

ANAESTHESIA RECORD

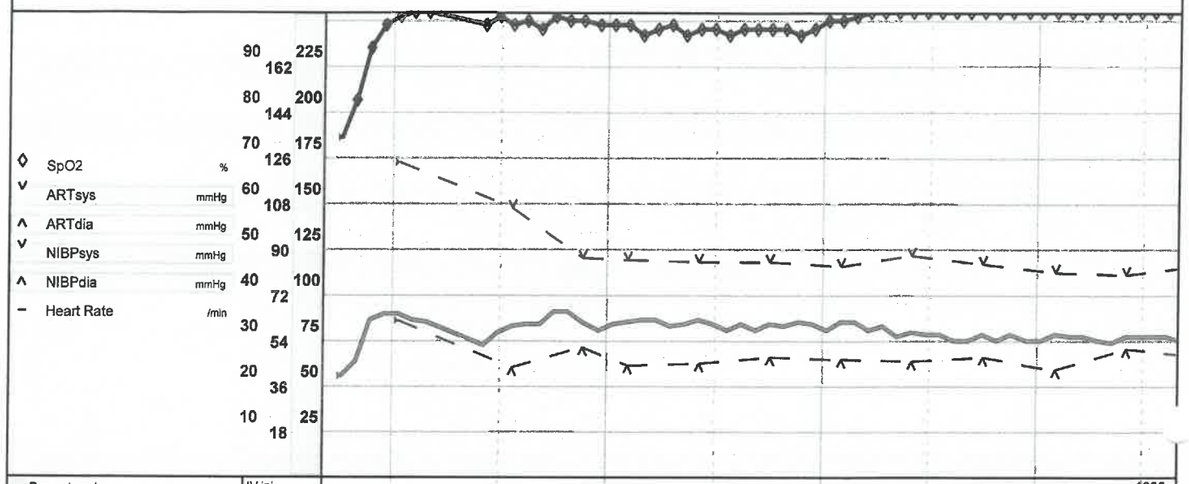
Main Theatre

PROCEDURE DATE 16-03-2016

Patient 65 [redacted]

H&C [redacted] DATE OF BIRTH [redacted]

16/03/2016 19:52 20:00 20:07 20:15



Paracetamol	IV inj mg	1000
Bupivacaine 0.5% HYPER [5 mg/mL]	Spinal mg	13
Fentanyl IT [50 µg/mL]	Spinal µg	25
Ondansetron [2 mg/mL]	IV inj mg	4
Gentamicin [40 mg/mL]	IV inj mg	160
NaCl 0.9%.	IV inf mL	(500)

AA	Sevoflurane Sevoflurane
Mode of ventilation	
Target ETAA	
Pmean cmH2O	
Exp Sevoflurane %	
Exp O2 %	
Exp Desflurane %	
Trigger flow L/min	
Exp Isoflurane %	
MAC %	
PEEPset cmH2O	
PEEP cmH2O	
Insp Sevoflurane %	
FiO2set %	
Insp Desflurane %	
Insp Nitrus Oxide %	
FiO2 %	
TVset mL	
TV	

Report printed [redacted] Page 2/4

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HSC SHSCT

Patient 65 [redacted]

ANAESTHESIA RECORD
Main Theatre

H&C [redacted]

PROCEDURE DATE [redacted]

DATE OF BIRTH [redacted]

POST OP INSTRUCTIONS

Separate Analgesia Obs Chart ✓
See Fluid Balance ✓
Postop O2 Hudson mask, 5l/min
O2 % 35

Drug Prescription	Date/Time/Sign	Date/Time/Sign	Date/Time/Sign

Other Post-Op Instructions

Anaesthetic Signature: [redacted]

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HSC SHSCT

ANAESTHESIA RECORD

Main Theatre

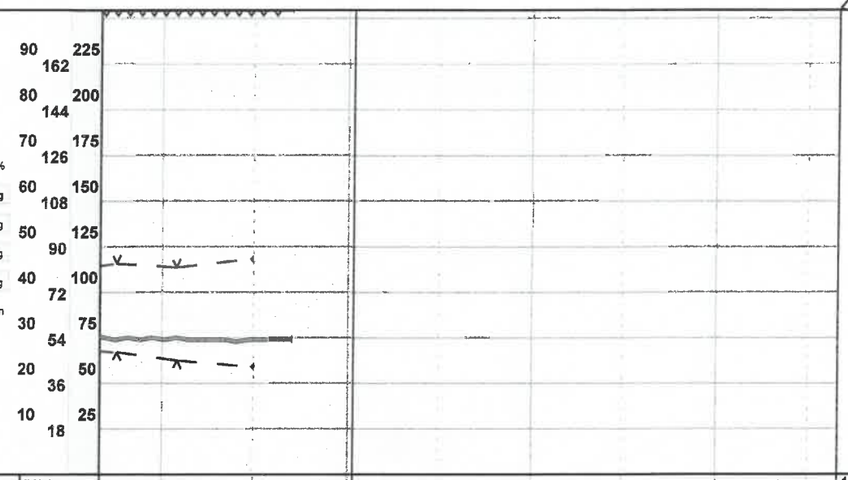
PROCEDURE DATE [Personal Information redacted by the USI]

Patient 65 [redacted]

H&C [Personal Information redacted by the USI]

DATE OF BIRTH [Personal Information redacted by the USI]

16/03/2016 | 20:22 | 20:30 | 20:37 | 20:45 | INTRAop



◊ SpO2	%		
v ARTsys	mmHg		
^ ARTdia	mmHg		
v NIBPsys	mmHg		
^ NIBPdia	mmHg		
- Heart Rate	/min		
Paracetamol	IV inj mg		1000 mg
Bupivacaine 0.5% HYPER [5 mg/mL]	Spinal mg		13 mg
Fentanyl IT [50 µg/mL]	Spinal µg		25 µg
Ondansetron [2 mg/mL]	IV inj mg		4 mg
Gentamicin [40 mg/mL]	IV inj mg		160 mg
NaCl 0.9%.	IV inf mL	500	500 mL
AA		Sevoflurane	
Mode of ventilation			
Target ETAA			
Pmean	cmH2O		
Exp Sevoflurane	%		
Exp O2	%		
Exp Desflurane	%		
Trigger flow	L/min		
Exp Isoflurane	%		
MAC	%		
PEEPset	cmH2O		
PEEP	cmH2O		
Insp Sevoflurane %	%		
FiO2set	%		
Insp Desflurane %	%		
Insp Nitrus Oxide	%		
FiO2	%		
TVset	mL		
TV			

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OPERATION NOTES

Affix La

Patient 65

HOSPITAL: CRAIGAVON AREA

Operations Performed: TURP

Date: 16 MARCH 16

Surgeon: JOHN O'BRIEN

Anaesthetist: JIM BENNETT

Assistant

Sister

Incision

Blood

Findings

Drains

Packs

PROCEDURE

Personal Information redacted by the USI

Signature of Surgeon: .....

OS17959

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

Patient 65

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		

Personal Information redacted by the USI

30723

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	Date	Clinical Notes
→		Personal Information redacted by the USI
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters Full Name Date of Birth Unit No. Ward/Dept. Address Consultant

[redacted] Patient 65

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
[redacted] Personal Information redacted by the USI		

Age

URINE Protein
Sugar
Acetone

WEIGHT

kg.

Age

URINE Protein
Sugar
Acetone

WEIGHT

kg.

30723

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