1.0 Introduction

This Guidance has been developed in response to the introduction within the Trust, during XXXX, of Northern Ireland Electronic Care Record. It sets out clearly the responsibility of clinicians with regard to requesting and acting on the results of diagnostic tests, in line with GMC good medical practice guidance
All the statements in this Policy assume that individuals are acting within the guiding principles of the Data Protection Act, the Trust Access to Medical Records Policy and the Trust Data Protection, Confidentiality and Disclosure Policy.

2.0 Purpose

Diagnostic tests can be used to determine what conditions, diseases or syndromes a patient may currently have or is likely to develop. These tests can be used in a variety of ways including screening, monitoring chronic conditions, suggesting diagnoses, ruling out or confirming suspected diagnoses, monitoring patients following treatment for side effects or recurrence, and predicting future events. Because of the variety of tests employed and the range of professional review and subsequent actions that may occur as a result of testing, there is an absolute need for clear pathways that identify how, when and to whom the results should be communicated.

The intention of this document is to enable all clinical Acute Directorate Trust staff in ensuring that all diagnostic tests undertaken within the organisation are appropriate and managed to minimise the risk to patients and to improve patient outcome and quality of care.

3.0 Definitions

Diagnostic Testing Procedures

This Guidance includes the management of test procedures and results relating to all diagnostic tests including:

- Radiological Imaging: Plain Film X-rays, Other X-Ray procedures,
- CT Scanning, MR Imaging, US Imaging and Isotope Imaging
- Endoscopy
- Pathology tests for all disciplines including Microbiology, Haematology, Biochemistry, Histopathology, Cytology, Immunology, Molecular biology, and Genetics.
- ECGs and other Physiology Measurement Tests such as Lung Function,
- Oeophageal function, Ambulatory Blood Pressure, Ambulatory Rhythm monitors and others

Standing Operating Procedures (SOPs)

A clear, step-by-step instruction of how to carry out agreed actions that promote uniformity to help clarify and augment processes. SOPs document the way activities are to be performed to facilitate consistent conformance to requirements and to support data quality. SOPs provide individuals with the information needed to perform a job properly and consistently.

Independent Contractors

The Trust uses a number of external laboratories and other contractors to provide specific tests or overall services. These external agencies are all subject to appropriate quality control measures and the Trust receives confirmation of their accreditation to undertake such tests. The results received from such independent contractors are entered into Trust systems so that they are available to clinicians through 'Review'.

Accredited Laboratories
See above

4.0 Duties within the Acute Directorate

Director of Acute Services

The Director of Acute Services takes final responsibility for adherence to, and the implementation of all this Guidance Document issued and approved by Acute Clinical Governance Committee

Acute Clinical Governance Committee

The Acute Clinical Governance Committee receives regular reports concerning clinical governance issues within the Acute Directorate, and this should include a report every year concerning the matters related to this guidance, particularly relating to the acknowledgment of receipt of tests, clinical incidents arising from the failure to act on a report and the overall safety of the diagnostic process to include the incorrect attribution of specimens or reports to individual patients.

Any serious incident concerning patient safety, patient confidentiality or data protection should initiate a review well before the issue is raised at the CGC.

The implementation of this policy is supported by the following:

Clinical Directorates and Lead Clinicians

Ensures the development, and adherence to, of local SOPs relating to diagnostic testing procedures and the management of associated risks (see 6.1). Monitors adherence to good Medical Practice with regard to Diagnostic tests

Healthcare and Administrative Staff

All healthcare and administrative staff involved in requesting, receiving, acknowledging and acting on diagnostic tests should be aware of their responsibilities in this role. They will be expected to undertake training as required and agreed. Formal training will be provided with regard to using the electronic processes for Diagnostic tests. Individual clinical departments may need to develop protocols or standing operating procedures (SOPs) to ensure safe and confidential practice.

5.0 Education and Training

All staff engaged by the Acute Directorate who are expected to access the diagnostic test systems will be expected to undergo a period of training to familiarise themselves with the electronic systems. All staff involved in diagnostic testing procedures, particularly junior and senior doctors, nursing and allied health professionals and clinical secretaries should be aware of the competencies needed and the training requirements expected by the organisation. Development of training in this area should be subject to a training needs analysis.
Many areas of diagnostic testing, such as Radiology, Neurophysiology and Endoscopy, are subject to external accreditation processes. The accreditation process is often subject to peer review on a rolling basis. Those leading the peer review process internally require support and training. Peer review itself often highlights further areas for remedial education and training.

All staff will be expected to be aware of their responsibilities in relation to this policy.

This Guidance will be disseminated to all staff through the Directorate Managers and Clinical Directors. All Clinical Leads will be expected to be aware of, and understand their responsibilities in terms of implementing this policy.

6.0 Duties of Clinicians, including Documentation

6.1 Duties of Clinicians (see Reference 2 under '8')

a. In line with Good Medical Practice (GMC), when diagnostic tests are requested details should be noted in the patients' record (electronic or otherwise), and clinicians should ensure that diagnostic tests comply with appropriate protocols for patient assessment
b. When using 'Review' to view results the clinician should document acknowledgment of results by 'Signing Off' electronically. By 'Signing Off' the result a Clinician is indicating that they have noted the result, and have taken appropriate action on the patients' behalf

c. The Requester of the test is the individual who has the responsibility for checking and acting on the test result. This responsibility may be delegated to a colleague with their consent, providing the requester is satisfied that the delegate has the qualifications, experience, knowledge and skills to act on the result. It is not acceptable to delegate responsibility for checking test results to untrained administrative staff.
d. Clinical teams will need 'fail-safe' mechanisms to ensure that results are reviewed in a timely manner, and that these results are acted on, particularly when the care of the patient is handed over to another provider or to primary care. Appendix B may help to agree processes within Teams
e. Where a test has been requested on an inpatient but the result is not available by the time the patient is discharged, the requester remains responsible for checking the result of the test and communicating the result to the patient or GP as appropriate.
f. The requester or delegate should sign off their results electronically to indicate that appropriate action has been taken. Results displayed in 'Review' will be highlighted red if numeric values fall outside the normal range. If written reports from radiology contain unexpected or expected findings of serious import they will be highlighted in red. Requesters are expected to ensure that 'codered' reports are signed off within 48 hours
g. If an individual without authority to take clinical decisions notes a seriously abnormal result, they must bring this to the attention of someone within the clinical team who can make the decision in a timely manner.
h. It is the responsibility of the reporting doctor/practitioner to validate and authorise the result in a timely fashion. It is the responsibility of the Trust to have systems in place to ensure results are received by the referring staff. Ensuring correct patient identification and referrer attribution is a key requirement of the system to ensure prompt and appropriate patient management.
i. It is the responsibility of all participating staff to be familiar with relevant processes, policies, protocols and software programmes to ensure that errors are kept to a minimum.
j. It is the responsibility of the Trust and relevant clinical team to investigate and act upon adverse events associated with inappropriate action or lack of action on test results

Non-compliance with this policy may result in disciplinary action.

6.2 Process for Requesting Diagnostic Tests

Having **ensured** the correct patient attribution, the requester should select tests through a tick box menu. In some diagnostic areas, such as Radiology, there will be requesting hierarchies. This will ensure that only appropriate members of the clinical staff can request certain tests, such as certain MR investigations. Vetting procedures will be embedded within the Radiology requesting process.
Having completed the selection, a request will be generated, either electronically for Radiology or through a linked printer for all other requests. The patient can then be instructed about the next steps, which might be immediate (eg blood tests) or delayed (eg some Radiology investigations).

Some tests will still be requested on paper such as Endoscopy and Neurophysiology but in time **all** tests requesting will become available through electronic systems.

6.3 Process for Receipt of Diagnostic Test Results

Diagnostic test results will be distributed electronically using the 'Review' system. These results will be accessible to all users of the system. Those individuals or teams who have made requests will be expected to view those results in a timely manner.
All results should be acknowledged within 15 days.
It is recognised that many patients will have test results available that have been requested by other teams, or in Primary Care. Acknowledgement of such results is the responsibility of the clinician who made the request, although there will be circumstances within the Trust where it would be more appropriate for the clinician with ongoing responsibility to acknowledge those results.
Communication of Critical, Urgent and Unexpected findings on Radiological Imaging Reports to Hospital Clinicians
Responsibilities of the radiology department:

a. Ensure that critical findings are emphasised and obvious and that the degree of urgency for action by the referring health professional is clear.
b. Developing a guidance for radiological imaging reports which require particularly timely and reliable communication; for example, abnormal, unexpected and/or critical ranges
c. Explicit timeframes for reporting results
d. Empowerment to reject inadequately completed requests for studies, in particular, those that do not contain clinical history, reason for request and details of referring health professional
e. Define and document "safety net" procedures; for example copy reports to GP, cancer services MDT or other identified health professional in consultation with the referring health professional
f. Ensure processes are in place to provide assurance that all results are reported
g. Facilitate the inherent audit functions of report review and acknowledgement on results 'Review'.

Methods of delivery

A. Timely and reliable communication

Reporting radiologist/ radiographer should judge whether findings are:

- *Critical*. Emergency action required as soon as possible
- *Urgent*. Medical evaluation is required within 24 hours.
- *Significant unexpected findings*. Cases where the reporting radiologist has concerns that the findings are significant for the patient and will be unexpected.

Critical reports should be communicated by the reporting radiologist/radiographer immediately and directly to the referring clinician. If the referring clinician cannot be contacted then the on call Registrar for the specialty the patient has been admitted under should be bleeped. The time of this communication and details of named clinician contacted should be documented at the end of the formal report.

The phrase ‘XXXX’ should be included at the end of the report such that the report appears in red in results Review and is highlighted as a significant report.

It remains necessary for the Clinician to review the report and the phone call does not replace the need to review the report.

Urgent reports should be communicated by the reporting radiologist/radiographer directly to the referring clinician. If the referring clinician cannot be contacted then the on call Registrar for the specialty the patient has been admitted under should be bleeped. The timing of this communication and details of named clinician contacted should be documented at the end of the formal report.

The phrase ‘XXXXX’ should be included at the end of the report such that the report appears in red in results Review and is highlighted as a significant report.

It remains necessary for the Clinician to review the report and the phone call does not replace the need to review the report.

Significant unexpected findings including first presentation of malignancy. The reporting radiologist/radiographer should insert the phrase ‘XXX’ at the end of the report using VR or typing. This will highlight the report in red on results Review and alert the clinician when reviewing reports to a significant unexpected finding. The reporting radiologist/radiographer should confirm the report appears appropriately in results Review. The term ‘code red’ will appear at the end of the report.

It is necessary for some cases of malignancy to be referred directly to the MDT in addition according to local policies.

B. Safety net in cases of significant unexpected clinical findings

All reports are available electronically for GP review on NIECR.
In cases of suspected cancer, patient details should be emailed to the MDT co-ordinator for that particular specialty if appropriate. These can then be included in the next MDT discussion. This should be appended to the report.

If a critical, urgent or significant unexpected finding is suspected by the radiographer carrying out the examination they should bring this to the attention of the Duty Radiologist.

C. Emphasis of critical findings

All reports falling into any of these categories should contain a clear conclusion, summarising findings and an indication of the degree of urgency in clinical management.

D. Timeframe for formal report to be available on results review following radiological review.

For critical findings the formal report should be verified and available on PACS/NIECR within 1 hour following communication of the verbal report to the clinician. All reports showing urgent findings should be available by the end of the working day. The majority of reports showing significant and significant unexpected findings should be reported within 24 hours. This recognises that further imaging or a second opinion may be necessary in some cases before a formal report can be issued.

E. Reject inadequately completed requests for studies

The booking clerks should ensure that all received requests are adequately completed. Details of the patient and referrer and renal function/eGFR will be mandatory fields in electronic requesting and request cannot be completed until these are included. Clinical details are added as free text and if insufficient the request will be returned to the referrer for further information. There will be an electronic process for this to occur.

F. Assurance that all results are reported

The radiology department will monitor exams waiting to be reported on a weekly basis. Any unreported exam will be expedited by escalating to the Duty Radiologist or the radiologist to whom it has been assigned.

G. Audit template

Compliance with these recommendations should be audited regularly. An audit template is included in Appendix C. Data could be collected by choosing a site-specific cancer (e.g. lung) and listing all MDT referrals for that cancer site in the last 3-6 months. The radiology reports could then be reviewed to assess if the urgent referral policy has been applied.

H. Accident and Emergency

It is suggested to further define the policy for A and E such that ALL reports where a fracture has been identified will have the phrase ‘code red’ added to the end of the examination report. These reports will appear in red in results review. Urgent, critical and unexpected findings in patients referred from A and E will also be highlighted as discussed in the above policy.

I. All Radiology Reports should be reviewed by Clinicians according to specific time frames outlined in the ‘Management of Diagnostic tests Policy’ as approved through CMB and JBD, see Appendix D and 6.1 e).

6.4 Taking Action on Diagnostic Test Results

It is the responsibility of the clinician or other individual accessing a result to act on that information in an appropriate and professional manner. If the individual who accesses the result cannot take appropriate action (such as a Medical Secretary), it is important that they bring this to the attention of someone who can.

Actions taken should be recorded and the method of communication indicated (face to face contact, phone call, letter, e-mail and so on)
Radiology tests requested by hospital clinicians are copied to the GP for information only. It remains the responsibility of the requester to ensure that the result is reviewed and acted upon.

6.5 Documenting Diagnostic Test Results

Retaining test results electronically means there is no need for paper copies to be filed in the notes. However, some Clinical Teams may feel that they wish to retain certain results as a paper copy. They should develop local policies for this.
Otherwise the documentation may be in the form of a flow chart, or a written communication (electronic or paper based) to the patient, another carer, another team or the patient's General Practitioner

6.6 Process for Communication of Diagnostic Test Results

a. It should be made clear to patients as to how and when they should expect to receive the results of a Diagnostic test.
b. The nature of the communication of the result will depend on the test itself and the implications of the result. Clinical teams may develop local policies or guidance around communication of results.

6.7 Audit

An audit of unacknowledged (not 'signed off') results will be undertaken on a regular basis. This will identify those teams or individuals who fail to acknowledge 'XXXX' results within 48 hours or who do not appear to view or sign off their results.

6.8 Equality Impact Assessment

This policy has been equality impact assessed. Please refer to Appendix A

7.0 Monitoring Compliance with the Document

7.1 Process for Monitoring Compliance

Compliance with this policy within local clinical teams or specialty areas will be the responsibility of the Lead Clinician, accountable to their Clinical Director.
The 'Review' system can provide an audit trail of all individuals who have accessed results

How will this be Monitored?

The System Administrator for the 'Review' and 'tQuest' products will be responsible for establishing processes to monitor compliance with acknowledgment. This will be managed through a system of exception reporting, initial reports going to Lead Clinicians and the

relevant Directorate management team; with summary reports included in the Annual report to CGC.

What will happen if any shortfalls are identified?

Initially this will be tackled at the local level through the Lead Clinician. Problems identified though system monitoring by the Administrator will be passed back to the Lead Clinician of the specialty involved. If serious this will be taken to the Associate Medical Director for that specialty and if necessary escalated to the Medical Director.

Where will the results of the Monitoring be reported

Within the specialty if just a local issue. Issues that are not resolved in a timely manner will be reported to the Clinical Director or Associate Medical Director.

How will the resulting Action Plan be progressed?

There will be a 'rolling' action plan updated by the System Administrator which will be reviewed by the Acute Clinical Governance Team every six months.

How will Learning take place?

This will be managed through the established Trust clinical governance programme with regular updates to all staff as required.

7.2 Standards / Key Performance Indicators

See Appendix D

8.0 References

1. National Patient Safety Agency (NPSA) alert No.16, Issued February 2007: **Early identification of failure to act on radiological imaging reports**.
2. The Royal College of Radiologists, Approved 29th February 2008 **Standards for the communication of critical, urgent and unexpected significant radiological findings**
3. SHA Document, South West, Issued 9th March 2009. **Radiology Review, Section 8**
4. BMA Document, October 2010 **Acting upon test results in an Electronic world**
5. Reporting of unexpected Radiological findings, May 2012 **Communication to SHA Medical Directors from Professor Sir Bruce Keogh, NHS Medical Director**
6. Radiology Department, Salisbury District Hospital, June 2012 **Communication of Critical, Urgent and Unexpected findings on Radiological Imaging Reports to Hospital Clinicians**

9.0 Associated and linked Documentation

Appendix A	Equality Impact Assessment Tool	Appendix A
Appendix B	Template document for the Local management of	Appendix B

	Diagnostic Testing Procedures	
Appendix C	Audit Tool for 'Communication of Urgent Radiology Reports'	Appendix C
Appendix D	Standards and Key Performance Indicators	Appendix D
Appendix E	Access levels for different groups of Employees working within the Trust	Appendix E

Urology	**Consultant**	
SAI Personal information redacted by	Mr O'Brien	SAI review
SAI Personal information redacted by	Mr O'Brien	SAI review
SAI Personal information redacted by	Mr O'Brien	SAI review
SAI Personal information redacted by USI [redacted]	Mr O'Brien	SAI review Complaint response
SAI Personal information redacted by	Mr O'Brien	SAI review
SAI Personal information redacted by	Mr O'Brien	SAI review
SAI Personal information redacted by	Mr O'Brien	SAI review
Complaint Personal information redacted by	Mr Glackin	Complaint response
SAI Personal information redacted by	Mr O'Brien	SAI review
Review of care		Review of Care
Screening – MDM process	Mr Young	Letter sent to Mr Young following screening regarding the MDT process.

Southern Health and Social Care Trust

Quality Care - for you, with you

SOUTHERN HEALTH AND SOCIAL CARE TRUST

GOVERNANCE COMMITTEE

TERMS OF REFERENCE

CONTENTS

1. CONSTITUTION

The Board hereby resolves to establish a Committee of the Board to be known as the Governance Committee (The Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

2. MEMBERSHIP OF THE COMMITTEE

The Committee shall be appointed by the Board from amongst the non-executive directors of the Trust following recommendation from the Trust Chair and shall consist of not less than three members. A quorum shall be two members. One of the members will be appointed the Chair of the Committee by the Board.

3. ATTENDANCE

The following senior staff shall be invited to attend meetings:

- Chief Executive
- Medical Director
- Director of Finance, Procurement and Estates
- Director of Children and Young People's Services/Executive Director of Social Work
- Director of Mental Health and Disability Services
- Interim Executive Director of Nursing
- Director of Acute Services
- Director of Older People and Primary Care Services
- Director of Human Resources and Organisational Development
- Director of Performance and Reform
- Assistant Director, Clinical and Social Care Governance
- Director of Pharmacy

Other members of Trust staff may be required to attend meetings as the Committee considers necessary.

The Board Assurance Manager, supported by the Committee Secretary, shall be secretary to the Committee and shall attend the meetings and provide appropriate support to the Chair and Committee members.

4. FREQUENCY OF MEETINGS

Meetings shall be held on a quarterly basis.

5. AUTHORITY

The Committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, through the relevant Director, and will be given the resources necessary to carry out its role. The Committee will be given full access to any information within the Southern Health and Social Care Trust that it requires to fulfil its function. The Committee is authorised by the Board to obtain external professional advice and to invite external personnel with relevant experience and expertise if it considers this necessary.

6. REMIT

The remit of the Committee is to ensure that:

- There are effective and regularly reviewed structures in place to support the effective implementation and continued development of integrated governance across the Trust.
- Assessment of assurance systems for effective risk management which provide a planned and systematic approach to identifying, evaluating and responding to risks and providing assurance that responses are effective.
- Principal risks and significant gaps in controls and assurances are considered by the Committee and appropriately escalated to Trust Board
- Timely reports are made to the Trust Board, including recommendations and remedial action taken or proposed, if there is an internal failing in systems or services.
- There is sufficient independent and objective assurance as to the robustness of key processes across all areas of governance.
- Recommendations considered appropriate by the Committee are made to the Trust Board recognising that financial governance is primarily dealt with by the Audit Committee.

In carrying out its work, the committee will utilise information from:

- Clinical and Social Care Governance systems
- Risk assessment and risk management systems
- Health and Safety
- Medicines management systems
- Information Governance systems
- Litigation systems
- National Audit outcomes
- Whistleblowing process

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. These will include, but will not be limited to any reviews by Department of Health commissioned bodies, the Regulation and Quality Improvement Authority (RQIA) or professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, other accreditation bodies, etc.).

The Committee will review the adequacy of all governance and risk management and control related disclosure statements (in particular the Governance Statement).

The Committee will work closely with the Audit Committee to provide comprehensive assurance to the Audit Committee's own scope of work.

The Committee will receive the minutes of the Trust's Mid-Year and End-Year Ground Clearing meetings for information.

7. REPORTING

The minutes of the Governance Committee shall be formally recorded by the Committee Secretary and submitted to the Trust Board following approval of the Governance Committee. The Chair of the Committee shall draw to the attention of the Board any issues that require executive action.

Any business conducted in a confidential session by the Governance Committee will be reported to a confidential session of the Trust Board.

The Chair of the Governance Committee will meet with the Trust Chair and Chief Executive following each Committee meeting and provide them with a written summary report on the meeting.

The Committee will report to the Board annually on its work in support of the Governance Statement.

OTHER MATTERS

The Committee shall be supported administratively by the Board Assurance Manager and the Committee Secretary, whose duties in this respect will include:

- Agreement of agenda with the Chair.
- Collation and distribution of papers no less than 5 working days in advance of the meeting.
- Producing the minutes of the meeting and taking forward matters arising and issues to be carried forward.
- Advising the committee on pertinent issues.

Stinson, Emma M

From: Boyce, Tracey [redacted]
Sent: 04 June 2018 15:35
To: Reid, Trudy
Subject: FW: Concerns raised by an SAI panel
Attachments: sai panels concerns.pdf

Hi Trudy
Below is my original email to Ronan and Esther - it's still on the system.

If you trawl down to the bottom you will see that I had to scan that letter to attach it - which means I only had a paper copy.

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy
[redacted]

-----Original Message-----
From: Boyce, Tracey [redacted]
Sent: 16 December 2016 16:34
To: Carroll, Ronan; Gishkori, Esther
Cc: Stinson, Emma M
Subject: Concerns raised by an SAI panel

Hi Ronan and Esther
Could we have chat about this next week - I am at a regional strategy day on Monday - perhaps we could get together on Tuesday?

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy
[redacted]

Learn more about mental health medicines and conditions on the Choiceandmedication website http://www.choiceandmedication.org/hscni/

-----Original Message-----
From: [redacted] Tracy Boyce's email address
Sent: 16 December 2016 16:30
To: Boyce, Tracey
Subject: Scan from YSoft SafeQ

Scan for the user Tracey Boyce (tracey.boyce) from the device CAH - Pharmacy Corridor - C308

15 December 2016

Dear Tracey

As you are aware the SAI review and report in relation to Patient 10 reference number W[Personal information redacted]s complete.

The remit of Patient 10 Serious Adverse Incident was to fully investigate the circumstances which contributed to her clinical incident. The Review Team was comprised Mr Anthony Glackin Consultant Urologist, Dr Aaron Milligan Consultant Radiologist, Mrs Katherine Robinson Booking and Contact Centre Manager, and Mrs Christine Rankin Booking Manager. To provide context, part of the work included a look-back exercise for 7 Urology patients who managed in the same manner as Patient 10 in October 2014. This was to satisfy the panel that there was a management plan in place and no harm had come to the other 7 patient (letters) which were not triaged on the week ending 30 October 2014. The manual look-back was done using the 6 available patient charts on 14 November 2016. These 6 patients all have been discharged or management plans in place. The 7th (patient initials Personal Informati) chart was not able to be found on Trust property at this time. Personal Information redacted by chart arrived to the Governance office on week commencing 28 November 2016. The look-back exercise was completed on13 December 2016. There is clinical detail within the dictated letter in relation to the Personal Information consultation which requires clinical validation. This has been given to Mr Anthony Glackin to review on 15 December 2016.

Upon conclusion, the Review Team agree there are a number of relevant and related issues/themes causing concern for the panel which have been exposed during the SAI investigation. The Panel would like to clarify that all relevant enquiries made while undertaking this report have been solely limited to the information which were independently provided by members of the Review panel in conjunction with Mrs Andrea Cunningham, Service Administrator. There have not been any approaches made directly to the Urology Clerical team, the Urology Head of Service or the Assistant Director of Surgery and Elective Care for any information or evidence of communication.

Issues and Themes of concern include:

- In May 2014, there was an informal process was implemented to monitor/manage Urology letters which had not been returned with management advice (not triaged). It appears that this process was created in an effort to limit risk of harm to the patient. The presence of this process implies that it was accepted that triage non-compliance was to be expected by a minority of consultants within the Urology specialty. On 6 November 2015, an email from the AD of Functional Service formally implementing this process. The Review Panel are anxious that the current process does not have a clear escalation plan which evidences inclusion of the Consultant involved. In addition, this process has not been effective in addressing triage non-compliance. From 28 July 2015 until 5 October 2016, there are 318 patient letters which were not triaged. Currently the Trust cannot provide assurance that the Urology non-triaged patient cohort are not being exposed to harm while waiting 74 weeks for a Routine appointment or 37 weeks for an urgent appointment.

- During the manual look-back exercise on 14 November 2016, Personal Information redacted by patient chart could not be found on Trust premises. Personal Information redacted by chart did appear in the Acute Governance office the week commencing 28 November 2016. After informal queries, it is understood that patient notes are not transported via Trust vehicles to or from Dr 6's outlying clinics (inc SWAH). This could compound efforts to establish any chart location or outstanding dictation. The Review panel acknowledge that processes should not be drafted to address one issue with one specialist team. On balance, the Review team agree there is sufficient cause for concern that Trust documentation may be leaving Trust facilities and the process of record transportation for this Specialty does need urgently addressed.

- There is clear evidence that this patient Personal Information redacted by the USI letter was not triaged by week ending 30 October 2014. Personal Information was seen in SWAH by Dr 6 in January 2015. The outpatient letter was dictated 11 November 2016 and typed 15 November 2016. The Review panel have grave concerns that there are other Urology patient letters not being dictated in a timely manner. Upon further investigation, the Panel have found that the Trust does monitor the number charts needing audio-typing of dictation but there does not appear to be a robust process to monitor if post-consultation patient dictation has been completed. This has the potential to be compounded if patient charts are leaving the Trust facilities. The SAI Panel are anxious that assurance is sought that there is reasonable compliance in relation to the timely dictation letters by Dr 6.

Southern Health and Social Care Trust

Quality Care - for you, with you

ACUTE DIRECTORATE DIRECTORATE GOVERNANCE GROUP

Terms of Reference

CONTENTS

ACUTE GOVERNANCE GROUP TERMS OF REFERENCE.
1.0 Constitution

The Senior Management Group of the Acute Directorate established a strategic Governance Group to specifically address all matters pertaining to this area of the Directorate's business. It will provide effective and robust assurances in the following areas:

- Provide clarity and transparency of function
- Drive Quality and Safety
- Provide adequate assurances to the SMT, Trust Board, Professional Bodies and the Public, on areas relating to risk, patient safety and non-compliance

The terms of reference provide

- Structure
- Communication flows
- Clarity of roles and functions
- Effective mechanisms in place to review learning across the whole system to inform SMT strategy in respect of patient safety priorities and risk

2.0 Main Purpose

The purpose of the Acute Governance Group is to develop, integrate, promote and monitor all aspects of governance in the acute division including clinical & social care, professional, financial, medicines, estates and human resources governance. The Forum aims to promote an ethos of awareness, accountability, continuous learning and improvement.

3.0 Membership

Acute SMT Governance

- Esther Gishkori - Chairperson - Director for Acute Services
- Anne McVey- Assistant Director Medicine and Unscheduled Care
- Ronan Carroll – Assistant Director Anaesthetics & Surgery & Elective Care
- Heather Trouton – Assistant Director
- Tracey Boyce –Director
- Barry Conway – Assistant Director
- Helen Walker - Assistant Director

- Clinical and Social Care Governance Coordinator

Others will be co-opted onto this group as necessary e.g. Litigation, finance, pharmacy and estates operational and governance leads, Standards and Guidelines lead, effectiveness and evaluation, Patient safety manager. Where by exception a member is not able to attend they must nominate a deputy to attend in their place. The deputy should have authority to take decisions on behalf of the standing member.

4.0 Frequency of Meetings

Meetings will be held monthly.
Venue: Meeting room Administration floor Craigavon Hospital
A quorum will be 5 members which must include the operational director and/or assistant director and the AMD and/or a nominated clinical director and a professional governance assistant director/lead.

5.0 Acute Governance Group - Members main responsibilities.
5.1 Provide specialist knowledge and expertise relevant to their area of work and responsibility;
5.2 Report and communicate with others within Acute and across the Trust on the progression of actions required within their area of knowledge and expertise; and report on any barriers to the implementation of those actions.
5.3 Contribute to the development of, and agree actions within any Task and Finish / Subgroups required in order, to meet the aims of the Acute Governance Group.
5.4 Contribute to the development of, and agree, systems and processes to support the provision of information on assurances on clinical and social care excellence within the Directorate.

6.0 Authority
The Acute Governance Group is authorised by the Trust Governance Committee to progress or investigate any activity within its terms of reference, to satisfy the Governance Committee via the Trust CSCG Working Body that effective governance arrangements are in place within Acute.

7.0 Main Responsibilities and Activities of the MHD Directorate Governance Group

- To review and monitor the Acute Governance Structure to ensure it facilitates the operation of effective governance arrangements.
- To ensure that an effective risk identification, mitigation and escalation process is in place which includes the completion of risk assessments, maintenance of risk registers and development of action plans to minimise and manage risk as appropriate.

- To consider those risks referred to the Directorate Governance Group which cannot be managed at Division level and/or may require consideration in respect of addition to the Directorate and/or Corporate Risk Registers.
- To ensure that there is effective reporting, investigation and follow-up of adverse and serious adverse incidents including monitoring the implementation of actions identified following incident investigation/reviews.
- To ensure that complaints are appropriately investigated/monitored/managed and areas of learning/recommendations from the investigation of complaints are implemented into practice.
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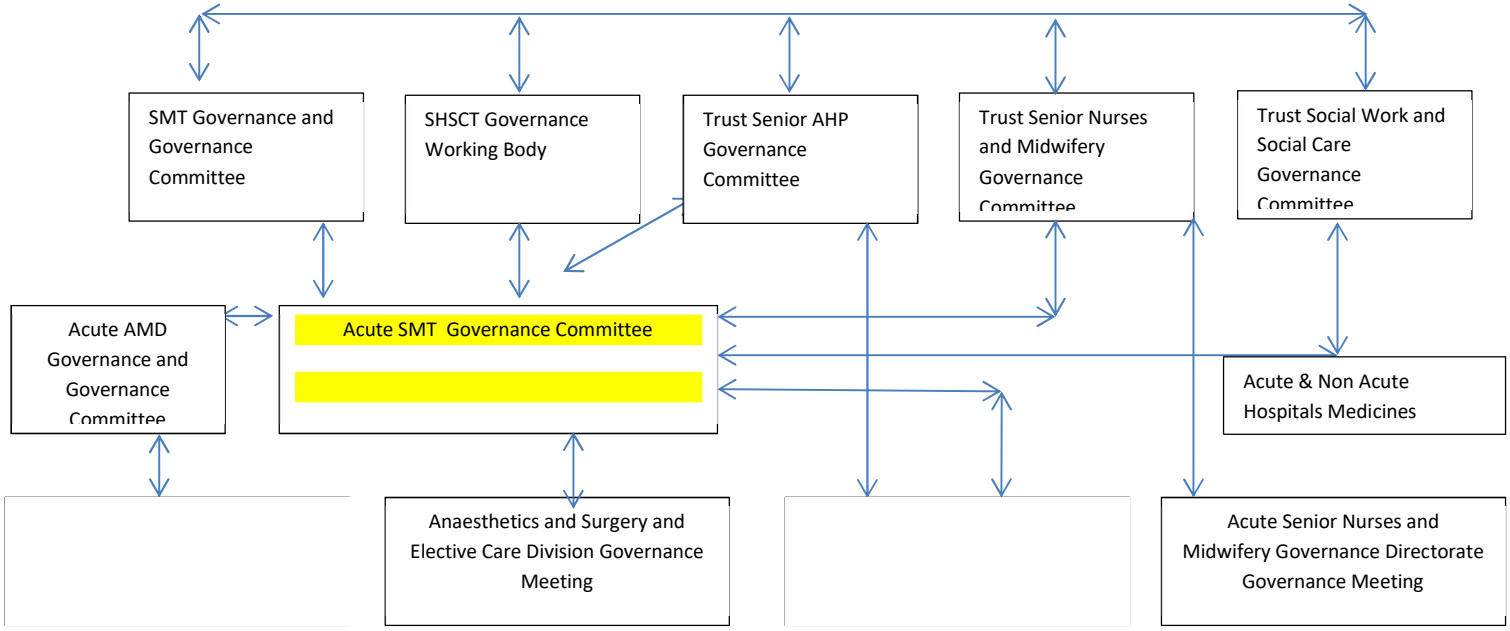
10.0 Governance Groups / Fora



Fora and Membership Acute Clinical Governance

- Esther Gishkori - Chairperson - Director for Acute Services
- Anne McVey- Assistant Director Medicine and Unscheduled Care
- Ronan Carroll – Assistant Director Anaesthetics & Surgery & Elective Care
- Heather Trouton – Assistant Director
- Tracey Boyce –Director
- Barry Conway – Assistant Director
- Anita Carroll- Assistant Director

- AMD Medicine and Unscheduled Care- Dr Philip Murphy
- AMD Anaesthetics & Surgery & Elective Care -Dr Charles McAllister
- AMD Cancer & Clinical & Womens Health Dr Martina Hogan
- Clinical and Social Care Governance Coordinator

Others will be co-opted onto this group as necessary e.g. Litigation, finance, pharmacy and estates operational and governance leads, Standards and Guidelines manager. Where by exception a member is not able to attend they must nominate a deputy to attend in their place. The deputy should have authority to take decisions on behalf of the standing member.

Division Fora

- Assistant Director
- Head of Service
  Lead Nurse
- OSL
- Clinical and Social Care Governance Coordinator

Responsibilities:

Directorate Divisional, Service Area & Professional Governance Fora

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Identify and escalate incidents, trends, risks, education requirements etc.

Chairs of Divisional and Service Area Governance Fora

The divisional, service area and professional governance fora chairpersons will act as the conduit between the Divisional Governance Group and their respective governance fora. They will be responsible for ensuring that actions/issues/risks arising from their respective governance fora are tabled and discussed at the Acute Governance Group (if required) and vice versa.

Southern Health and Social Care Trust

Quality Care - for you, with you

ACUTE CLINICAL GOVERNANCE GROUP

Terms of Reference

CONTENTS

ACUTE CLINICAL GOVERNANCE GROUP TERMS OF REFERENCE
1.0 Constitution

The Senior Management team and Associated Medical Directors in the Acute Directorate established a strategic Governance Group to specifically address all matters pertaining to this area of the Directorate's business. It will provide effective and robust assurances in the following areas:

- Provide clarity and transparency of function
- Drive Quality and Safety
- Provide adequate assurances to the SMT, Trust Board, Professional Bodies and the Public, on areas relating to risk, patient safety and non-compliance

The terms of reference provide

- Structure
- Communication flows
- Clarity of roles and functions
- Effective mechanisms in place to review learning across the whole system to inform SMT strategy in respect of patient safety priorities and risk

2.0 Main Purpose

The purpose of the Acute Clinical Governance Group is to develop, integrate, promote and monitor all aspects of governance in the acute division including clinical & social care, professional, financial, medicines, estates and human resources governance. The Forum aims to promote an ethos of awareness, accountability, continuous learning and improvement.

3.0 Membership

Acute SMT Governance

- Esther Gishkori - Chairperson - Director for Acute Services
- Anne McVey- Assistant Director Medicine and Unscheduled Care
- Dr Philip Murphy
- Ronan Carroll – Assistant Director Anaesthetics & Surgery & Elective Care
- Dr C McAllister
- Heather Trouton – Assistant Director

- Dr Martina Hogan
- Tracey Boyce –Director
- Barry Conway – Assistant Director
- Anita Carroll- Assistant Director
- Helen Walker - Assistant Director – Helen hasn't been invited to date
- Clinical and Social Care Governance Coordinator

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4.0 Frequency of Meetings

Meetings will be held monthly.
Venue: Board room, Ground Floor, Craigavon Hospital
A quorum will be 5 members which must include the operational director and/or assistant director and the AMD and/or a nominated clinical director and a professional governance assistant director/lead.

5.0 Acute Clinical Governance Group - Members main responsibilities.
5.1 Provide specialist knowledge and expertise relevant to their area of work and responsibility;
5.2 Report and communicate with others within Acute and across the Trust on the progression of actions required within their area of knowledge and expertise; and report on any barriers to the implementation of those actions.
5.3 Contribute to the development of, and agree actions within any Task and Finish / Subgroups required in order, to meet the aims of the Acute Governance Group.
5.4 Contribute to the development of, and agree, systems and processes to support the provision of information on assurances on clinical and social care excellence within the Directorate.

6.0 Authority
The Acute Clinical Governance Group is authorised by the Trust Governance Committee to progress or investigate any activity within its terms of reference, to satisfy the Governance Committee via the Trust CSCG Working Body that effective governance arrangements are in place within Acute.

7.0 Main Responsibilities and Activities of the Acute Directorate Governance Acute Clinical Governance Group

- To review and monitor the Acute Clinical Governance Structure to ensure it facilitates the operation of effective governance arrangements.
- To ensure that an effective risk identification, mitigation and escalation process is in place which includes the completion of risk assessments, maintenance of risk registers and development of action plans to minimise and manage risk as appropriate.
- To consider those risks referred to the Directorate Acute Clinical Governance Group which cannot be managed at Division level and/or may require consideration in respect of addition to the Directorate and/or Corporate Risk Registers.
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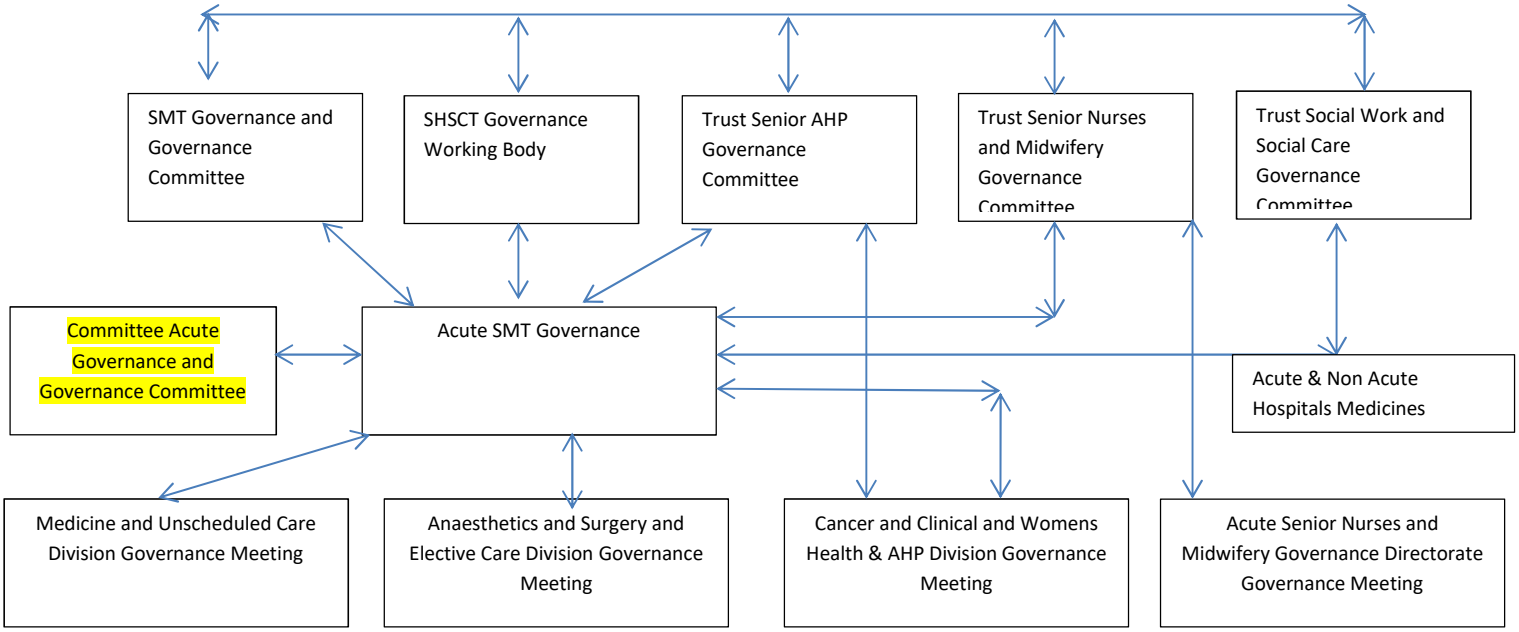

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Stinson, Emma M

From: Carroll, Ronan [redacted]
Sent: 16 June 2017 14:03
To: Weir, Colin; Haynes, Mark
Cc: Reid, Trudy
Subject: FW: Screening
Attachments: Time line [redacted].xlsx; Time line [redacted].xlsx; Time line [redacted].xlsx; Time line [redacted].xlsx; Time line [redacted].xlsx; Time line [redacted].xlsx; Time line [redacted].xlsx

Importance: High

Colin/mark
When could we meet next week to screen – I will be in ACH mon, tues & thurs

---

From: Reid, Trudy
Sent: 16 June 2017 10:31
To: Carroll, Ronan
Subject: FW: Screening

Ronan please see attached time lines for screening

SEC	[redacted]	CT showed PE not actioned - Mark
SEC	[redacted]	Delay in diagnosis and treatment of prostate cancer - Colin
sec	[redacted]	Delay in diagnosis and management of prostate cancer -Colin
SEC	[redacted]	Delay in diagnosis and treatment of prostate cancer - Colin
SEC	[redacted]	Delay in tumour management - Mark
SEC	[redacted]	Not preped for CT scan - aspirated –Mark
SEC	[redacted]	Not referred from urology MDM to endocrine - colin

Regards,

Trudy

Trudy Reid
Acute Clinical and Social Care Governance Coordinator
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ
Telephone [redacted]

Mobile Personal Information redacted by the USI

Patient 11

Data Source	Date	Time	Professional Group	Key Facts	Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
NICER	17/07/2016		GP	GP referral to urology	Reason for Referral/ History of Presenting Complaint Description: overactive bladder Comment: This Personal Information is having increased problems in recent months with storage and voiding LUTS. I have commenced him on Oxybutinon, but would value a full bladder assessment from the Continence Service in SWAH, whom he has attended in the past. Many thanks.		IEAP					
NICER	28/07/2016		GP	GP referral to urology	Reason for Referral/ History of Presenting Complaint Description: Elevated PSA. Comment: This Personal Information redacted by the USI has mixed symptoms of overactive bladder and prostatism. Recent MSU and urinalysis were normal, but PSA was 5.6. On examination he has a moderately enlarged smooth prostate. I have commenced him on Oxybutynin recently and he has felt some improvement in his LUTS. Please see and advise regarding further management of his elevated PSA. I have also referred this man to the Continence Service for bladder studies.		IEAP					
NICER	18/01/2017		Consultant Urologist	Letter to patient	Dear Patient 11 I am following up a referral your GP sent in July 2016. At the time of this referral your prostate blood test was elevated slightly above normal range. I would be grateful if you could arrange to have repeat of this blood test checked with your GP at your earliest convenience using the enclosed blood test request form. Once a result is available I will be making arrangements to review in clinic.							
NICER	21/01/2017 reported 27/01/2017			Histology report	REPORT CLINICAL_DETAILS Right colonic biopsies - diarrhoea PATHOLOGISTS_REPORT Sections of the 3 white tissue fragments received show normal colonic mucosa with no evidence of inflammation, dysplasia or malignancy. DIAGNOSIS: COLONIC MUCOSA NO PATHOLOGIC DIAGNOSIS							
NICER	20/02/2017		Consultant Urologist	Letter to GP	Diagnosis: Elevated PSA with LUTS Outcome: MRI prostate and TRUS biopsy Trial of Tamsulosin I reviewed Patient 11 today who has had a two year history of frequency of urination and some stinging inside which is relieved by urination. He also feels he has intermittent incomplete emptying. He previously had marked symptoms of urgency which have improved since starting Oxybutynin and this was on the background of having previous urodynamics several years ago that did describe an overactive bladder however I could not find these results today, this information was from the patient. He describes no haematuria but does have nocturia up to 6 times at night, some hesitancy and terminal dribbling. There is no history of incontinence. His weight is stable and his appetite is good. His PSA in July 2016 was 5.6 and January 2017 5.5 ng/ml. On PR examination the base was smooth but I was unable to access the top of the prostate. He underwent flow and post void residual today which showed a post void residual of 7mls and a maximum flow of 16.2mls. His urinalysis was negative. His kidneys were normal. His prostate was identified as having a volume of 31cc with some areas of focal calcification. In view of his elevated PSA and smaller prostate and evidence of calcification this gentleman would benefit from further investigation to rule out any malignancy of his prostate and in light of this I have arranged an MRI of his prostate then TRUS biopsies. I have given him a trial of Tamsulosin today to see if this will improve some of his symptoms and have suggested that should he not see symptom Patient 11							
NICER	20/02/2017		Consultant Urologist	Letter to Pt	Dear Patient 11 Further to your recent clinic attendance I have seen the result of your MRI scan. As you are aware this was performed to further assess the raised prostate blood test. The MRI scan does show a small area of abnormality in the left side of the prostate. I believe arrangements have been made for you to have biopsies of the prostate and this will include some additional biopsies of this area of abnormality on the left side.							
NICER	27/02/2017	16:10			MRI pelvis and prostate							

NICER	06/03/2017	09:21	Radiology	Urology MRI report	27/02/2017 17:10 MRI Pelvis prostate, Author: RRO, Regional Admin MRI PROSTATE CLINICAL HISTORY PSA 5.5. 30 cc. Calcification on ultrasound.? Prostatic malignancy FINDINGS Prostate volume 28 mL. There is an area of decreased T2 W signal in the left peripheral zone measuring 17 x 14 x 25 mm (PI-RADS 5). DWI is been degraded by the THRs. Normal seminal vesicles. No enlarged pelvic lymph nodes. Small focus of decreased T1 W signal in the left ilium of equivocal significance. No other bony lesions. CONCLUSION T2, N0, M0 left peripheral zone carcinoma. (Assumed ilial lesion to be benign but bone scintigraphy recommended). This report of an unexpected significant finding has been notified to the imaging department using the agreed protocol.							
	04/04/2017 reported 11/04/2017			Histology report	CLINICAL DETAILS Recent MRI - area of abnormality left side. PSA: 5.5. Prostate Vol: 27.8 cc. Specimen - Prostate. PATHOLOGIST'S REPORT GROSS DESCRIPTION NATURE OF SPECIMEN: Needle core biopsy SITE: 1. Right base - Three cores measuring 5 mm, 6 and 5 mm along with fragments. (Clinically two cores, on slides fragmented) SITE: 2. Right mid - Three cores easuring 17, 9 and 7 mm along with fragment. (Clinically two cores, on slides fragmented) SITE: 3. Right apex - Two cores measuring 16 and 15 mm. SITE: 4. Left base - Three cores measuring 19, 18 and 12 mm. SITE: 5. Left mid - Four cores measuring 16, 5, 12 and 7 mm alongwith fragment. (Clinically three cores on slides fragmented) SITE: 6. Left apex - Four cores measuring 10, 6, 9 and 4 mm along with fragment. (Clinically two cores on slides fragmented) HISTOLOGY HISTOLOGICAL TYPE: Adenocarcinoma DIFFERENTIATION/GLEASON SUM SCORE: Overall 3+3 = 6 NUMBER OF CORES/CHIPS INVOLVED: 7 of 19 Right base - No tumour identified. Right mid - No tumour identified. Right apex - No tumour identified. Left base - 3 of 3 cores, Gleason 3+3, 11.2 mm max length, 75-80% of tissue. Left mid - 3 of 4 cores, Gleason 3+3, 35-40% of tissue. Left apex -1 of 4 cores, Gleason 3+3, <5% of tissue. INVASION INTO: Seminal vesicle: No Extracapsular fat: No PERINEURAL INVASION: Yes LYMPHOVASCULAR INVASION: No FURTHER COMMENTS: Within 7 of the 19 prostatic core biopsies there are infiltrates of Gleason 3+3 adenocarcinoma. This occupies approximately 20% of the overall tissue examined. There is perineural invasion but no lymphovascular invasion of extracapsular extension. DIAGNOSIS: PROSTATE CORE BIOPSIES							
NICER	04/04/2017		Nurse specialist	Letter to GP	Patient 11 attended Thorndale Unit on 4th April. Written consent was obtained. Local anaesthetic inserted and following guidance from his recent MRI scan a total of 14 core biopsies of prostate were collected. Patient 11 found the procedure somewhat uncomfortable but recovered quickly when the probe was removed. He was provided with a 3 day course of prophylactic antibiotics and discharged home care of a family member. His histology results will be discussed at urology MDM and reviewed by Mr Haynes thereafter. Yours sincerely dictated but not signed							
NICER	04/04/2017			US Guided biopsy prostate transrectal	Report 04/04/2017 09:46 US Guided biopsy prostate transrectal, Author: Radiology, Admin This examination was performed by the Urologist. Please see patient notes.							
NICER	10/04/2017		Medical	SWAH discharge letter for admission 6/4/17 to 10/4/17	Personal Information redacted by the USI gentleman was admitted with pyrexia following a recent prostate biopsy two days previous. He reported feeling generally unwell with aches as well as complaining of ongoing urinary frequency and hesitancy. Patient continued to spike temperatures while in hospital and blood cultures were taken. This gentleman was discussed with urology in CAH where he underwent the biopsy who advised starting Patient 11 on Ciprofloxacin and Gentamicin to which he responded well. CRP peaked at 221.1 but is now improving. Patient 11 is feeling well, he is apyrexic and is surgically fit for discharge with further 7 days of oral Ciprofloxacin. Many thanks for your ongoing care of this gentleman.							

NICER	03/05/2017		Consultant Urologist	Letter to GP	Diagnosis: Low risk prostate cancer Outcome: Bone scan and subsequent outpatient review Patient 11 prostate biopsies have shown a gleason 3+3=6 prostate cancer. His presenting PSA is 5.5 and on MRI scan his local staging would be T2 N0. A bone scan has been arranged to complete his staging. I would anticipate this to be satisfactory given the low risk nature of his disease. His treatment options are either proceeding to treatment with curative intent with either radical surgery, external beam radiotherapy or brachytherapy or alternatively proceeding to active surveillance. He has been given written information regarding prostate cancer and information regarding each of these treatment options. I plan to review him in clinic after his bone scan to discuss these further. Yours sincerely							
NICER	18/05/2017	12:00 reported 18 :26	Radiology	NM bone whole body	Report 18/05/2017 16:14 NM Bone whole body, Author: Vallely, Stephen No evidence of bony metastatic disease. Bilateral hip replacements noted							

Received from Trudy Reid on 16/05/2023. Annotated by the Urology Services Inquiry.

Personal Information redacted by the USI

Data Source	Date	Time	Professional Group	Key Facts	Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
NICER	10/03/2016		Medical	Discharge letter post hip replacement	Principle Discharge Diagnosis :-Right total hip replacement. Operations/Procedures/Radiology -Right total hip replacement. Additional Information for GP -Past Medical/Surgical History -TIA, Heart failure, Cardiac valve: tricuspid valve repair, Left THR, Multiple gallstones, Pancreatitis, C5-C6 spondylotic myelopathy with nerve root entrapment, Left THR, Fibrotic lung disease Changes to Medications - Start/Stop Analgesia: PRN CLEXANE: FOR 5 WEEKS POST OP. SURGERY ON 24/2/2016. Furosemide: was held during admission as patient had AKI. This resolved and patients furosemide was restarted. **Clinical Information/Comments** Patient underwent Right total hip replacement under Mr Patton on 24/2/2016. Post operative instructions included: Routine observations, 24 Hours flucloxicillin, Clexane for 5 weeks, Mobilise Full weight bearing, Avoid Abduction exercises 6/52, Check XRays, AP pelvis and lateral hip, Review 6/52 OPD. Patient made good post operative progress with physiotherapy. During admission patients inguinal hernia became problematic, as patient found it slightly more difficult to reduce. An urgernt referral to Mr Hewitt Consultant general surgeon was sent to surgeons secretary. His discharge was delayed solely due to delays with implementing social input. Patient was deemed fit for discharge on 10/3/2016.						
NICER	23/06/2017			Referral from GP	Reason for Referral/ History of Presenting Complaint Description: gallstones Comment: Thank you for seeing this gentleman who had pancreatitis in 2013 as a result of gall stones. He was told at the time he would be reviewed in 3 mth but that has not yet happened. He had been well but recently he has had vomiting and nausea off and on since 5 days since ate cheese. no diarrhoea.bitter taste in mouth. His main concern is when he had pancreatits due to gall stones surgeon warned him about something leaking out and eroding stomach. I told him this happens in pancreatitis if bad but he no longer has pancreatitis. I am grateful for rv re gall stones.						
NICER	11/07/2016			Referral from GP	Reason for Referral/ History of Presenting Complaint Description: Vascular surgery Comment: severe v veins...has developed phlebitis on L side....previous bleeding DU on oral nsaids....topical nsaid given...referral for advice re ? further management of varicose veins Many thanks. Personal						
NICER	21/07/2016		Consultant	OP letter to GP	I assessed Personal today. He has had trouble in the past relating to his gallbladder and gallstone pancreatitis although he has a lot of medical co-morbidities. I note though recently that he has got a new iron deficiency anaemia and I think before we consider doing anything with his gallbladder that needs to be investigated. I have talked to him about an OGD and colonoscopy today which I think he is fit for and I have booked these procedures on a red flag basis.						
NICER	27/07/2016		Specialty doctor	Letter to Consultant	Personal s under investigation for microcytic anaemia. He underwent an OGD which demonstrated polyps within the stomach. There is no dysplasia or malignancy. The morphological features were non-diagnostic of the gastric polyps. Duodenal biopsies have shown no evidence of coeliac disease. Within the colon there is evidence of diverticulosis and also colonic polyps within the ascending colon. Biopsies of these have showed a tubular adenoma with low grade dysplasia. There is no obvious cause for his anaemia demonstrated on CT of his chest abdomen and pelvis performed. There were no malignant features within the scan however sub-segmental and segmental embolus seen in the right lung which will require further follow up. From a colonoscopy view he will require a repeat colonoscopy in 5 years' time due to the 2 polyps on the ascending colon. I will leave further follow up with						
NICER	02/08/2016	13:50	Consultant Surgeon		CT performed Chest and abdomen						
NICER	07/08/2016	08:09	Radiology	CT report	Requested by Consultant surgeon :- Clinical Info From Order Personal with iron def anaemia. OGD and colonoscopy no cause found. Diverticular disease. **02/08/2016 15:06** CT Chest and abdo and pelvis with contrast Hx: Fe def aenaemia. No cause on OGD and colonoscopy. **Technique:** Spiral imaging of the chest and abdo/pelvis **Findings:** Chest: No overt lymphadenopathy. Cardiomegaly. Midline sternotomy and tricuspid valve replacement. No pericardial effusion or central PE. However segmental PE is seen in the lat seg ML image 148 and posterobasal RLL image 187. Subsegmental embolus ML image 176. No pleural lesion or effusion. No central endobronchial lesion. The lungs show some mild reticulations, small airways changes and atelectatic bands without any significant nodule or mass to suggest malignancy. Triangular intrapulmonary node LLL image 175. Abdo/pelvis: No liver lesion. Small cysts noted. Gallstones no biliary dilatation. Unremarkable spleen, pancreas and adrenals. Renal cysts no mass or hydronephrosis. Pelvic viscera obscured by artefact. No bowel dilatation. No overt fat stranding. Paucity of fat limits assessment but reassuring results from endoscopies. L inguinal hernia containing sigmoid. Diverticulosis noted. No adenopathy, ascites or omental disease. Normal calibre aorta. Bilateral THRs. Spondylotic changes no overt destructive skeletal lesion. **Conclusion:** No malignant features within scan limits. However subsegmental and segmental emboli seen in the R lung. **Message to referring clinicians via medica.** Dr A Wallis Consultant Radiologist GMC 6102974 Medica Reporting Ltd	Audit trail of CT result Request date 27.7.16 Examination CT chest abdomen and pelvis – Red Flag Exam performed 2.8.16 Reported 7.8.16 by Medica Reporting Radiologist Reported communicated urgently emailed D McKay re urgent report on 08/08/2016 10:13 Ruth Gribben					
Email	08/08/2016			Audit trail	Reported communicated urgently emailed D McKay re urgent report on 08/08/2016						
NICER	30/08/2016				OP review by orthopaedics						
NICER	24/01/2017				RVH cardiology review						
NICER	24/02/2017				1 year review post hip surgery						

NICER	03/03/2017		ED consultant	chest Xray	03/03/2017 16:17 XR Chest, Author: RRO, Regional Admin X-RAY chest FINDINGS:CTR 160/325. Sternotomy sutures are in situ. No signs of heart failure or pleural effusion. Some shadowing in the right base extending down from the right hilum. It is most likely to be inflammatory. A followup chest x-ray after course of antibiotics is recommended in 4-6 weeks							
NICER	04/03/2017		Requested by Consultant physician reported radiology	CT result	04/03/2017 13:18 CT Angiogram pulmonary, Author: Johnston, Norlinda Technique: Enhanced volume scan of the chest as per CTPA protocol. Comparison study: CT chest dated 2 August 2016. Findings: Previous median sternotomy and tricuspid annuloplasty. No evidence of central or segmental pulmonary embolism. Two tiny filling defects are noted within the subsegmental left lower lobe pulmonary arteries (image 195) in keeping with a small volume pulmonary embolism. No pericardial effusion. The pleural spaces are clear. Dependent changes at the lung bases. No focal area of collapse or consolidation. No skeletal infiltration. Summary: Tiny subsegmental pulmonary embolism of the left lower lobe. No central PE.							
NICER	06/03/2017	13:45 performed reported 13:54		Discharge letter CAH	Admission Reason Increasing shortness of breath ?PE Patient Receiving Palliative Care? No Principle Discharge Diagnosis Pulmonary embolus Operations/Procedures/Radiology CTPA Additional Information for GP Past Medical/Surgical History Previus PE 2016, tricuspid valve repair 2013 (severe TR), pancreatitis, hernia repair, CCF, BPH, OA, R THR (2016), L THR (1997). iron deficinecy anaemia - polyps and diverticulosis on OGD Changes to Medications - Start/Stop Started Apixaban and Laxido Clinical Information/Comments [redacted] gentleman was admitted with increasing shortness of breath over the past 3-4 weeks. Started on a course of Amoxicillin and Prednisolone by GP 1 week prior to admission. When there was no improvement, Furosemide was added. As still no imrpovement [redacted] attended ED. Chronic dry cough. O/E bilateral ankle oedema [redacted] was initally treated with therapeutic Enoxaparin, IV fluids, and furosemide held. CTPA showed tiny subsegmental PE in left lower lobe. Started Apixaban during admission - initially 10 mg BD then switching to 5mg BD on 10/03/2017. Reviewed by the Medical Team today - [redacted] is feeling well, keen for home and up and mobilising freely. Observations remain stable and [redacted] s now medically fit for discharge home.							

Received from Trudy Reid on 16/05/2023. Annotated by the Urology Services Inquiry.

Data Source	Date	Time	Professional Group	Key Facts	Patient 14 Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
NICER	03/06/2016		GP	GP referral	Reason for Referral/ History of Presenting Complaint Description: Raised PSA Comment: Many thanks for seeing this patient - Small rise in PSA noted on routine testing earlier in year - had returned to Normal on repeat testing but mot recent test raised again (5.63) . Few LUTS and nil overt on clinical examination . Please see and advise regards further investigation .		IEAP					
NICER	07/02/2017		Consultant urologist	letter to pt	Dear Patient 14 I am writing to you with the results of your recent MRI. I am pleased to say there are no significant abnormalities of your prostate. There are however some changes within a small area of the prostate so we cannot completely exclude a tumour. Given that your PSA remains raised for your age I would like to offer you a prostate biopsy that is performed under local anaesthetic in the Thorndale outpatients. I will arrange for you to have biopsies and you will be sent an appointment in due course, however if you don't wish to proceed with biopsies at the present time or wish to discuss this further we would be more than happy to hear from you. If you have any queries please contact us on the number above, otherwise I will see you with your biopsy results						
NICER	07/02/2017		Consultant urologist	letter toGP	Thank you for referring Personal Information redacted by the USI who has a raised PSA of 5.63. Prior to that it had been 4.4 and 5.5. On questioning Patient 14 reports no troublesome lower urinary tract symptoms. He has some occasional hesitancy however he is very happy with his waterworks at present. On examination his abdomen was soft and non-tender and he has a non-palpable bladder. The area revealed moderately enlarged and generally firm but benign feeling prostate. Given that it has been 8 months since his last PSA I have repeated this today at clinic. If it remains elevated or has risen further I will proceed with an MRI of his prostate as he has no contra-indications to this. If however his PSA remains stable I think it is reasonable to continue with 6 monthly surveillance PSA. I will be in touch with his results when they are available. Yours sincerelyThank you for referring Personal Information redacted by the USI who has a raised PSA of 5.63. Prior to that it had been 4.4 and 5.5. On questioning Patient 14 reports no troublesome lower urinary tract symptoms. He has some occasional hesitancy however he is very happy with his waterworks at present.						
NICER	07/02/2017		Consultant urologist	letter to pt	Dear Patient 14 I am writing to inform you of your latest PSA prostate blood test result. Your PSA has dropped slightly to 5.5 from 5.6 last year. Overall this is reassuring. Given that it remains slightly elevated for your age I will proceed with booking an MRI scan of your prostate as discussed at clinic. You will receive an appointment in due course.							
NICER	24/02/2017	08:20			MRI Pelvis prostate							
NICER	06/03/2017	19:21	Radiology	MRI report	Report 24/02/2017 09:05 MRI Pelvis prostate, Author: Williams, Marc Prostate volume of 37cc. There is a small volume of reduced T2 and ADC signal change related to the posterolateral peripheral zone of the left apex to mid gland. No overt restricted diffusion. The appearances are therefore of equivocal significance and may represent a small focus of tumour. Extension to but not definitively beyond the prostatic capsule. Non specific minor reduced T2 and ADC signal changes within the posterolateral and peripheral zones of both sides of the mid gland to base. Within the limitations of transition zone assessment, no definite transition zone tumour is identified. The seminal vesicles appear unremarkable.5mm utricular cyst. No pelvic lymphadenopathy. Probable degenerative change at L5/S1. An 11mm low T1 signal focus within the right femoral neck is not thought to be significant. CONCLUSION: There is no definite radiological evidence of significant prostate tumour. A small volume of signal change within the posterolateral peripheral zone of the left apex to mid gland is regarded as suspicious. Mild signal change elsewhere within the peripheral zone as described is equivocal. If biopsies are being considered, you may wish to consider additional biopsies of the left apex to mid gland peripheral zone. If tumour should be present, the appearances are thought to represent organ confined disease.						
NICER	28/03/2017			US Guided biopsy prostate transrectal	Report Final 28/03/2017 10:36 US Guided biopsy prostate transrectal, Author: Newell, Denise This examination was performed by the Urologist. Please see patient notes.							
NICER	28/03/2017		Nurse specialist	letter toGP	Patient 14 attended Thorndale Unit today. Written consent was obtained, local anaesthetic inserted and following guidance from his recent MRI scan a total of 15 core biopsies of prostate were obtained. He was provided with a 3 day course of prophylactic antibiotics and discharged home care of a family member. His histology results will be discussed at the urology MDM and he will be reviewed by Mr O'Donoghue thereafter.							

NICER	28/03/2017 reported 5/4/2017			Histology report	CLINICAL DETAILS Recent MRI. SPECIMEN - Prostate. PATHOLOGIST'S REPORT GROSS DESCRIPTION : NATURE OF SPECIMEN: needle core biopsy. SITE: 1. Right base - 2 cores and fragments the longest measuring 18 mm. SITE: 2. Right mid - 2 cores the longest measuring 20 mm. SITE: 3. Right apex - 4 cores the longest measuring 8 mm. SITE: 4. Left base - 2 cores the longest measuring 16 mm. SITE: 5. Left mid - 4 cores the longest measuring 20 mm. SITE: 6. Left apex - 3 cores the longest measuring 19 mm. HISTOLOGY HISTOLOGICAL TYPE: Adenocarcinoma. DIFFERENTIATION/GLEASON SUM SCORE: 3+3=6 NUMBER OF CORES/CHIPS INVOLVED: Right base - Not involved. Right mid -Not involved. Right apex - 1 of 2 cores involved. Gleason 3+3. 40% tissue. Left base - 2 of 2 cores involved. Gleason 3+3. 50% tissue. 6.5mm max length Left mid - 1 of 4 cores. Gleason 3+3. 1% tissue Left apex - 3 of 3 cores involved. Gleason 3+3. 20% tissue. INVASION INTO: Seminal vesicle: No. Extracapsular fat: No. PERINEURAL INVASION: No. LYMPHOVASCULAR INVASION: No. Prostatic adenocarcinoma of overall Gleason sum score 3 + 3 = 6 is present in 7 of 17 cores with a maximum tumour length of 6.5 mm. The tumour occupies approximately 15% of the total tissue volume. DIAGNOSIS PROSTATE NEEDLE CORE BIOPSY ADENOCARCINOMA						
NICER	06/04/2017		Chair MDM	MDM letter to GP	This patient was discussed at the Urology MDM @ The Southern Trust On 06/04/2017. Diagnosis: Prostate cancer Gleason Score 3 + 3 MDM Update: CONSULTANT MR O'DONOGHUE: This Personal Information redacted by the USI who has a raised PSA of 5.63ng/ml. Prior to that it had been 4.4ng/ml and 5.5ng/ml. He reports no troublesome lower urinary tract symptoms, he has some occasional hesitancy. The area revealed moderately enlarged and generally firm but benign feeling prostate. MRI, 24.02.17 - There is no definite radiological evidence of significant prostate tumour. A small volume of signal change within the posterolateral peripheral zone of the left apex to mid gland is regarded as suspicious. Transrectal prostatic biopsy, 28.03.17 - Prostatic adenocarcinoma of Gleason score 3 + 3 = 6, is present in 7 of 17 cores with a maximum tumour length of 6.5mm. The tumour occupies approximately 15% of the total tissue volume. MDM Plan: Discussed at Urology MDM 06.04.17. Patient 14 has low risk, organ confined prostate cancer. For review with Mr O'Donoghue to discuss all treatment options. Signee: If you have any queries or require further information, please do not hesitate to contact us.						
NICER	19/04/2017		Consultant urologist	letter toGP	This gentleman as you know recently had prostate biopsies for a PSA of 5.63ng/ml. The histology has come back showing adenocarcinoma of the prostate Gleason score 3+3=6 in 7 of 17 cores. The tumour occupied approximately 15% of the total tissue. His MRI showed no definite radiological evidence of a significant prostate tumour. There was a small volume of signal change within the posterolateral peripheral zone of the left apex to mid-gland which was regarded as suspicious. As per MDT I have went through the various options for treatment with this low risk organ confined prostate cancer with Patient 14. We discussed radical radiotherapy, radical surgery and active surveillance and he wishes to pursue a period of active surveillance. I will see him in 4 months' time with a PSA 1 week beforehand and in 1 years' time I will re-biopsy his prostate. Yours sincerely						

Patient 12

Data Source	Date	Time	Professional Group	Key Facts	Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
NICER	08/09/2016		GP	Referral to urology	Reason for Referral/ History of Presenting Complaint Description: lower urinary tract symptoms and elevated PSA. Comment: Dear Urologist Please may I have your advice on this Personal Information redacted by the USI with lower urinary tract symptoms and elevated PSA. This man has previously been reviewed in regards to an elevated PSA. He complains of increasing lower urinary tract symptoms of frequency and nocturia. He denies any haematuria or dysuria. He decided to stop his combodart due to erectile dysfunction. He denies any erectile dysfunction while taking Contiflo. His PSA has had a slow general increase over the last number of years and is now 7.34. I would appreciate your opinion on biopsy of his prostate.		IEAP					
NICER	30/01/2017		GP	Referral to urology	Reason for Referral/ History of Presenting Complaint Description: elevated PSA Comment: Please find attached my previous referral in regards to this Personal Information redacted by the USI. I have repeated his PSA at a reasonable interval and it has elevated to 9.43. I would appreciate it if you could upgrade his referral to red flag.		IEAP					
NICER	06/02/2017		LAT3 in Urology	Letter to GP	Diagnosis: Raised PSA Plan: MRI prostate Thank you for referring this Personal Information redacted by the USI who has a rising PSA. Over the last 12 months it has gone from 7.3 to 6.9 and subsequently 9.43 in January 2017. I note that he has had previous investigations including a TRUS biopsy in 2008 which was benign. He reports some urgency and occasional dribbling but is not overly troubled with his lower urinary tract symptoms. He has had no haematuria, UTIs or weight loss. Of note he had previously been on Combodart however he discontinued this due to erectile dysfunction. He is now only on Contiflo. On examination this gentleman has a moderately enlarged but benign feeling prostate. There is a nodule present just left of the midline however I note that this was present in 2007 as documented in an outpatient letter at that time. I have discussed the options with Patient 12 and we have agreed to proceed with an MRI of his prostate. If this shows any abnormalities we will carry out a TRUS biopsy. I will be in touch with the result of his scan in due course.							
NICER	14/02/2017				MRI performed							
NICER	01/03/2017			MRI report	14/02/2017 09:42 MRI Pelvis prostate, Author: RRO, Regional Admin. MRI prostate Oncology report CLINICAL HISTORY Rising PSA 9.4 from 6.9 last year, left lobe nodule on rectal examination FINDINGS Prostate volume 60 mL. There is a 1 cm nodule seen in the left posterior peripheral zone bulge in the capsule, with restricted diffusion (PIRADS 5) and also a possible lesion seen in the right anterior lobe and some PIRADS 3 changes in the right peripheral zone posteriorly. The seminal vesicles collapsed but grossly normal. Normal visualised rectum and bladder. No significantly enlarged lymph nodes or bony deposit in the pelvis CONCLUSION If biopsy-proven, at most, T3a N0, MX							
NICER	07/03/2017		Consultant Urologist	Letter to Pt	Dear Patient 12 I am writing to you with results of your recent MRI. The scan has detected some changes within your prostate which require further investigation. As we discussed at clinic, the next step is to perform a biopsy of the prostate. This can be performed under local anaesthetic at our outpatient unit. I will arrange this and will be in touch with appointment details in the near future.							

NICER	11/04/2017			Histology report	REPORT CLINICAL DETAILS Total cores taken 14. ?? abnormality left mid - base on MRI. PSA 9.43 ng/ml. Prostate volume 31.8. Medication Combodart. SPECIMEN - Prostate. PATHOLOGIST'S REPORT GROSS DESCRIPTION NATURE OF SPECIMEN: Needle core biopsy SITE: 1. Right base - 2 cores measuring 15 and 6 mm along with fragment. SITE: 2. Right mid - 2 ragged cores measuring 14 and 13 mm. SITE: 3. Right apex - 1 core measuring 14 mm. SITE: 4. Left base - 2 ragged cores measuring 18 and 12 mm. SITE: 5. Left mid - 6 cores measuring 11, 10, 14, 12, 5 and 3 mm along with fragments. SITE: 6. Left apex - 1 core measuring 10 mm along with fragment. HISTOLOGY HISTOLOGICAL TYPE: Adenocarcinoma OVERALL GLEASON SUM SCORE: 3+4 = 7 (Grade Group 2) NUMBER OF CORES INVOLVED: 8 of 14 Right base - No tumour identified. Right mid - 2 of 2 cores, Gleason 3+3, < 5% of tissue. Right apex - No tumour identified. Left base - No tumour identified. Left mid - 6 of 6 cores, Gleason 3+4, 6.3 mm max length, 20-25% of tissue. Left apex - No tumour identified. INVASION INTO: Seminal vesicle: No Extracapsular fat: No PERINEURAL INVASION: No LYMPHOVASCULAR INVASION: No FURTHER COMMENTS: The macroscopically described 2 cores within the block 5C got fragmented into 5 small bits, two of which show neoplastic glands. It is difficult to be certain but would be best regarded as 2 of 2 cores involved. Within 8 of the 14 prostatic core biopsies there are infiltrates of Gleason 3+3 and 3+4 adenocarcinoma. This occupies approximately 5% of the overall examined material. There is no perineural invasion, lymphovascular invasion or extracapsular extension. Selected slides (5B, 5C) were discussed with Dr G McClean. DIAGNOSIS PROSTATE CORE BIOPSIES ADENOCARCINOMA				
NICER	20/04/2017		Chair of MDM	MDM meeting letter to GP	This patient was discussed at the Urology MDM @ The Southern Trust On 20/04/2017. Diagnosis: Prostate cancer Gleason Score 3 + 4 MDM Update: CONSULTANT MR HAYNES: This Personal Information redacted by the USI has had a rising PSA it had gone from 7.3ng/ml to 6.9ng/ml and subsequently 9.43ng/ml in January 2017. He has had previous investigations including a TRUS biopsy in 2008 which was benign. He reports some urgency and occasional dribbling but is not overly troubled with his lower urinary tract symptoms. On examination he has a moderately enlarged but benign feeling prostate. MRI, 14.02.17 - If biopsy-proven, at most, T3a N0, MX Transrectal prostatic biopsy, 11.04.17 - Adenocarcinoma, Gleason 3+4 = 7. Number of cores involved - 8 of 14. MDM Plan: Discussed at Urology MDM 20.04.17. Patient 12 has high risk prostate cancer. He should be seen in clinic and have a discussion with regard to curative treatment. Signee: If you have any queries or require further information, please do not hesitate to contact us.				
NICER	03/05/2017		Consultant Urologist	Letter to GP	Diagnosis: High risk non metastatic prostate cancer Outcome: Commence Bicalutamide 50mgs once a day, 28 day course Please commence Decapeptyl 11.25mg first dose to be given week commencing 15th May and continued every 12 weeks thereafter Isotope bone scan Refer to Oncology for consideration of radiotherapy in addition to androgen deprivation Patient 12 prostate biopsies have confirmed a high risk prostate cancer and radiologically on his MRI this would appear to be stage T3a with no nodal metastases. Given this the recommended treatment would be hormones and radiotherapy. I have outlined this to him. He does require a bone scan to complete his staging which I have arranged. I have commenced him on his Bicalutamide today and would be grateful if you could arrange his Decapeptyl as above. I have referred him to my Oncology colleagues				

Patient 137

Data Source	Date	Time	Professional Group	Key Facts	Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
NIECR	20/12/2016			CT Chest and abdo and pelvis with contrast	20/12/2016 11:28 CT Chest and abdo and pelvis with contrast At the posterior aspect of the RUL, there is a 42 x 21 x 21 mm irregular soft tissue abnormality with an air bronchogram, adjacent to the oblique fissure present. Minimal linear atelectasis in the right base and mild bilateral basal hypoventilation atelectatic changes. Several accentuated subcarinal lymph nodes measuring up to 12 mm. Normal both kidneys with mildly accentuated collecting system (likely of no clinical significance). In the left perirenal space, anterior to the upper pole of the kidney, there is a large (78 x 68 x 72 mm) well defined fatty tumour with some soft tissue component, abutting mildly thickened adrenal. Enlarged prostate. Normal liver, bile ducts, pancreas, right adrenal, spleen and urinary bladder. No sinister process of the imaged skeleton. Partial lumbarisation of S1. Two small sclerotic lesions within the L3 vertebral body (bony islands?). A small T12 vertebral body haemangioma. **Conclusion:** Right upper lobe pulmonary abnormality suggesting a dense consolidation. Please correlate with clinical features. Follow-up recommended. A large fatty tumour in the left perirenal space which may be in keeping with an angiomyolipoma with extrarenal growth. Differential diagnosis should include liposarcoma, adrenal teratoma or adrenal myelolipoma. Specialist referral is advised. Time Reported 20-Dec-2016 15:42							
NIECR	21/12/2016			Letter from respiratory physician to GP	Diagnosis: 1. Right upper lobe community acquired pneumonia. - CT chest 20/12/16, right upper lobe consolidation. 2. Left perirenal mass. - CT chest abdomen 20/12/16, large fatty tumour (78 mm) left perirenal space. 3. Left hydrocele repair 2012. 4. Hypertension. 5. Recurrent episodes of hiccups. Comment: This Personal Information redacted by the USI was reviewed at the Respiratory Clinic today following his recent discharge from hospital. His CT imaging is as detailed above. I reviewed the patient's CT imaging with Dr Clarke, Consultant Radiologist today. The left perirenal mass differential diagnosis includes an adrenal myelolipoma, atypical lipoma or a liposarcoma. Action: 1. I have explained the CT results and further management plan to the patient. 2. I would be grateful if you could provide this patient with 7 days of Amoxicillin and Clarithromycin as per handwritten note and telephone call to your surgery today. 3. Red flag referral to Urology Team, Craigavon Area Hospital has been arranged. 4. Repeat chest x-ray has been booked for 6 weeks' time. 5. No review is planned at the Respiratory Clinic.							
NIECR	21/12/2016			Red flag referral from respiratory physician to Urologist	I would be grateful for your urgent assessment of this Personal Information redacted by the USI who has been found to have a 78 mm left perirenal mass. Please find a copy of the most recent correspondence attached. Thank you for your help.							
NIECR	23/12/2016			MDT letter to chair of MDT from Consultant Urologist 2	We have received communication from the chest physician colleagues in the Erne re this Personal Information redacted by the USI with pneumonia, but has had an incidental finding of a mass lesion in the left perirenal area. I don't think that this is renal in origin; I would agree with their sentiments that this could either be of adrenal origin, I suspect it would be difficult to biopsy. I would be grateful if his films could be reviewed. This would probably be beneficial before speaking to [redacted] Patient 137 himself							
NIECR	12/05/2017			GP letter	Reason for Referral/ History of Presenting Complaint Description: L renal mass Comment: Patient 137 has never had an appointment re this matter-- ? has referral been made and what are the rv arrangements							
NIECR	18/05/2017			OPD letter to GP from Consultant	Many thanks for your letter Patient 137. Unfortunately it would appear that the referral to the Endocrine Team has not happened. I have done a referral which is attached and I would anticipate Patient 137 will hear from the Endocrine Team in due course.							

NIECR	18/05/2017			OPD letter to Endocrine consultant from Urology Consultant	I would be grateful if you could arrange for review of Patient 137 's imaging and clinical review with yourself. He was referred following a CT scan which was performed in December 2016 following an admission under the care of the General Physicians in South West Acute Hospital. Incidentally the CT scan showed an abnormality in the left peri-renal space. This was reviewed at the Urology MDM in Craigavon Hospital on 12th January where it was felt to represent an adrenal abnormality and referral to yourself was recommended. Unfortunately this referral does not appear to have occurred and a new letter was sent by Patient 137 's GP today. The view of the Urology MDT was given that it would appear to be an adrenal abnormality and further management would be appropriate under your care. I would be grateful if you could arrange for review of your imaging at MDT and subsequent clinic review with yourself regarding further managem							

Received from Trudy Reid on 16/05/2023. Annotated by the Urology Services Inquiry.

Personal Information redacted by the USI

Data Source	Date	Time	Professional Group	Key Facts	Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
ED record	30/04/2017	14:06		Arrival at ED	Arrived ED by ambulance - alone							
ED record	30/04/2017	14:06	Nursing Hannah Donnelly	Triage	Shortness of Breath adults New abnormal pulse SOBAR today, denies CP feels otherwise well Pulse 109 BP 92/55, RR 28 temp 36.7 SaO2 94 Location resus							
ED record	30/04/2017	OA	Medical Gilbert Rice	Assessment	Personal Information generally unwell x2 episode vomit yesterday SOB, Øpyrexia, Ø cough BO 1/7 ago Sister stated vomiting ++ for 1/52 mild cognitive impairment 2o to stroke **PMH** DM type 2 ↑chol prev ICH HTN O/E HS 1+11+0 calves SNT Chest ↓A/E L base. Abdomen distended ++ non tender BS↓ Na 126, K5.7 Cl78, ur 14.4,cr 178 eGFR 25 (41) trop 43 (29) LFT N, wcc 14.3 CRP 39.3							
ED record	30/04/2017			Diagnosis	1. Acute Bowel obstruction 2. Hyperkalaemia 3. AKI							
NIECR	30/04/2017	15:42		Abdominal X-ray	30/04/2017 16:21 XR Abdomen, Author: McReynolds, Andrew There is marked dilatation of multiple small and large bowel loops. The colon appears oedematous and there is subtle intramural pneumatosis in the ascending colon. I note the subsequent CT report. AMcR/PFR							
NIECR	30/04/2017	15:42		Chest X-ray	30/04/2017 16:21 XR Chest, Author: Fourways, 4W Admin Radiology Report Date: 08/06/2017 19:10 Date: 30 April 2017 Examination: Chest x-ray Technique: AP Clinical Indications: Query bowel obstruction or lung lesion Findings: The heart size is normal both lungs are of normal volume. There is minimal subsegmental collapse at the left base but there is no free air under the hemidiaphragms to suggest perforation. There is no focal consolidation or collapse. No change is seen compared to previous films of February 2017.							
ED record	30/04/2017	16:00			Referred to surgical team							
ED record	30/04/2017		Nursing Hannah Donnelly		Prioritised in resus							
ED record					CXR→consolidation L Base AXR → Large dilated bowel loop							
NIECR		17:37		CT abdomen	NB! This is a change of a previously given preliminary report 30/04/2017 17:57 CT Abdomen and pelvis, Author: Hutchinson, Christopher Subsequently contrast was administered per rectum in an attempt to delineate the possible calibre change further. There is a 40mm long apple core tumour present in the recto sigmoid region. This is causing almost complete obstruction however a small amount of contrast has passed beyond it. No significant local or regional lymphadenopathy has been identified. Again pneumatosis intestinalis is present in the ascending and transverse colon. There is no evidence of portal venous gas. **Conclusions:** Obstructing lesion in the recto sigmoid region has appearances highly suspicious for malignancy. I am now informed the patient has had previous pelvic radiotherapy. A stricture secondary to this is possible but thought less likely given the degree of shouldering of the lesion. The continued lack of portal venous gas leads me to suspect that the pneumatosis intestinal is is secondary to obstruction rather than ischaemia. **Findings discussed directly with the referring team Reported on call by C Hutchinson St5** 30/04/2017 17:57 CT Abdomen and pelvis, Author: Hutchinson, Christopher **Indication:** Personal Information redacted by the USI with PMHx traumatic brain injury. A/w 1/52 intermittent vomiting, 1/7 of acute abdo distension and 1/7 no BO. On presentation to ED hypotensive, abdomen tense and distended. lactate 13.2. WCC 14, CRP 40 **Technique:** Due to renal function, non contrast CT abdomen and pelvis. **Findings**: The large bowel is distended and filled with fluid and faeces until an abrupt calibre change in the recto sigmoid region. This is adjacent to the suture material from the frevious hysterectomy. The is significant pneumatosis in the ascending and transverse colon to the splenic flexure. There is no portal venous gas. Being non contrast, it has not been possible to assess the mesenteric arteries. There is some calcification of the aorta but non of the mesenteric vessels. The small bowel and stomach is distended and fluid filled. Within the limitations of this non contrast study, there is no significant abnormality of the liver, pancreas spleen or adrenals. Gallstones noted. There is no free fluid or gas.							
ED record		19:30	J Anderson		Urinary catheter inserted aseptically							
ED record		18:45	E Jones		Attended for CT abdo. Placed in 4 North but returned to Resus after scan ABG repeated							
NIECR		19:37			Clinical Info From Order 1/7 distended abdomen + No BO. Vomitting 1/52. Lactate 13. CTAP - distended LB loops ?adhesional LBO ?pseudoobstruction Time Reported 04-May-2017 10:31							
ED record		20:10	E Jones		For further CT scan with contrast. Surgical Dr to acompany. Not for wrd until result of scan as may need to go to theatre							
ED record					Admit to ward - Theatre							
ED record				Discharge obs	P 120, BP 121/56, resp 18, tmp 36, SPO2 99% intubated							

ED record		22:10			Left department							
ED record continuation		22:10	E Jones		Retrospective note Pt brought to CT scan for further CT abdo with rectal contrast. Accompaied by surgical Dr IV access tissued on route to scan. IV fluids stopped. When on scanner pt had rectal catheter inserted and Dr began to give contract. Monitored throughout. Obs stable. Shortly after contract started pt began to vomit profusely. Suctioned while on scanner, became very cyanosed. O2 therapy applied. Assisted airway. Colour remained poor and became more unresponsive crash team called as peri arrest call. Anaesthetic team also contacated. NG tube inserted and pt intubated and ventilated. Proceeded with CT scan as planned. Taken to theatre to await report may need laparotomy tonight. Surgical reg spoke with sister and updated her. Family decided to go home phone numbers given. I will hand over to theatre staff to update family as and when needed							
Medical notes		22:15	I Soric Surgical reg		Pt waas taken to CT ???rectal contrast. Vomited during the procedure and became very hypoxic and unresponsive. Anaesthetic team got involved. Pt was intubated in CT. CT verbal report→Stricturing lesion upper rectum- most likely neoplastic →large bowel obstruction D/W with Personal Information redacted by the USI the situation. Explained the situation deteriorated dramatically and our expectations are very guarded. Personal Information redacted by the USI aware very understanding and they saw a decline in Persona l condition over latst 2/52 and news was not entirely unexpected to them. Explained that after conversation with consultant on call Mr Hewitt and anaesthetic team we feel the best next step is surgery to remove the obstructed large bowel. Personal Information redacted by the USI agreed with the plan and totally understood that Perso nal may not survive the operation or immediate postoperative period. Family ???? to be informed of further changed in Personal Informati condition							
Southern Trust Acute Surgical Admission			HO/Soric		**Presenting Complaint** Abdominal distension **History of presenting complaint** Vague historian. Patient states that she had an episode of collapse yesterday Sister states patient had been vomiting for 1/52 Last BO yest. Abdomen ↑distension over 1/7 Denise any abdo pain **Past medical/surgical history** TBI →SAH 1997 T2BM, HTN, Endometrial CA - TAH 2006 **Abdomina**l Grossly distended & tense. Non peritonitis **Bloods** HB 127, WBC 14.3, PLT 639, CRP 39, NA 126, K 5.7, CL 78, Urea 14.4, Creat 128, eGFR 25 TP 69, ALb 43, Bili 13.2, ALP 83, AST 22, ALT 20 GGT 33 **Imaging** CTAP dilated LB ? pneumatosis ? adhesions LBO ? pseudo-obstruction **Problem list/differentials** Adhesional LBO vs pseudo-obstruction AKI **Management plan** Resuscitation Gastrografin n enema with CTAP →if contrast pass throught →conserva tive management v caecum flex sig →if blockage of contradt → ? laparotomy Waiting **Senior Review** Personal Information redacted by the USI . Very unwell. Abod distension ? large bowel obstruction on CT ? pneumatosis caecum and ascending colon D/W Mr Hewitt →suggested to do a CT with Gastrografin enema to confirm the presentation of large bowel obstruction. Mr Hewitt happy with the plan							
Southern Trust Acute Surgical Admission			Anaesthetist		Neurological Diwson, Moore, ST anaes 2116 30/4/17 Fast asleep to CT @20:44 on immediate arrival A -? copious vomit B -SpO2 ~60%/cyanosed partially obstructed RR ~18 C -P144 no BP possible no IV access D -AV P U Actions 10 Access tibia (2 failed ???in side) M'son C NGT - 500mls drained RSI ??50 ? ROC 100mg McGrath CT pass 7.5 coexPropofol 100mls/hr 16# ESR Handed over to the night team and D?W R McKee							
Medical notes			CT 2		Written in retrospect Patient transferred to CT scanner by myself, ED nurse and porter at 20:20. Stable pre-transfer, normotensive, communicative X comfortable. Platient lay on right lateral position for insertionof catheter PR & contract injection. During instillation of PR contract patient aspirated with acute destauration. Mouth suction but unable to protect the airway. Cardiac arrest team & anaesthetics fast bleeped to CT scanner. Patient cnscious throughout with no loss of output. NG inserted by SPR Soric. 10 access obtained. Patient intubated via RSI, Following discussion between surgical & anaesthetic team, dicision made to perform CT scan as anaesthetic team in attendance. CT scan R/V by SpR Soric & D/W on call radiologist & Mr Hewitt. Given CT findings, blood results & patients clinical stable, decision made to perform laparotomy. Anaesthetic team in agreement. Family informed of events							
Operative notes			Soric & Crawford		Midline laparotomy **Finding**- Grossly distended large bowel. Impeding perforation caecum and transverse colon. Obstructing lesion upper rectum ……..							
NIECR	01/05/2017			Chest X-ray	Date: 1 May 2017 Examination: Chest x-ray Technique: AP Clinical Indications: Query line placement query pneumothorax query aspiration **Findings:** The heart size is within normal limits. The ET tube and right internal jugular line are in a good position with no pneumothorax. There is marked consolidation within the right lung compatible with infection. These changes have markedly worsened compared to 30 April 2017.							
NIECR	01/05/2017			Letter to GP	I regret to inform you of the death of Personal Information redacted . She attended Craigavon ED on 30/4/17 with vomiting and abdominal distension. CT showed bowel. obstruction due to a rectosigmoid tumour and she proceeded to laparotomy for a subtotal colectomy. She was transferred to ICU post-op and had high inotrope and ventilator requirements. She also had haemodialysis. However, despite maximal treatment, she continued to deteriorate. After discussions with her family, care was withdrawn on the afternoon of 1/5/17 and she passed away peacefully at 15:50. Her MCCD was completed as follows: 1) a) Multi-organ failure b) Small bowel obstruction c) Recto-sigmoid tumour 2) Chronic Kidney disease, Diabetes Mellitus							

Received from Trudy Reid on 16/05/2023. Annotated by the Urology Services Inquiry.

Personal Information redacted by the USI

Data Source	Date	Time	Professional Group	Key Facts	Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
ED record	19/11/2015	11:23			Presented to ED with GP letter							
ED record	19/11/2015	11:24		Triage	Abdominal pain in adults Mod pain Abdo pain for 4/7 no D/V treated fro UTI HX kidney stones BP 137/89 RR18 temp 36 SaO2 97 ALert Pain score 6							
ED record	19/11/2015	11:30	Doctor 1	Assessment	Personal HX pain RIF Gradual onset. Constant pain worse on movement 6/10 severity. Associated anorexia. No nausea/vomiting . Sweating at night no temps. No bowel movement from Sunday until this morning - usually regular. No urinary symptoms O?E Pt looks well RR 18, SpO2 97%RA Temp 36.0 BP 137/89 HR 90 HS 1+11+0 Chest clear CRP 324, WCC 15.6 neut 84.4 PLT 341 Amylase 36 LFTs N U&E N RIF tenderness with guarding fullness R side Plan AXR, urinalysis Bloods							
NIECR	19/11/2015	12:46		XR Abdomen	No abnormal bowel dilatation seen. Calcific opacity seen in the right lumbar region. Degenerative changes seen in the spine. Vascular calcification noted. Time Reported 20-Nov-2015 10:18							
NIECR	19/11/2015	16:00		CT Abdomen and pelvis with contrast	Technique: Volume scan of the abdomen and pelvis following IV and oral contrast. **Findings:** A tubular structure exits the posterior aspect of the caecum, believed to represent a retrocaecal appendix. This is significantly enlarged with a maximum axial diameter of approximately 1.7 cm and it displays mural thickening and hyperenhancement. A small bleb of extraluminal gas is noted posterior to the appendix and there is a focal collection of fluid measuring approximately 5 cm in maximum axial diameter adjacent to this. Inflammatory stranding and subcentimeter lymphadenopathy is present in the surrounding fat of the right iliac fossa. Overall appearances are thought to represent acute retrocaecal appendicitis with localised perforation and formation of a focal fluid collection. The collection is thin walled but displays some peripheral rim enhancement. Of note, there is soft tissue thickening present at the base of the appendix/tip of the caecum. Further assessment is advised in this area. Scattered diverticula are noted throughout the entire colon. Within the limitations of an unenhanced study, the small and large bowel are otherwise unremarkable. No other intraperitoneal air or fluid. Two sub centimetre foci of ill-defined low attenuation are present within the right lobe of liver. These are essentially too small to categorise accurately. No other significant liver pathology demonstrated. A cortical cyst is present within the lower pole of each kidney, larger on the right side than the left. Both display foci of peripheral calcification and will require follow-up. A 1 cm calculus is present in the upper pole of the right kidney. The kidneys are otherwise unremarkable. The gallbladder, pancreas, spleen and adrenal glands are normal. Calcified mesenteric abdominal lymph nodes are present which may represent previous granulomatous disease. The visualised lung bases are clear. Degenerative changes are present in the visualised thoracolumbar spine. Lucent lesions within the L2-L5 vertebral bodies are fat attenuation and are most likely to represent incidental haemangiomas. **Conclusion: 1.** Appearances in the right iliac fossa are thought to represent an acute retrocaecal appendicitis with localised perforation and formation of a focal fluid collection. The collection is thin walled but diplays peripheral enhancement. Soft tissue thickening is present at the base of the appendix/tip of the caecum and evaluation of this region is advised in due course to exclude other pathology. **2.** Sub-centimetre foci of low attenuation in the right lobe of liver are essentially too small to characterise. A 3 month interval US scan is advised to ensure no progression. In the presence of a known sinister pathology these might be viewed with more suspicion and MRI should then be considered. **3.** Bilateral renal cysts which display peripheral calcification and require follow-up. A repeat CT of kidneys is advised in 1 year. **4**. Other incidental findings as discussed. Result discussed with surgical registrar on call at time of report. Time Reported 20-Nov-2015 10:18							
ED record	19/11/2015	16:00			Discharge observations P 86 HR 153/74, resp 18, temp 37.8 SpO2 96% GCS 15/15 Left dept at 15:05 to ward							
Person Cenred Nursing Assessment and Plan of Care	19/11/2015				Admitted to MSW Abdominal Pain							
NIECR	27/11/2015			Medical Hospital Discharge letter	RIF pain Initial Diagnosis ?appendicitis ?walled-off appendix ?malignancy Method of Admission Emergency Patient Receiving Palliative Care? No Principle Discharge Diagnosis Perforated appendix - conservatively managed Investigations Bloods on admission: Hb 129, WCC 15.6, Plt 9.8, Na 137, K 4.9, Urea 9, Creat 100, eGFR >60. CRP 324. LFTs normal. Amylase 36. Urine MSSU - no growth (16/11/15) ECG - AF with old RBBB Echo - sinus rhythm. LVF is low normal with EF approx 55%. Mild bi-latrial dilation. Mild aortic valve stenosis. AVA 1.9m2 Operations/Procedures/Radiology CT A/P - acute retrocaecal appendicitis with localised perforation and formation of a fluid collection. Collection thin walled with peripheral enhancement. Soft tissue thickening at base of appendix/tip of caecum. Evaluation of this region advised to exclude other pathology. Suc-centimetre foci of low attentuation in right lobe of liver too small to characterise. 3 month interval US scan advised to ensure no progression. Additional Information for GP Past Medical/Surgical History CVA Drinks alcohol socially - 1 glass wine per day Non smoker. Walks 6 miles/week. Changes to Medications - Start/Stop To complete a total of 14 days of antibiotics Started on Apixaban for AF Clinical Information/Comments 79yo male. Presented to ED with RIF pain. No other symptoms. 1/52 hx of pain on the right side. Pain unchanged during that week. No urinary symptoms. Last BO the same morning of presentation. No diarrhoea, no PR bleeding. No weight loss. No temperatures. OE, fullness and tenderness in RIF. No guarding. BS present. Patient was admitted for CT abdomen, kept fasting, given IV fluids. CT AP performed. CT findings - as above. Decision made to treat conservatively with antibiotics. Inflammatory markers continued to improve during treatment with antibiotics. During admission, new onset AF discovered on ECG. Patient asymptomatic of same. Impression was of AF secondary to sepsis. Reviewed by medical team - echo performed (result as above), advised to treat AF with apixaban due to CHADS score of 4 (for age and hx of CVA). Clinical impression on 27/11/2015 was that Pers was improving and fit for discharge with completion of a 14 day course of antibiotics (switched to co-amoxiclav). Had 9 days IV Abx. He is for repeat CT in 3/52. Colonoscopy in 8-10/52. To attend SAU level 3 DHH on Monday 7th Dec at 10am for repeat routine bloods. He is to be given the telephone number of Mr Gilpin's secretary in case of problems and has been strongly advised to seek medical advice should he feel unwell. Did the patient receive a blood transfusion? No							
Person Cenred Nursing Assessment and Plan of Care	01/12/2015				Patient had appointment at SAU today. Was admitted to ward query appendix abscess/mass							
NIECR	02/12/2015	16:15		CT Abdomen and pelvis	CT abdomen and pelvis performed following oral and intravenous contrast. Comparison made with previous CT scan examination of 19/11/2015. **Findings** 10x10 x 5.5 cm collection seen in the right iliac fossa. The posterior wall of the cecum is markedly thick walled. Two illdefined hypodense lesion seen in the segment V of the liver meauring upto 8.8mm. Gallbladder, spleen and pancreas appear normal. 8.3 mm calculus seen in the right kidney with no obstructive changes. 4.3 cm cyst also seen in the right kidney anteriorly. 13 mm hypodense lesions seen in the left kidney. Normal urinary bladder. Atherosclerotic calcification of the aorta and its branches seen. Degenerative changes are seen in the spine. There is suggestion of haemangioma in L3 vertebral body. **Conclusion** 10x10 cm collection in the right iliac fossa region. Thickening of the posterior ceacal wall which is highly concerning for neoplastic lesion. Two ill-defined hypodense lesion in the liver. These are too small to characterise however the differential diagnosis include metastasis. Ultrasound/MRI suggested for further evaluation. 13mm hypodense lesion in the left kidney. Follow up suggested. Time Reported 03-Dec-2015 10:18							

NIECR	04/12/2015	11:00		CT Guided drainage abdomen	04/12/2015 14:23 CT Guided drainage abdomen Procedure: Written informed consent obtained. Using CT guidance and aseptic technique a 12-French pigtail catheter was positioned within the previously described right-sided collection. Sample provided for microbiology. No immediate complication. The patient was returned to the ward for post procedural observations.Time reported 04-Dec-2015 15:18							
NIECR	04/12/2015			Medical hand over	Admitted recently with acute appendicitis and a mass. He was already on Plavix at that time so was treated conservatively. He was readmitted with further sepsis. CT scan confirms an abscess which is for radiological drainage today. The CT scan also suggests that there may be an underlying lower pole caecal carcinoma.							
NIECR	08/12/2015	10:11		CT Abdomen and pelvis	08/12/2015 11:14 CT Abdomen and pelvis Comparison made with previous examinations. **Findings** Mild right-sided pleural effusion with posterior basal consolidation. The collection in the right iliac fossa now measure 9.5x9.7x 6.2 cm and show septation/loculation. The drain tube is in the superolateral part of the collection. Rest of the abdominal findings reported on the previous examinations are unchanged. Time Reported 09-Dec-2015 08:54							
Medical notes	09/12/2015				Open drainage of appendix abscess							
Medical notes	10/12/2015			Ward round	Day 1 post I+D Δ appendix abcess NEWS 2 score on O2 Patient off 02 currently, pain improved from yesterday BO Plan Dietician, Bloods Switch to antibiotics- septrin + metronidazole							
NIECR	16/12/2015			Medical Hospital Discharge letter	Patient's Description of Their Complaint Abdominal pain Initial Diagnosis Appendiceal mass Method of Admission Emergency Patient Receiving Palliative Care? No Principle Discharge Diagnosis Appendiceal abscess Investigations Comparison with CT 19/11/2015: 10x10 cm collection in the right iliac fossa region. Thickening of the posterior ceacal wall which is highly concerning for neoplastic lesion. Two ill-defined hypodense lesion in the liver. These are too small to characterise however the differential diagnosis include metastasis. Ultrasound/MRI suggested for further evaluation. 13mm hypodense lesion in the left kidney. Follow up suggested. Operations/Procedures/Radiology CT-guided drain insertion Incision and drainage of appendiceal abscess: E coli and bacteriodes from wound culture Additional Information for GP Past Medical/Surgical History AF (apixaban) Stroke 2014 (right basal ganglia infarct) Hypercholesterolaemia Ex-smoker Changes to Medications - Start/Stop Start fortisip compact, pro-cal shots and forceval Clinical Information/Comments This Personal Information presented with abdominal pain and general malaise. Recently discharged following conservative treatment of perforated appendix. Is a/w Colonoscopy with Mr Gilpin as thickened caecum noted on previous CT. Commenced on antibiotics and analgesia. Underwent CT-guided drainage of appendiceal mass. Underwent incision and drainage of same. Seen by physio, OT and dietician. Reviewed by cardiology for AF. Currently bloods and symptoms improved. Obs stable. Surgically fit for discharge. Many thanks for continuing this patient's care. Did the patient receive a blood transfusion? No							
NIECR	18/12/2015			OPD letter surgical to GP	This Personal Information presented at the unit for review. He is presently systemically well and apyrexic. He has a history of open drainage of an appendix abscess on the 9 December 2015. On examination the wound site is healing satisfactorily the staples have been removed today from the main wound. No dehiscence of wound following removal of staples. There is no evidence of any surrounding overt erythema underlying collection or discharge. The wound has been redressed and we will review him again in the Surgical Assessment Unit on the 23 December 2015. Bloods for FBP, U&E and CRP have been sent off.							
NIECR	23/12/2015			SAU letter to GP	This Personal Information presented at the unit for review. He is presently systemically well, apyrexic and is feeling a lot better than before. His appetite is improving, bowels are moving, waterworks NAD. He has a history of appendix abscess with open drainage on the 9 December 2015. On examination the abdomen was soft and non-tender. RIF wounds are healing satisfactorily. Superior larger wound is healing well by primary intention. Infer lateral smaller wound shows some scant serous discharge but is otherwise healthy. The wound site has been redressed and he is to have regular dressings via the district nurse. He is presently awaiting a colonoscopy via the DPU. No further review has been planned in the Surgical Assessment Unit but if the need arises we shall be more than happy to see him again.							
ED record	30/01/2016	11:04			Self referral to ED @11:04							
ED record	30/01/2016	11:10		Triage	Wounds ? Infection Had appendectomy 6/52 ago drain in place prior pain and redness overnight lower abdomen Hand written note IVF 957/0(35 On amoxicillin form yesterday . ???red around old drain site BP137/71, RR16, temp 36 SaO2 97 A Pain score 6 65.5kg							
ED record	30/01/2016			Assessment	Appendectomy ?? RIF→???..... Tazocin 4.5g IV prescribed 14:15 administered 14:30							
Person Cenred Nursing Assessment and Plan of Care	30/01/2016				Admitted to FSW ward Pelvic abscess							
NICER	31/01/2016	09:00		CT Abdomen and pelvis with contrast	31/01/2016 12:11 CT Abdomen and pelvis with contrast The clinical history was noted. The history states the patient has had an appendicectomy. I see no evidence of appendicular histopathology in "lab centre". Please clarify clinical history. **Comparison** was made to the CT from 8 December 2015. There has been considerable reduction in the amount of abscess present in the right iliac fossa. A small right iliac fossa collection remained between the lateral aspect of the psoas muscle, anterior to the iliac muscle and extending to and involving the anterior abdominal wall with a low density tract seen extending to the skin. On maximal axial dimensions the liquefied portion of the intra-abdominal component to the abscess measures only 4.2 cm x 1.5 cm. This area was adjacent to an enlarged and abnormal looking appendix. Excess cecal pole mass was also present. Has the patient had a colonoscopy to exclude cecal pole mass? No small bowel dilatation. Elsewhere, the remainder of the abdominal findings were as described on the recent CT reports (particular reference was made to the CT report from the 2/12/15) . **Conclusion**. Ongoing right iliac fossa inflammatory abnormality with appendicitis. Overall there has been considerable reduction in size of the abscess when directly compared to initial CT scans. A small residual abscess communicating with the base of the appendix and extending laterally to the anterior abdominal wall with an associated entero-cutaneous fistula remained. Comment. At some stage colonoscopy of the cecal pole will be required in order to exclude cecal pole mass/tumour (if not already performed). Possible caecal pole mass may be contributing to the ongoing inflammatory process as the appendix does appear distended and may be obstructed at the base. A prominant ileocaecal valve area is considered and is possible but there is not much fat in this abnormal area. Please see selected images.Time Reported 31-Jan-2016 13:07							
Endoscopy day cae person centred nursing record	04/02/2016				Colonoscopy							
NIECR	04/02/2016				CLINICAL DETAILS Appendix/ caecal mass on CT. Biopsied irregular mucosa in caecum. Caecal pole biopsies PATHOLOGIST'S REPORT The specimen consists of multiple pieces of tissue processed in two cassettes (A & B) Histology show colonic mucosa with a villous architecture. There is a spectrum of low grade and high grade dysplasia. In one fragment dysplastic glands elicit a desmoplastic response and there is disruption of the muscularis mucosa and dysplastic glands adjacent to large sub-mucosal type blood vessels. A few small fragments of detached non-dysplastic mucosa are present. The appearances are those of an adenocarcinoma. There is a background of low and high grade dysplasia CAECAL MUCOUS MEMBRANE ADENOCARCINOMA Reported 12-Feb-2016 16:42							
NIECR	05/02/2016			Medical hand over	This man was admitted a couple of months ago with right iliac fossa pain and CT scan shows an appendix mass. It was initially treated conservatively. He then developed an appendix abscess which was drained percutaneously. Then he was taken to theatre for open drainage without an appendectomy. His sepsis settled after draining of the abscess and IV antibiotics. He was readmitted again last weekend with discharging sinus in his anterior abdominal wall and small abscess which was drained in theatre. He had a repeat CT scan which showed a small collection around his cecum and possible cecal lesion. I done a colonoscopy today down to his cecum and there is a small lesion in his cecal pole. This was biopsied today and he remains on IV antibiotics and we are awaiting results of his cecal biopsies. I have explained the likelihood of cecal carcinoma to him and his wife and he will need to be discussed at MDT.							

NIECR	07/02/2016			Medical Hospital Discharge letter	Initial Diagnosis Deep abdominal collection Method of Admission Emergency Patient Receiving Palliative Care? No Principle Discharge Diagnosis Discharging anterior abdominal wall sinus and small abscess Small collection at caecum and ?small lesion at caecal pole ?caecal malignancy Operations/Procedures/Radiology CT abdomen : Ongoing right iliac fossa inflammatory abnormality with appendicitis. Overall there has been considerable reduction in size of the abscess when directly compared to initial CT scans. A small residual abscess communicating with the base of the appendix and extending laterally to the anterior abdominal wall with an associated entero-cutaneous fistula remained. Possible caecal pole mass may be contributing to the ongoing inflammatory process as the appendix does appear distended and may be obstructed at the base. A prominant ileocaecal valve area is considered and is possible but there is not much fat in this abnormal area. Colonoscopy: diverticula around the sigmoid, caecal lesion, ?neoplastic ?inflammatory. Biopsies taken. Additional Information for GP Past Medical/Surgical History AF - on apixaban CVA Changes to Medications - Start/Stop No change Clinical Information/Comments This gentleman was recently discharged from Daisy Hill with abdominal pain. CT scan showed an appendix mass which was initially treated conservatively but later required drainage. He was readmitted with a three day history of exudate from his wound and feeling sweaty. He had no respiratory or urinary symptoms and his bowels were opening normally. On examination he was apyrexic, obs stable, abdomen soft and non-tender with a small superficial fluctuant swelling in the RIF with surrounding erythema. WCC 10 and CRP 56. Impression was of an abdominal abscess or collection. He was commenced on IV tazocin and gentamicin and the wound was opened and drained. A CT scan was carried out which showed a reduction in size of the collection, enlarged and abnormal appendix, caecal pole mass and entero-cutaneous fistula. An eakin bag was in place which drained serrous fluid. Colonscopy showed a caecal lesion which has been biopsied ?malignancy. Coloscopy findings have been discussed with the patient and family. For discussion at MDM next week.							
NIECR	07/02/2016			Consultant 4 to Consultant 3 referral	Many thanks for agreeing to see this Personal Information for consideration of right hemicolectomy as per the outcome of the MDT today. Personal as you know has caecal cancer proven on biopsy and on CT scan. He initially presented with an appendix abscess which was drained percutaneously back in December. This was followed by open drainage under general anaesthetic of the abscess as it had reoccurred. His op note states that his appendix was removed at the same time, but on checking his chart his appendix is still intact. I have contacted him today via the phone and explained to him the diagnosis and the fact that he will require a right hemicolectomy. He is on Apixaban for previous stroke and he will need to stop this prior to his surgery. I will leave that in your hands. Yours sincerely							
NIECR	07/02/2016			Consultant 4 to GP letter	Further to this gentleman's recent colonoscopy as an inpatient, caecal biopsies have confirmed the diagnosis of adenocarcinoma of the caecum. He was recently discussed at our colorectal MDT, and the plan is to proceed to a right hemicolectomy under Mr McKay. I have contacted the patient and informed him of the results of the biopsy and the outcome of the MDT discussion.							
NICER	11/02/2016	10:40		US Abdomen	11/02/2016 11:06 US Abdomen There are two small echogenic areas in the right lobe of liver which appear similar in size to previous CT (31/1/16). They measure 8.1mm and 8.2mm and are suggestive of haemangiomas. Due to patient history it is recommended to repeat scan of liver in 3 months to check for stability. Right kidney BPD measures 9.8 cm. There is a calculus in the upper pole and a cyst with fine septation in the lower pole(3.4cm) Left kidney BPD measures 10.5 cm. No hydronephrosis. The spleen is normal in size and texture. The pancreas is obscured with bowel gas. The aorta and IVC are normal in calibre. Time Reported 11-Feb-2016 11:13							
NIECR	18/02/2016			MDM Update:	Mr 1 Personal Information , h/o appendix abscess which was drained on 4/12/2015; 3 day h/o tenderness at drain site - noted to have small fluctuant abscess. This was incised and drained; however pus noted to be emerging through wound from deeper abscess. ?deeper collection. CT 31/01/16 Abd/Pel 31/01/16 - At some stage colonoscopy of the cecal pole will be required in order to exclude cecal pole mass/tumour (if not already performed). Possible caecal pole mass may be contributing to the ongoing inflammatory process as the appendix does appear distended and may be obstructed at the base. A prominant ileocaecal valve area is considered and is possible but there is not much fat in this abnormal area. Colonoscopy 04/02/16. Pathology - adenocarcinoma. Dear Dr XX On 18/02/2016. This patient was discussed at the Lower GI MDM @ The Southern Trust Consultant Surgeon Mr 2Yours sincerely, Discussed at Colorectal MDM 18/02/16. Patient to be referred to Mr 3 for surgery. If you have any queries or require further information, please do not hesitate to contact us.							
NIECR	29/02/2016			OPD letter consultant 3 to GP	I assessed Pers today. Pers has got a caecal cancer he unfortunately presented with perforation, either of the caecum itself or more likely a perforated obstructed appendix secondary to the tumour. He has had a difficult time with multiple trips in and out of hospital and his family were somewhat unhappy today with the care that he has received. In any case he has now been referred to the colorectal team. He requires a right hemicolectomy. He has not yet had a CT chest and we will book this for him a couple of weeks post-surgery given that he is for theatre on Wednesday. I have explained the risks and benefits of the procedure to him including the risks of infection, bleeding, DVT, PE, anastomotic leak rate, risk of mortality and so on. He is keen to proceed and we will admit him on Wednesday morning. He is off his Apixaban and we will restart it when it is safe post-operatively. He previously had a stroke but his exercise tolerance is excellent with approximately 3 miles he can walk at present. He is not diabetic and I hope he will do well.							
Medical notes	02/03/2017				Admitted for Right hemicolectomy							
NIECR	02/03/2017			Histology result	Final REPORT CLINICAL DETAILS Right hemicolectomy, perforated caecal cancer, extended resection - right hemicolectomy+abdominal wall+roof of abscess cavity. Macroscopic R0 PATHOLOGIST'S REPORT GROSS DESCRIPTION Specimen dissected by: Dr Karel Dedic Type of specimen: right hemicolectomy Site of tumour: caecum Length of specimen: terminal ileum 35 mm, caecum and ascending colon 150 mm Maximum tumour diameter: 35 mm Nature of tumour: Polypoid Tumour perforation: Yes - retroperitoneal Distance of tumour from nearest cut end: 50 mm from proximal limit HISTOLOGY Histological type: Adenocarcinoma Differentiation: Moderate Local invasion: pT4b (in colonic carcinoma, involvement of abdominal wall or adjacent loops of bowel equates to pT4b) Maximum distance of spread beyond muscularis propria: 4 mm Lymphovascular invasion: No Venous invasion: Extramural Lymph nodes: Number of lymph nodes identified = 20 Number infiltrated by tumour = 0 Apical node: Not involved Peritoneal involvement: None Proximal margin: Not involved Distal margin: Not involved Non-peritonealised circumferential margin: Not involved Histological measurement from tumour to non-peritonealised margin 5 mm pathology: None Pre-operative therapy given: Unknown Histologically confirmed metastatic disease: No Pathological staging: Dukes' B (growth beyond m. propria, nodes negative) pTNM staging: pT4bN0 Complete resection: Yes (R0) Mismatch repair IHC and KRAS: not performed; if required, couldbe performed on block C Diagnosis: Colon Adenocarcinoma lymph node negative for tumor cells							
NIECR	08/03/2016			Medical Hospital Discharge letter	Admission Reason Elective Admission for Right Hemicolectomy Patient Receiving Palliative Care? No Principle Discharge Diagnosis Caecal Adenocarcinoma Operations/Procedures/Radiology Right hemicolectomy Additional Information for GP Changes to Medications - Start/Stop as below Clinical Information/Comments Personal admitted for Right hemicolectomy following diagnosis of caecal adenocarcinoma. Well post op. On one occasion HR increased to 136. Treated with a stat of oral bisoprolol. Discussed with Cardiology. As HR usually 70-80 bpm, advised OP 24hour tape to assess whether or not rate control is suitable. Fit for discharge 08/03/2016.							
NIECR	09/03/2016			Letter from consultant 3 to patient	Your follow up CT chest has not shown any increase in the size of this little lung nodule, whch is good news, and means it is very unikely to be of any concern whatsoever. I will review you in outpatients.							
NIECR	10/03/2016			MDM Update:	Diagnosis: Carcinoma of caecum CONSULTANT: MR 3 Personal Information , h/o appendix abscess which was drained on 4/12/2015; 3 day h/o tenderness at drain site - noted to have small fluctuant abscess. This was incised and drained; however pus noted to be emerging through wound from deeper abscess. ?deeper collection. CT 31/01/16 Abd/Pel 31/01/16 - At some stage colonoscopy of the cecal pole will be required in order to exclude cecal pole mass/tumour (if not already performed). Possible caecal pole mass may be contributing to the ongoing inflammatory process as the appendix does appear distended and may be obstructed at the base. A prominant ileocaecal valve area is considered and is possible but there is not much fat in this abnormal area. Colonoscopy 04/02/16. Pathology - adenocarcinoma. Right Hemi 02/03/16. Pathology - adenocarcinoma, pT4b N0 R0, no LVI, Extramural Venous Invasion present, 0/20 nodes involved, Dukes B. MDM Update: Dear Dr On 10/03/2016. This patient was discussed at the Lower GI MDM @ The Southern Trust MDM Plan: Yours sincerely, Discussed at Colorectal MDM 10/03/16. Consultant to discuss chemotherapy with patient. If you have any queries or require further information, please do not hesitate to contact us.							
NICER	18/03/2016	13:45		CT Chest with contrast	18/03/2016 13:45CT chest with contrast. **Findings** Lung emphysema. 6mm pleural base triangular opacity seen in the right base laterally. Band opacity seen in the anterior segment of the right upper lobe. There is no hilar or mediastinal lymphadenopathy. Multiple thoracic vertebrae show slight anterior wedging. **Conclusion** No thoracic metastasis seen. Nonspecific small pleural based triangular opacity in the right base laterally. Follow up noncontrast CT of the chest in six months time suggested. Time Reported 20-Mar-2016 10:11							

NIECR	25/04/2016			Letter from consultant 3 to patient	I reviewed Pers today. He is keeping very well. He is getting back to pretty much all normal activities since his open right hemicolectomy for a T4b N0 adenocarcinoma of the caecum, which had previously locally perforated. He is still on iron tablets. I see his last haemoglobin is still on 95, so we have rechecked his full blood count and iron studies today, he certainly should continue on iron until these have improved. He is going to start playing golf again. There is no strong indication for adjuvant chemotherapy in his case and we will adopt a watchful waiting approach. I have checked his CEA today and we will see him again in four months' time							
	12/09/2016	13:30		CT Chest	12/09/2016 13:21 CT Chest CT chest without contrast. Comparison made with previous examination 18/03/2016. **Findings** The pleural based opacity in the right base laterally show no inerval increase in size. Time Reported 28-Sep-2016 20:02							
				OPD letter consultant 3 to GP	I reviewed Pers today. He is keeping really very well. He had a right hemi colectomy with abdominal wall resection of perforated caecal cancer in March of this year of this year. He has made a very good recovery. He is back playing gold. He does have a bit of a new facial twitch but I think he has been referred for a CT scan of brain and neurology opinion. From my point of view he is doing very well. I have booked a CT scan of his chest, abdomen and pelvis for follow up. I have also organised a follow up colonoscopy for him and checked his CEA today.							
	19/12/2016	10:00		CT Chest and abdo and pelvis with contrast	19/12/2016 10:05 CT Chest and abdo and pelvis with contrast **Indication**: Perforated caecal cancer operated in March 2016. Query metastasis. Technique: Arterial phase chest and portal venous phase abdomen pelvis volume scans with oral contrast. Comparison is made to the previous recent CT scans. **Findings**: The thoracic findings are stable with no convincing evidence of metastatic disease. A sub centimetre hypodensity inferiorly in the right lobe of the liver is also stable. Postinflammatory / surgical change in the right iliac fossa appears be resolving with no definite evidence of local recurrence. The right kidney has a 12 mm caliceal stone and an unchanged (4 cm diameter) slightly complex Bosniak class two cyst. A 10 mm low density lesion arising from the inter polar region of the left kidney has attenuation higher than a simple cyst, and although too small to accurately characterise is suggestive of at least a complex cyst and should be kept under surveillance with subsequent routine CTs. The adrenal glands, spleen and pancreas are unremarkable. The aorta has normal calibre, and there is no significant lymphadenopathy or destructive osseous lesion. **Conclusion**: No convincing evidence of disease recurrence. Time Reported 29-Dec-2016 18:13							
Endoscopy day care person centred nursing record	27/01/2017				Colonoscopy							
NIECR	22/05/2017			OPD letter consultant 3 to GP	I reviewed Pers today. He has been keeping well apart from some discomfort in the right iliac fossa. I had a look back at his CT scan that was performed earlier in December and just asked radiology to review the images from it to see if there was any concern. They certainly did not report any significant thickening of the anastomosis and he has had a subsequent colonoscopy to the anastomosis which was okay. I have rechecked his CEA today. We will wait until we hear back from radiology and if the CEA is raised we will rebook a quicker CT than we previously planned. Otherwise he himself looks well and is getting on with his life as normal. We will see how he gets on from here. Yours sincerely							

Southern Health and Social Care Trust

ACUTE DIRECTORATE

Process for the Reporting of Serious Adverse Incidents (SAI) & Reporting Early Alerts – June 2016 update

When a Serious Adverse Incident (SAI) occurs:

1. **The Staff member, on becoming aware of the incident, must telephone their Line Manager who will notify their Head of Service, Assistant Director and Acute Governance Coordinator.**
   The Staff member must also immediately complete a Trust Adverse Incident Reporting Form (IR1) online via Datix Web. [redacted]

*NB some incidents (e.g. high media profile incidents / homicide / inpatient suspected suicide etc. will require immediate meeting/conference call between AD/ Director/AMD/HoS/Governance Coordinator and subsequent contact with the Chief Executive's Office and Public Relations Department.

An adverse incident is defined as: "*Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation'*, arising during the course of the business of a HSC organisation / Special Agency or commissioned service: The following regional criteria will determine whether or not an incident constitutes an SAI. This list is not exhaustive: (if in doubt report!)

4.2.1. Serious injury to, or the unexpected/unexplained death of:
- a service user, (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)
- a staff member in the course of their work
- a member of the public whilst visiting a HSC facility;

4.2.2. Unexpected serious risk to a service user and/or staff member and/or member of the public;

4.2.3. Unexpected or significant threat to provide service and/or maintain business continuity;

4.2.4. Serious self-harm or serious assault (including attempted suicide, homicide and sexual assaults) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;

4.2.5. Serious self-harm or serious assault (including homicide and sexual assaults)
- on other service users,
- on staff or
- on members of the public

by a service user in the community who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) **and / or known to/referred** to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and / or learning disability services, in the 12 months prior to the incident;;

4.2.6. Suspected suicide of a service user who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) **and /or known to/referred** to mental health and related services (Including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident;

4.2.7. Serious incidents of public interest or concern relating to:
- any of the criteria above
- theft, fraud, information breaches or data losses
- a member of HSC staff or independent practitioner

CONTACT DETAILS:

Acute Governance Coordinator: Trudy Reid
Tel: [redacted] or [redacted]
E-mail: [redacted]

Connie Connolly: [redacted]

Medicine & Unscheduled Care:-
Anne McVey (Asst Dir): [redacted]

Heads of Service
(HoS) Mary Burke: [redacted]
(HoS) Kay Carroll: [redacted]
(HoS) Katriona McGoldrick: [redacted]
(HoS) Louise Devlin: [redacted]

Surgery & Elective Care and Anaesthetics Theatres Intensive Care Services
Ronan Carroll (Asst Dir): [redacted]

Heads of Service
(HoS) Martina Corrigan: [redacted]
(HoS) Amie Nelson: [redacted]
(HoS) Brigeen Kelly: [redacted]
HoS) Mary McGeough: [redacted]

Integrated Maternity & Womens Health and Cancer & Clinical Services:
Heather Trouton (Asst Dir): [redacted]

Heads of Service.
(HoS) Patricia McStay: [redacted]
(HoS) Brian Magee: [redacted]
(HoS) Fiona Reddick: [redacted]
(HoS) Jeanette Robinson: [redacted]

Function Services:
Anita Carroll (Asst Dir): [redacted]

Pharmacy:
Tracey Boyce (director of pharmacy: [redacted]

2. EARLY ALERT PROCESS:

The decision about activating the DHSSPSNI/HSC BOARD "Early Alert"(EA) process will be **taken solely by the Director / Assistant Director** (*following discussion with the Governance Coordinator and Head of Service) in order to ensure that DHSSPSNI and/or the HSC Board are notified as appropriate. (The purpose of the Early Alert System is to ensure that the Trust notifies DHSSPSNI and HSC Board in a **timely way** of any issues that may require the attention of the Minister or the Chief Officers.

Current Regional Early Alert criteria are:

1. **RISK & WIDER HSC:** Urgent regional action is required by the DHSSPS e.g. where risk identified that could impact on the wider HSC service or systems.

2. **TRUST NEED TO CONTACT PATIENTS/CLIENTS re HARM/POTENTIAL HARM:** The Trust is going to contact a number of patients or clients about harm or possible harm that has occurred as result of care they received.

3. **TRUST TO ISSUE PRESS RELEASE RE HARM/POTENTIAL HARM:** The Trust is going to issue a press release about harm or potential harm to patients or clients (may relate to one patient or client)

4. **MEDIA ENQUIRY ABOUT EVENT:** The media have enquired about the event

5. **PSNI INVOLVED IN INVESTIGATION OR DEATH/SERIOUS HARM:** The PSNI is involved in the investigation of a death or serious harm that has occurred in the HSC service (where there are concerns that a HSC service or practice issue whether by omission or commission may have contributed to or caused the death of a patient or client)

(this **does not include any deaths routinely referred to the Coroner** unless there has been an event which has given rise to a Coroner's investigation; or evidence comes to light during Coroner's investigation or inquest which suggests possible harm was caused to patient as result of treatment or care they received or the coroner's inquest is likely to attract media interest.)

6. **IMMEDIATE SUPENSION OF STAFF** There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.

7. **DEATH/SIGNIFICANT HARM – CHILDRENS SERVICES**
   a. Always notify the following
      - Death of or significant harm to a child, and abuse or neglect are known or suspected toe a factor;
      - Death of or significant harm to a Looked after Child or a child on the Child Protection Register;
      - Allegation that a child accommodated in a children's home has committed a serious offence;
      - Any serious complaint about a children's home or person working there.

3. ROLES & RESPONSIBILITIES

All Staff
Report the incident immediately & verbally to line management & also via Datix, after taking all immediate, appropriate, reasonable and proportionate actions to minimise the likelihood of the incident recurring. The situation must be made safe.

Assistant Director / Heads of Service via their Team Leaders / Ward & Facility Managers will ensure that:

- Ensure isolation & centralization of healthcare notes / all relevant documentation (if applicable). Original notes are to be sent to the Acute Governance Department, CAH.
- Where appropriate and where it would be beneficial to assist in the investigation of the incident, photographs should be taken and retained as evidence – this is particularly useful in Health and Safety type incidents or where damage had occurred to property
- CCTV footage should be sourced and a copy made for all cases which would be subject to PSNI investigation or where CCTV can assist with immediate review of events e.g. AWOLs etc.
- Security staff and/or the PSNI should be informed immediately, where appropriate. PSNI advice should be followed until directed otherwise by them e.g. where they advise to cordon off a specific area/room etc. Staff should document the content of conversations/interaction with PSNI.
- Consideration should be given to the need to activate site based emergency / contingency plans if necessary (in line with current emergency procedures).
- An immediate debrief is conducted and any staff support requirements are identified, offered and /or provided in a timely manner.(see Appendix 1)
- In liaison with the Governance Coordinator ensure that the SAI review is completed and a report is provided to the Director / Assistant Director for submitting to all relevant agencies where applicable e.g. RQIA/HSC Board/Coroner.
- Ensure that any SAI review action plan/recommendations are implemented & monitored and that any learning is disseminated appropriately. The HOS will provide regular updates to the relevant governance fora on the implementation of recommendations.

The Acute CSC Governance Office in liaison with the reporting staff member(s) / Head(s) of Service / Assistant Director / Director / AMD will:-

1. Notify Chief Executive's office and Communications Department *where appropriate.

2. Assist the Assistant Director / Director in reporting an Early Alert, if required.

3. Report the SAI to all relevant bodies within the required timescales via the Corporate Governance Office.

4. Coordinate **all stages** of the SAI review process including service user/family engagement and report compilation/submission process.

5. Maintain central coordination function between Acute and other departments/agencies e.g. Litigation Dept. (who process requests from coroner for statements/casenotes); Health & Safety Dept.; nominated PSNI liaison person etc.; HSCB/RQIA/DHSS. All communications with external agencies should be issued via the Governance Office.

6. Liaise with the Trust's Lead Social Worker for Adult Safeguarding, Professional Governance and external agencies where appropriate.

APPENDIX 1
ACUTE DIRECTORATE

Brief Guidance on supporting Acute staff during the respectful management and review of an adverse incident / serious adverse incident –

The Trust promotes an open, just, honest and participatory culture in which adverse incidents can be reported, discussed and reviewed without fear of reprisal. This enables lessons to be identified; allows for active learning to take place and the necessary changes made to improve our services and practices. A key part of that culture involves the need to respectfully support staff during the adverse incident management and investigation/review process.

Staff Support
Depending upon the nature and circumstances of an adverse incident the levels of support required by staff will vary. Such support can be provided by line managers in a number of ways, for example:

- Providing immediate assistance/aid if required.

- Contacting the relevant staff member(s) as soon as possible following the incident to discuss same.

- Facilitating an immediate informal and/or formal debrief of the staff / team involved in the incident allowing sufficient time to do so. This should include providing staff with the opportunity to discuss their involvement and/or the circumstances leading up to the incident and how they feel about it.

- Reaffirming confidence in staff and not apportioning blame or accountability either directly or inferred.

- Informing staff of the Directorate's processes in relation to incident investigation / review; keeping staff informed of likely next steps in that process; the rationale for same, and, informing staff of who they can contact for advice including the Acute Governance Office on Tel 028 3861 2932 who coordinate all serious adverse incident reviews. In some circumstances staff may be required to prepare a statement as part of the incident investigation/review data gathering process. Where this is the case support for development of such statements may be provided by the Acute Governance Office, the Trust Litigation Department, Trust Legal Advisors or via the appropriate professional bodies.

- Being visible to all staff members. Physical presence by line managers post-incidents helps decrease anxiety related to an investigation/review and provides an accessible resource for clarification of any issues staff may have.

- Providing information on the Trust and external support systems currently available for staff who may be distressed by incidents. This includes counselling services offered by professional bodies; stress management courses; Occupational Health Services, Carecall or Hospital Chaplains.

- For incidents involving Violence and Aggression, refer to the MOVA Guide to Post Incident Management Support, Reporting and Analysis (click here).

- Providing feedback to staff at the different stages of an investigation/review and in particular in relation to the outcome(s) of incident investigations / reviews and any lessons learned.

USEFUL CONTACT NUMBERS
In addition to contacts within your operational team:

Name - Role	Contact Details
Trudy Reid (Acute Clinical & Social Care Governance Coordinator)	Personal Information redacted by the USI or Tel: Personal Information redacted by the USI
Karen Wasson / Marian Fitzsimons (Litigation Department)	Personal Information redacted by the USI or Personal Information redacted by the USI or Tel Personal Information redacted by the USI
Carmel Harney (Assistant Director AHP Governance, Workforce Development & Training)	Personal Information redacted by the USI or Tel Personal Information redacted by the USI
Fiona Wright (Assistant Director for Nursing Governance)	Personal Information redacted by the USI or Tel Personal Information redacted by the USI
Lynn Fee (Assistant Director of Nursing Workforce Development & Training)	Personal Information redacted by the USI or Tel: Personal Information redacted by the USI
Ray King Head of Health & Safety SHSCT	Personal Information redacted by the USI
Victim Support Northern Ireland	028 9024 4039 or 0845 3030 900
Citizens Advice Bureau	028 9023 1120
Community Safety Unit	028 9082 8555
Care call	0808 800 0002
Samaritans	0845 790 9090
The Compensation Agency	028 9024 9944
Law Society of Northern Ireland	028 9023 1614
Trade Union Side Office, Newry	028 3083 5166
Catriona Campbell - Occupational Health –	Personal Information redacted by the USI
Management of Violence & Aggression (MOVA) Specialist Advisors for MHD - Eamonn Hughes / Margaret Tierney	Personal Information redacted by the USI
Anne Coyle – Bereavement Co-ordinator	Personal Information redacted by the USI or Personal Information redacted by the USI
Edel Corr – Quality & Patient Support manager	Personal Information redacted by the USI (Craigavon Hospital Office Tuesday – Friday) Personal Information redacted by the USI (Daisy Hill Hospital Office Mondays only)

APPENDIX 2
ACUTE DIRECTORATE

Brief Guidance on the Role and Responsibilities of an SAI Review Independent Chairperson -

The Acute Directorate will request the assistance the Medical Director to regionally request an independent chair for SAI review. The Chairperson leads an SAI review team. The Chairperson's main aim is to ensure that the SAI Review Team explores in an open, fair and critical manner the circumstances surrounding the incident, and establishes what, if any, lessons arising need to be incorporated into practice in order to prevent or minimise the likelihood of reoccurrence of the incident. The review should identify not only areas for improvement but also areas of good practice.

The main responsibilities of the review Chairperson are:

1.0 Prior to the Review:

1.1 liaising with the Acute Governance Coordinator to agree the SAI Review Team Membership ensuring that the process involves all relevant members of the MDT, staff who were involved in the incident, any member of staff with specialist knowledge considered appropriate and, where appropriate, involve services users/family members and other external agencies/stakeholders in the review process.

1.2 reviewing all relevant case notes, statements, synopsis of care reports and relevant sections of policies and procedures related to the incident.

2.0 During the Review

2.1 at the outset of the review explain the rationale for same including the requirement by Trusts to have in place systems/processes to review practice.

2.2 ensuring that all attendees at the review are introduced to each other and are aware of their role.

2.3 facilitating a process that is conducive to learning and analysis without interference from personal disagreements, criticisms, perceptions or dissatisfaction.

2.4 ensuring that the review is open, fair and participative and focuses on systems and processes rather than on a punitive approach aimed at individual performance.

2.5 ensure that participants in the review are supported / offered time-out as required / appropriate. The chair should also remind participants about further sources of support as needed, such as Care Call, Line managers etc. and reference/direct staff to the "*Acute Brief Guidance on supporting Acute staff during the respectful management and review of an adverse incident / serious adverse incident"* (see Appendix 1).

2.6 chairing the review in a manner which ensures that: all salient facts, a clear chronology of events and interventions, areas of strength/weakness of policy or practice are identified and clear action plans are formulated and agreed. Refer to the review meeting agenda template below (Appendix 3). and incident investigation guidance. (Appendix 4).

2.7 concluding the review meeting when all matters have been attended to and summarise the conclusions and recommendations (if any).

3.0 Following the Review:

3.1 liaising with the Governance Coordinator to ensure that a comprehensive report with recommendations / action points and timescales (where relevant) is produced and agreed ensuring that all relevant stakeholders are given an opportunity to check the information they have contributed to the report for factual accuracy. The Chairperson should sign off/approve the report prior to the report being sent to the AMD / Assistant Director / Director.

3.2 If there are queries / comments raised by the AMD / Assistant Director/ Director following their perusal of the draft report, the Chair should consider these and reconvene the review team if necessary to address same.

3.3 reporting practices, systems or other issues which the review team feel require immediate attention to the relevant Assistant Director, Head of Service and Associate Medical Director where appropriate. Chairs should also be mindful of their responsibility to report any serious concerns identified in relation to a doctor to the Trust Medical Director / Responsible Officer.

3.4 where required and when appropriate, meet with patients/relatives/carers to discuss the findings of the review team after approval by the Trust SMT and within the parameters of the Data Protection Act, supported by the Governance Coordinator and relevant senior operational staff.

The most important qualities of a good Chairperson are impartiality, firmness, tact, diligence, courtesy, patience and common sense.

APPENDIX 3

ACUTE DIRECTORATE

Suggested Format of Adverse & Serious Adverse Incident Review Meetings –

Note incident investigations may vary depending upon the type of incident and the degree of severity. Therefore this template may be adapted in order to suit both the specialist nature of the incident and the specific requirements of the Trust.

1. Introduction

Brief outline of the purpose of the review meeting.

2. Note of Methodology for Investigation

e.g. Review of patient / service user records (if relevant), Review of staff / witness statements (if available).

3. Analysis / Summary of Incident/Case

A summary of the incident including consequences. The following can provide a useful focus but please note this section is not solely a chronology of events:

- Brief factual description of the adverse incident
- People, equipment and circumstances involved
- Any intervention / immediate action taken to reduce consequences
- Chronology of events
- Relevant past history
- Outcome / consequences / action taken

OR

If Root Cause Analysis is Used:

i) Care Delivery Problems (CDP) *E.g. problem related to the direct provision of care, usually actions or omissions by staff e.g. failure to monitor, observe or act; incorrect decision, NOT seeking help when necessary.*

ii) Service Delivery Problems (SDP).*e.g. acts and omissions not associated with direct care provision. e.g. failure to undertake risk assessment, equipment failure, lack of guidance.*

ii) Contributory Factors for each CDP of SDP identified: e.g.: factors may include: Individual/Staff, Team and Social, Communication, Task, Education & Training, Equipment and Resource, Working Conditions, Organisational and Management, Patient / Client.

4. Conclusions

List of issues that need to be addressed (if required). Discussion of good practice identified. Where appropriate include details of any ongoing engagement / contact with family members or carers.

5. Recommendations

List of improvement strategies or recommendations for addressing the issues above (if required)

- Local recommendations
- Regional recommendations
- National recommendations

6. Learning

Identify to whom learning should be communicated.

Reference: HSC Regional Template and Guidance for Incident Investigation/Review Reports. DHSSPSNI. Sept. 2007

APPENDIX 4
ACUTE DIRECTORATE

Acute Brief Incident Investigation Guidance.

A key principle of the CSC governance framework is that incidents are investigated and analysed to find out what can be done to prevent their recurrence. Therefore, a key principle of the incident investigation process is that when an incident occurs the important issue is not 'who is to blame for the incident?' but 'how and why did it occur? Investigations need to be undertaken in a proportionate, non-threatening manner to identify the root causes of the event.

Although there will be some incidents which require investigation using methodologies as contained within e.g. individual agency reviews, adult safeguarding investigations, health & safety investigations, the majority of incidents can be reviewed using the National Patient Safety Agency (NPSA) root cause analysis tools. Nonetheless all incident investigations will ask the core questions of:

- What actually happened? (The facts)
- How did what happened vary from what should have or was expected to happen?
- Why did it happen in that way? (The causes)
- Is there any learning to share with the team or wider Trust services to minimise the likelihood of recurrence?

The above can be expanded to include where appropriate:

- Was there anything about the task/procedure involved?
- Was there anything about the way that the team works together or perceives each other's roles?
- Was there anything about the equipment involved?
- Was there anything related to the working environment or conditions of work?
- Was there anything about the training and education of the staff in relation to their competence to (a) provide the care/service required and (b) manage the incident when it occurred?
- Was there anything relating to communication systems between individual members of the team, departments, or electronic communications, for example, test results via computer?
- Was there anything about the availability, or quality of any guidance notes, polices or procedures?
- Was there anything about the Trust's strategy, its strategic objectives and priorities?

Further detailed advice in relation to incident investigation techniques including Root Cause Analysis (RCA) Methodologies can be sought from the Directorate Governance Office on Tel Personal Information redacted by the USI emailing Personal Information redacted by the USI or visiting the NPSA RCA toolkit resource here.

Stinson, Emma M

From: Reid, Trudy [redacted]
Sent: 29 June 2017 11:25
To: Carroll, Ronan
Subject: FW: Screening
Attachments: Time line [redacted].xlsx; Time line [redacted].xlsx; Time line [redacted].xlsx; Time line [redacted].xlsx; Time line [redacted].xlsx; Time line [redacted].xlsx; Time line [redacted].xlsx

Ronan just checking if you had a date for screening?

Regards,

Trudy

Trudy Reid
Acute Clinical and Social Care Governance Coordinator
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ
Telephone [redacted]
Mobile [redacted]

From: Reid, Trudy
Sent: 16 June 2017 10:31
To: Carroll, Ronan
Subject: FW: Screening

Ronan please see attached time lines for screening

SEC	[redacted]	CT showed PE not actioned
SEC	[redacted]	Delay in diagnosis and treatment of prostate cancer
sec	[redacted]	Delay in diagnosis and management of prostate cancer
SEC	[redacted]	Delay in diagnosis and treatment of prostate cancer
SEC	[redacted]	Delay in tumour management
SEC	[redacted]	Not preped for CT scan - aspirated
SEC	[redacted]	Not referred from urology MDM to endocrine

Regards,

Trudy

Trudy Reid
Acute Clinical and Social Care Governance Coordinator
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ
Telephone Personal Information redacted by the USI
Mobile Personal Information redacted by the USI

Patient 11

Data Source	Date	Time	Professional Group	Key Facts	Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
NICER	17/07/2016		GP	GP referral to urology	Reason for Referral/ History of Presenting Complaint Description: overactive bladder Comment: This Personal Information is having increased problems in recent months with storage and voiding LUTS. I have commenced him on Oxybutinon, but would value a full bladder assessment from the Continence Service in SWAH, whom he has attended in the past. Many thanks.		IEAP					
NICER	28/07/2016		GP	GP referral to urology	Reason for Referral/ History of Presenting Complaint Description: Elevated PSA. Comment: This Personal Information redacted by the USI has mixed symptoms of overactive bladder and prostatism. Recent MSU and urinalysis were normal, but PSA was 5.6. On examination he has a moderately enlarged smooth prostate. I have commenced him on Oxybutynin recently and he has felt some improvement in his LUTS. Please see and advise regarding further management of his elevated PSA. I have also referred this man to the Continence Service for bladder studies.		IEAP					
NICER	18/01/2017		Consultant Urologist	Letter to patient	Dear Patient 11 I am following up a referral your GP sent in July 2016. At the time of this referral your prostate blood test was elevated slightly above normal range. I would be grateful if you could arrange to have repeat of this blood test checked with your GP at your earliest convenience using the enclosed blood test request form. Once a result is available I will be making arrangements to review in clinic.							
NICER	21/01/2017 reported 27/01/2017			Histology report	REPORT CLINICAL_DETAILS Right colonic biopsies - diarrhoea PATHOLOGISTS_REPORT Sections of the 3 white tissue fragments received show normal colonic mucosa with no evidence of inflammation, dysplasia or malignancy. DIAGNOSIS: COLONIC MUCOSA NO PATHOLOGIC DIAGNOSIS							
NICER	20/02/2017		Consultant Urologist	Letter to GP	Diagnosis: Elevated PSA with LUTS Outcome: MRI prostate and TRUS biopsy Trial of Tamsulosin I reviewed Patient 11 today who has had a two year history of frequency of urination and some stinging inside which is relieved by urination. He also feels he has intermittent incomplete emptying. He previously had marked symptoms of urgency which have improved since starting Oxybutynin and this was on the background of having previous urodynamics several years ago that did describe an overactive bladder however I could not find these results today, this information was from the patient. He describes no haematuria but does have nocturia up to 6 times at night, some hesitancy and terminal dribbling. There is no history of incontinence. His weight is stable and his appetite is good. His PSA in July 2016 was 5.6 and January 2017 5.5 ng/ml. On PR examination the base was smooth but I was unable to access the top of the prostate. He underwent flow and post void residual today which showed a post void residual of 7mls and a maximum flow of 16.2mls. His urinalysis was negative. His kidneys were normal. His prostate was identified as having a volume of 31cc with some areas of focal calcification. In view of his elevated PSA and smaller prostate and evidence of calcification this gentleman would benefit from further investigation to rule out any malignancy of his prostate and in light of this I have arranged an MRI of his prostate then TRUS biopsies. I have given him a trial of Tamsulosin today to see if this will improve some of his symptoms and have suggested that should he not see symptom Patient 11							
NICER	20/02/2017		Consultant Urologist	Letter to Pt	Dear Patient 11 Further to your recent clinic attendance I have seen the result of your MRI scan. As you are aware this was performed to further assess the raised prostate blood test. The MRI scan does show a small area of abnormality in the left side of the prostate. I believe arrangements have been made for you to have biopsies of the prostate and this will include some additional biopsies of this area of abnormality on the left side.							
NICER	27/02/2017	16:10			MRI pelvis and prostate							

NICER	06/03/2017	09:21	Radiology	Urology MRI report	27/02/2017 17:10 MRI Pelvis prostate, Author: RRO, Regional Admin MRI PROSTATE CLINICAL HISTORY PSA 5.5. 30 cc. Calcification on ultrasound.? Prostatic malignancy FINDINGS Prostate volume 28 mL. There is an area of decreased T2 W signal in the left peripheral zone measuring 17 x 14 x 25 mm (PI-RADS 5). DWI is been degraded by the THRs. Normal seminal vesicles. No enlarged pelvic lymph nodes. Small focus of decreased T1 W signal in the left ilium of equivocal significance. No other bony lesions. CONCLUSION T2, N0, M0 left peripheral zone carcinoma. (Assumed ilial lesion to be benign but bone scintigraphy recommended). This report of an unexpected significant finding has been notified to the imaging department using the agreed protocol.							
	04/04/2017 reported 11/04/2017			Histology report	CLINICAL DETAILS Recent MRI - area of abnormality left side. PSA: 5.5. Prostate Vol: 27.8 cc. Specimen - Prostate. PATHOLOGIST'S REPORT GROSS DESCRIPTION NATURE OF SPECIMEN: Needle core biopsy SITE: 1. Right base - Three cores measuring 5 mm, 6 and 5 mm along with fragments. (Clinically two cores, on slides fragmented) SITE: 2. Right mid - Three cores easuring 17, 9 and 7 mm along with fragment. (Clinically two cores, on slides fragmented) SITE: 3. Right apex - Two cores measuring 16 and 15 mm. SITE: 4. Left base - Three cores measuring 19, 18 and 12 mm. SITE: 5. Left mid - Four cores measuring 16, 5, 12 and 7 mm alongwith fragment. (Clinically three cores on slides fragmented) SITE: 6. Left apex - Four cores measuring 10, 6, 9 and 4 mm along with fragment. (Clinically two cores on slides fragmented) HISTOLOGY HISTOLOGICAL TYPE: Adenocarcinoma DIFFERENTIATION/GLEASON SUM SCORE: Overall 3+3 = 6 NUMBER OF CORES/CHIPS INVOLVED: 7 of 19 Right base - No tumour identified. Right mid - No tumour identified. Right apex - No tumour identified. Left base - 3 of 3 cores, Gleason 3+3, 11.2 mm max length, 75-80% of tissue. Left mid - 3 of 4 cores, Gleason 3+3, 35-40% of tissue. Left apex -1 of 4 cores, Gleason 3+3, <5% of tissue. INVASION INTO: Seminal vesicle: No Extracapsular fat: No PERINEURAL INVASION: Yes LYMPHOVASCULAR INVASION: No FURTHER COMMENTS: Within 7 of the 19 prostatic core biopsies there are infiltrates of Gleason 3+3 adenocarcinoma. This occupies approximately 20% of the overall tissue examined. There is perineural invasion but no lymphovascular invasion of extracapsular extension. DIAGNOSIS: PROSTATE CORE BIOPSIES							
NICER	04/04/2017		Nurse specialist	Letter to GP	Patient 11 attended Thorndale Unit on 4th April. Written consent was obtained. Local anaesthetic inserted and following guidance from his recent MRI scan a total of 14 core biopsies of prostate were collected. Patient 11 found the procedure somewhat uncomfortable but recovered quickly when the probe was removed. He was provided with a 3 day course of prophylactic antibiotics and discharged home care of a family member. His histology results will be discussed at urology MDM and reviewed by Mr Haynes thereafter. Yours sincerely dictated but not signed							
NICER	04/04/2017			US Guided biopsy prostate transrectal	Report 04/04/2017 09:46 US Guided biopsy prostate transrectal, Author: Radiology, Admin This examination was performed by the Urologist. Please see patient notes.							
NICER	10/04/2017		Medical	SWAH discharge letter for admission 6/4/17 to 10/4/17	This Personal Information redacted by the USI was admitted with pyrexia following a recent prostate biopsy two days previous. He reported feeling generally unwell with aches as well as complaining of ongoing urinary frequency and hesitancy. Patient continued to spike temperatures while in hospital and blood cultures were taken. This gentleman was discussed with urology in CAH where he underwent the biopsy who advised starting Patient 11 on Ciprofloxacin and Gentamicin to which he responded well. CRP peaked at 221.1 but is now improving. Patient 11 feeling well, he is apyrexic and is surgically fit for discharge with further 7 days of oral Ciprofloxacin. Many thanks for your ongoing care of this gentleman.							

NICER	03/05/2017		Consultant Urologist	Letter to GP	Diagnosis: Low risk prostate cancer Outcome: Bone scan and subsequent outpatient review Patient 11 prostate biopsies have shown a gleason 3+3=6 prostate cancer. His presenting PSA is 5.5 and on MRI scan his local staging would be T2 N0. A bone scan has been arranged to complete his staging. I would anticipate this to be satisfactory given the low risk nature of his disease. His treatment options are either proceeding to treatment with curative intent with either radical surgery, external beam radiotherapy or brachytherapy or alternatively proceeding to active surveillance. He has been given written information regarding prostate cancer and information regarding each of these treatment options. I plan to review him in clinic after his bone scan to discuss these further. Yours sincerely							
NICER	18/05/2017	12:00 reported 18 :26	Radiology	NM bone whole body	Report 18/05/2017 16:14 NM Bone whole body, Author: Vallely, Stephen No evidence of bony metastatic disease. Bilateral hip replacements noted							

Received from Trudy Reid on 16/05/2023. Annotated by the Urology Services Inquiry.

Personal Information redacted by the USI

Data Source	Date	Time	Professional Group	Key Facts	Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
NICER	10/03/2016		Medical	Discharge letter post hip replacement	Principle Discharge Diagnosis :-Right total hip replacement. Operations/Procedures/Radiology -Right total hip replacement. Additional Information for GP -Past Medical/Surgical History -TIA, Heart failure, Cardiac valve: tricuspid valve repair, Left THR, Multiple gallstones, Pancreatitis, C5-C6 spondylotic myelopathy with nerve root entrapment, Left THR, Fibrotic lung disease Changes to Medications - Start/Stop Analgesia: PRN CLEXANE: FOR 5 WEEKS POST OP. SURGERY ON 24/2/2016. Furosemide: was held during admission as patient had AKI. This resolved and patients furosemide was restarted. **Clinical Information/Comments** Patient underwent Right total hip replacement under Mr Patton on 24/2/2016. Post operative instructions included: Routine observations, 24 Hours flucloxicillin, Clexane for 5 weeks, Mobilise Full weight bearing, Avoid Abduction exercises 6/52, Check XRays, AP pelvis and lateral hip, Review 6/52 OPD. Patient made good post operative progress with physiotherapy. During admission patients inguinal hernia became problematic, as patient found it slightly more difficult to reduce. An urgernt referral to Mr Hewitt Consultant general surgeon was sent to surgeons secretary. His discharge was delayed solely due to delays with implementing social input. Patient was deemed fit for discharge on 10/3/2016.						
NICER	23/06/2017			Referral from GP	Reason for Referral/ History of Presenting Complaint Description: gallstones Comment: Thank you for seeing this gentleman who had pancreatitis in 2013 as a result of gall stones. He was told at the time he would be reviewed in 3 mth but that has not yet happened. He had been well but recently he has had vomiting and nausea off and on since 5 days since ate cheese. no diarrhoea.bitter taste in mouth. His main concern is when he had pancreatits due to gall stones surgeon warned him about something leaking out and eroding stomach. I told him this happens in pancreatitis if bad but he no longer has pancreatitis. I am grateful for rv re gall stones.						
NICER	11/07/2016			Referral from GP	Reason for Referral/ History of Presenting Complaint Description: Vascular surgery Comment: severe v veins...has developed phlebitis on L side....previous bleeding DU on oral nsaids....topical nsaid given...referral for advice re ? further management of varicose veins Many thanks. Personal						
NICER	21/07/2016		Consultant	OP letter to GP	I assessed Personal today. He has had trouble in the past relating to his gallbladder and gallstone pancreatitis although he has a lot of medical co-morbidities. I note though recently that he has got a new iron deficiency anaemia and I think before we consider doing anything with his gallbladder that needs to be investigated. I have talked to him about an OGD and colonoscopy today which I think he is fit for and I have booked these procedures on a red flag basis.						
NICER	27/07/2016		Specialty doctor	Letter to Consultant	Personal is under investigation for microcytic anaemia. He underwent an OGD which demonstrated polyps within the stomach. There is no dysplasia or malignancy. The morphological features were non-diagnostic of the gastric polyps. Duodenal biopsies have shown no evidence of coeliac disease. Within the colon there is evidence of diverticulosis and also colonic polyps within the ascending colon. Biopsies of these have showed a tubular adenoma with low grade dysplasia. There is no obvious cause for his anaemia demonstrated on CT of his chest abdomen and pelvis performed. There were no malignant features within the scan however sub-segmental and segmental embolus seen in the right lung which will require further follow up. From a colonoscopy view he will require a repeat colonoscopy in 5 years' time due to the 2 polyps on the ascending colon. I will leave further follow up with						
NICER	02/08/2016	13:50	Consultant Surgeon		CT performed Chest and abdomen						
NICER	07/08/2016	08:09	Radiology	CT report	Requested by Consultant surgeon :- Clinical Info From Order Personal with iron def anaemia. OGD and colonoscopy no cause found. Diverticular disease. **02/08/2016 15:06** CT Chest and abdo and pelvis with contrast Hx: Fe def aenaemia. No cause on OGD and colonoscopy. **Technique:** Spiral imaging of the chest and abdo/pelvis **Findings:** Chest: No overt lymphadenopathy. Cardiomegaly. Midline sternotomy and tricuspid valve replacement. No pericardial effusion or central PE. However segmental PE is seen in the lat seg ML image 148 and posterobasal RLL image 187. Subsegmental embolus ML image 176. No pleural lesion or effusion. No central endobronchial lesion. The lungs show some mild reticulations, small airways changes and atelectatic bands without any significant nodule or mass to suggest malignancy. Triangular intrapulmonary node LLL image 175. Abdo/pelvis: No liver lesion. Small cysts noted. Gallstones no biliary dilatation. Unremarkable spleen, pancreas and adrenals. Renal cysts no mass or hydronephrosis. Pelvic viscera obscured by artefact. No bowel dilatation. No overt fat stranding. Paucity of fat limits assessment but reassuring results from endoscopies. L inguinal hernia containing sigmoid. Diverticulosis noted. No adenopathy, ascites or omental disease. Normal calibre aorta. Bilateral THRs. Spondylotic changes no overt destructive skeletal lesion. **Conclusion:** No malignant features within scan limits. However subsegmental and segmental emboli seen in the R lung. **Message to referring clinicians via medica.** Dr A Wallis Consultant Radiologist GMC 6102974 Medica Reporting Ltd	Audit trail of CT result Request date 27.7.16 Examination CT chest abdomen and pelvis – Red Flag Exam performed 2.8.16 Reported 7.8.16 by Medica Reporting Radiologist Reported communicated urgently emailed D McKay re urgent report on 08/08/2016 10:13 Ruth Gribben					
Email	08/08/2016			Audit trail	Reported communicated urgently emailed D McKay re urgent report on 08/08/2016						
NICER	30/08/2016				OP review by orthopaedics						
NICER	24/01/2017				RVH cardiology review						
NICER	24/02/2017				1 year review post hip surgery						

NICER	03/03/2017		ED consultant	chest Xray	03/03/2017 16:17 XR Chest, Author: RRO, Regional Admin X-RAY chest FINDINGS:CTR 160/325. Sternotomy sutures are in situ. No signs of heart failure or pleural effusion. Some shadowing in the right base extending down from the right hilum. It is most likely to be inflammatory. A followup chest x-ray after course of antibiotics is recommended in 4-6 weeks							
NICER	04/03/2017		Requested by Consultant physician reported radiology	CT result	04/03/2017 13:18 CT Angiogram pulmonary, Author: Johnston, Norlinda Technique: Enhanced volume scan of the chest as per CTPA protocol. Comparison study: CT chest dated 2 August 2016. Findings: Previous median sternotomy and tricuspid annuloplasty. No evidence of central or segmental pulmonary embolism. Two tiny filling defects are noted within the subsegmental left lower lobe pulmonary arteries (image 195) in keeping with a small volume pulmonary embolism. No pericardial effusion. The pleural spaces are clear. Dependent changes at the lung bases. No focal area of collapse or consolidation. No skeletal infiltration. Summary: Tiny subsegmental pulmonary embolism of the left lower lobe. No central PE.							
NICER	06/03/2017	13:45 performed reported 13:54		Discharge letter CAH	Admission Reason Increasing shortness of breath ?PE Patient Receiving Palliative Care? No Principle Discharge Diagnosis Pulmonary embolus Operations/Procedures/Radiology CTPA Additional Information for GP Past Medical/Surgical History Previus PE 2016, tricuspid valve repair 2013 (severe TR), pancreatitis, hernia repair, CCF, BPH, OA, R THR (2016), L THR (1997). iron deficinecy anaemia - polyps and diverticulosis on OGD Changes to Medications - Start/Stop Started Apixaban and Laxido Clinical Information/Comments This Personal Information was admitted with increasing shortness of breath over the past 3-4 weeks. Started on a course of Amoxicillin and Prednisolone by GP 1 week prior to admission. When there was no improvement, Furosemide was added. As still no imrpovement, Personal attended ED. Chronic dry cough. O/E bilateral ankle oedema Personal was initally treated with therapeutic Enoxaparin, IV fluids, and furosemide held. CTPA showed tiny subsegmental PE in left lower lobe. Started Apixaban during admission - initially 10 mg BD then switching to 5mg BD on 10/03/2017. Reviewed by the Medical Team today - Personal is feeling well, keen for home and up and mobilising freely. Observations remain stable and Personal is now medically fit for discharge home.							

Patient 14

Data Source	Date	Time	Professional Group	Key Facts	Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
NICER	03/06/2016		GP	GP referral	Reason for Referral/ History of Presenting Complaint Description: Raised PSA Comment: Many thanks for seeing this patient - Small rise in PSA noted on routine testing earlier in year - had returned to Normal on repeat testing but mot recent test raised again (5.63) . Few LUTS and nil overt on clinical examination . Please see and advise regards further investigation .		IEAP					
NICER	07/02/2017		Consultant urologist	letter to pt	Dear Patient 14 I am writing to you with the results of your recent MRI. I am pleased to say there are no significant abnormalities of your prostate. There are however some changes within a small area of the prostate so we cannot completely exclude a tumour. Given that your PSA remains raised for your age I would like to offer you a prostate biopsy that is performed under local anaesthetic in the Thorndale outpatients. I will arrange for you to have biopsies and you will be sent an appointment in due course, however if you don't wish to proceed with biopsies at the present time or wish to discuss this further we would be more than happy to hear from you. If you have any queries please contact us on the number above, otherwise I will see you with your biopsy results							
NICER	07/02/2017		Consultant urologist	letter toGP	Thank you for referring this Personal Information redacted by the USI who has a raised PSA of 5.63. Prior to that it had been 4.4 and 5.5. On questioning Patient 14 reports no troublesome lower urinary tract symptoms. He has some occasional hesitancy however he is very happy with his waterworks at present. On examination his abdomen was soft and non-tender and he has a non-palpable bladder. The area revealed moderately enlarged and generally firm but benign feeling prostate. Given that it has been 8 months since his last PSA I have repeated this today at clinic. If it remains elevated or has risen further I will proceed with an MRI of his prostate as he has no contra-indications to this. If however his PSA remains stable I think it is reasonable to continue with 6 monthly surveillance PSA. I will be in touch with his results when they are available. Yours sincerelyThank you for referring this Personal Information redacted by the USI who has a raised PSA of 5.63. Prior to that it had been 4.4 and 5.5. On questioning Patient 14 reports no troublesome lower urinary tract symptoms. He has some occasional hesitancy however he is very happy with his waterworks at present.							
NICER	07/02/2017		Consultant urologist	letter to pt	Dear Patient 14 I am writing to inform you of your latest PSA prostate blood test result. Your PSA has dropped slightly to 5.5 from 5.6 last year. Overall this is reassuring. Given that it remains slightly elevated for your age I will proceed with booking an MRI scan of your prostate as discussed at clinic. You will receive an appointment in due course.							
NICER	24/02/2017	08:20			MRI Pelvis prostate							
NICER	06/03/2017	19:21	Radiology	MRI report	Report 24/02/2017 09:05 MRI Pelvis prostate, Author: Williams, Marc Prostate volume of 37cc. There is a small volume of reduced T2 and ADC signal change related to the posterolateral peripheral zone of the left apex to mid gland. No overt restricted diffusion. The appearances are therefore of equivocal significance and may represent a small focus of tumour. Extension to but not definitively beyond the prostatic capsule. Non specific minor reduced T2 and ADC signal changes within the posterolateral and peripheral zones of both sides of the mid gland to base. Within the limitations of transition zone assessment, no definite transition zone tumour is identified. The seminal vesicles appear unremarkable.5mm utricular cyst. No pelvic lymphadenopathy. Probable degenerative change at L5/S1. An 11mm low T1 signal focus within the right femoral neck is not thought to be significant. CONCLUSION: There is no definite radiological evidence of significant prostate tumour. A small volume of signal change within the posterolateral peripheral zone of the left apex to mid gland is regarded as suspicious. Mild signal change elsewhere within the peripheral zone as described is equivocal. If biopsies are being considered, you may wish to consider additional biopsies of the left apex to mid gland peripheral zone. If tumour should be present, the appearances are thought to represent organ confined disease.							
NICER	28/03/2017			US Guided biopsy prostate transrectal	Report Final 28/03/2017 10:36 US Guided biopsy prostate transrectal, Author: Newell, Denise This examination was performed by the Urologist. Please see patient notes.							
NICER	28/03/2017		Nurse specialist	letter toGP	Patient 14 attended Thorndale Unit today. Written consent was obtained, local anaesthetic inserted and following guidance from his recent MRI scan a total of 15 core biopsies of prostate were obtained. He was provided with a 3 day course of prophylactic antibiotics and discharged home care of a family member. His histology results will be discussed at the urology MDM and he will be reviewed by Mr O'Donoghue thereafter.							

NICER	28/03/2017 reported 5/4/2017			Histology report	CLINICAL DETAILS Recent MRI. SPECIMEN - Prostate. PATHOLOGIST'S REPORT GROSS DESCRIPTION : NATURE OF SPECIMEN: needle core biopsy. SITE: 1. Right base - 2 cores and fragments the longest measuring 18 mm. SITE: 2. Right mid - 2 cores the longest measuring 20 mm. SITE: 3. Right apex - 4 cores the longest measuring 8 mm. SITE: 4. Left base - 2 cores the longest measuring 16 mm. SITE: 5. Left mid - 4 cores the longest measuring 20 mm. SITE: 6. Left apex - 3 cores the longest measuring 19 mm. HISTOLOGY HISTOLOGICAL TYPE: Adenocarcinoma. DIFFERENTIATION/GLEASON SUM SCORE: 3+3=6 NUMBER OF CORES/CHIPS INVOLVED: Right base - Not involved. Right mid -Not involved. Right apex - 1 of 2 cores involved. Gleason 3+3. 40% tissue. Left base - 2 of 2 cores involved. Gleason 3+3. 50% tissue. 6.5mm max length Left mid - 1 of 4 cores. Gleason 3+3. 1% tissue Left apex - 3 of 3 cores involved. Gleason 3+3. 20% tissue. INVASION INTO: Seminal vesicle: No. Extracapsular fat: No. PERINEURAL INVASION: No. LYMPHOVASCULAR INVASION: No. Prostatic adenocarcinoma of overall Gleason sum score 3 + 3 = 6 is present in 7 of 17 cores with a maximum tumour length of 6.5 mm. The tumour occupies approximately 15% of the total tissue volume. DIAGNOSIS PROSTATE NEEDLE CORE BIOPSY ADENOCARCINOMA						
NICER	06/04/2017		Chair MDM	MDM letter to GP	This patient was discussed at the Urology MDM @ The Southern Trust On 06/04/2017. Diagnosis: Prostate cancer Gleason Score 3 + 3 MDM Update: CONSULTANT MR O'DONOGHUE: This Personal Information redacted by the USI who has a raised PSA of 5.63ng/ml. Prior to that it had been 4.4ng/ml and 5.5ng/ml. He reports no troublesome lower urinary tract symptoms, he has some occasional hesitancy. The area revealed moderately enlarged and generally firm but benign feeling prostate. MRI, 24.02.17 - There is no definite radiological evidence of significant prostate tumour. A small volume of signal change within the posterolateral peripheral zone of the left apex to mid gland is regarded as suspicious. Transrectal prostatic biopsy, 28.03.17 - Prostatic adenocarcinoma of Gleason score 3 + 3 = 6, is present in 7 of 17 cores with a maximum tumour length of 6.5mm. The tumour occupies approximately 15% of the total tissue volume. MDM Plan: Discussed at Urology MDM 06.04.17, Patient 14 has low risk, organ confined prostate cancer. For review with Mr O'Donoghue to discuss all treatment options. Signee: If you have any queries or require further information, please do not hesitate to contact us.						
NICER	19/04/2017		Consultant urologist	letter toGP	This gentleman as you know recently had prostate biopsies for a PSA of 5.63ng/ml. The histology has come back showing adenocarcinoma of the prostate Gleason score 3+3=6 in 7 of 17 cores. The tumour occupied approximately 15% of the total tissue. His MRI showed no definite radiological evidence of a significant prostate tumour. There was a small volume of signal change within the posterolateral peripheral zone of the left apex to mid-gland which was regarded as suspicious. As per MDT I have went through the various options for treatment with this low risk organ confined prostate cancer with Patient 14. We discussed radical radiotherapy, radical surgery and active surveillance and he wishes to pursue a period of active surveillance. I will see him in 4 months' time with a PSA 1 week beforehand and in 1 years' time I will re-biopsy his prostate. Yours sincerely						

Patient 12

Data Source	Date	Time	Professional Group	Key Facts	Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
NICER	08/09/2016		GP	Referral to urology	Reason for Referral/ History of Presenting Complaint Description: lower urinary tract symptoms and elevated PSA. Comment: Dear Urologist Please may I have your advice on this Personal Information redacted by the USI with lower urinary tract symptoms and elevated PSA. This man has previously been reviewed in regards to an elevated PSA. He complains of increasing lower urinary tract symptoms of frequency and nocturia. He denies any haematuria or dysuria. He decided to stop his combodart due to erectile dysfunction. He denies any erectile dysfunction while taking Contiflo. His PSA has had a slow general increase over the last number of years and is now 7.34. I would appreciate your opinion on biopsy of his prostate.		IEAP					
NICER	30/01/2017		GP	Referral to urology	Reason for Referral/ History of Presenting Complaint Description: elevated PSA Comment: Please find attached my previous referral in regards to this Personal Information redacted by the USI. I have repeated his PSA at a reasonable interval and it has elevated to 9.43. I would appreciate it if you could upgrade his referral to red flag.		IEAP					
NICER	06/02/2017		LAT3 in Urology	Letter to GP	Diagnosis: Raised PSA Plan: MRI prostate Thank you for referring this Personal Information redacted by the USI who has a rising PSA. Over the last 12 months it has gone from 7.3 to 6.9 and subsequently 9.43 in January 2017. I note that he has had previous investigations including a TRUS biopsy in 2008 which was benign. He reports some urgency and occasional dribbling but is not overly troubled with his lower urinary tract symptoms. He has had no haematuria, UTIs or weight loss. Of note he had previously been on Combodart however he discontinued this due to erectile dysfunction. He is now only on Contiflo. On examination this gentleman has a moderately enlarged but benign feeling prostate. There is a nodule present just left of the midline however I note that this was present in 2007 as documented in an outpatient letter at that time. I have discussed the options with Patient 12 and we have agreed to proceed with an MRI of his prostate. If this shows any abnormalities we will carry out a TRUS biopsy. I will be in touch with the result of his scan in due course.							
NICER	14/02/2017				MRI performed							
NICER	01/03/2017			MRI report	14/02/2017 09:42 MRI Pelvis prostate, Author: RRO, Regional Admin. MRI prostate Oncology report CLINICAL HISTORY Rising PSA 9.4 from 6.9 last year, left lobe nodule on rectal examination FINDINGS Prostate volume 60 mL. There is a 1 cm nodule seen in the left posterior peripheral zone bulge in the capsule, with restricted diffusion (PIRADS 5) and also a possible lesion seen in the right anterior lobe and some PIRADS 3 changes in the right peripheral zone posteriorly. The seminal vesicles collapsed but grossly normal. Normal visualised rectum and bladder. No significantly enlarged lymph nodes or bony deposit in the pelvis CONCLUSION If biopsy-proven, at most, T3a N0, MX							
NICER	07/03/2017		Consultant Urologist	Letter to Pt	Dear Patient 12 I am writing to you with results of your recent MRI. The scan has detected some changes within your prostate which require further investigation. As we discussed at clinic, the next step is to perform a biopsy of the prostate. This can be performed under local anaesthetic at our outpatient unit. I will arrange this and will be in touch with appointment details in the near future.							

NICER	11/04/2017			Histology report	REPORT CLINICAL DETAILS Total cores taken 14. ?? abnormality left mid - base on MRI. PSA 9.43 ng/ml. Prostate volume 31.8. Medication Combodart. SPECIMEN - Prostate. PATHOLOGIST'S REPORT GROSS DESCRIPTION NATURE OF SPECIMEN: Needle core biopsy SITE: 1. Right base - 2 cores measuring 15 and 6 mm along with fragment. SITE: 2. Right mid - 2 ragged cores measuring 14 and 13 mm. SITE: 3. Right apex - 1 core measuring 14 mm. SITE: 4. Left base - 2 ragged cores measuring 18 and 12 mm. SITE: 5. Left mid - 6 cores measuring 11, 10, 14, 12, 5 and 3 mm along with fragments. SITE: 6. Left apex - 1 core measuring 10 mm along with fragment. HISTOLOGY HISTOLOGICAL TYPE: Adenocarcinoma OVERALL GLEASON SUM SCORE: 3+4 = 7 (Grade Group 2) NUMBER OF CORES INVOLVED: 8 of 14 Right base - No tumour identified. Right mid - 2 of 2 cores, Gleason 3+3, < 5% of tissue. Right apex - No tumour identified. Left base - No tumour identified. Left mid - 6 of 6 cores, Gleason 3+4, 6.3 mm max length, 20-25% of tissue. Left apex - No tumour identified. INVASION INTO: Seminal vesicle: No Extracapsular fat: No PERINEURAL INVASION: No LYMPHOVASCULAR INVASION: No FURTHER COMMENTS: The macroscopically described 2 cores within the block 5C got fragmented into 5 small bits, two of which show neoplastic glands. It is difficult to be certain but would be best regarded as 2 of 2 cores involved. Within 8 of the 14 prostatic core biopsies there are infiltrates of Gleason 3+3 and 3+4 adenocarcinoma. This occupies approximately 5% of the overall examined material. There is no perineural invasion, lymphovascular invasion or extracapsular extension. Selected slides (5B, 5C) were discussed with Dr G McClean. DIAGNOSIS PROSTATE CORE BIOPSIES ADENOCARCINOMA				
NICER	20/04/2017		Chair of MDM	MDM meeting letter to GP	This patient was discussed at the Urology MDM @ The Southern Trust On 20/04/2017. Diagnosis: Prostate cancer Gleason Score 3 + 4 MDM Update: CONSULTANT MR HAYNES: This Personal Information redacted by the USI has had a rising PSA it had gone from 7.3ng/ml to 6.9ng/ml and subsequently 9.43ng/ml in January 2017. He has had previous investigations including a TRUS biopsy in 2008 which was benign. He reports some urgency and occasional dribbling but is not overly troubled with his lower urinary tract symptoms. On examination he has a moderately enlarged but benign feeling prostate. MRI, 14.02.17 - If biopsy-proven, at most, T3a N0, MX Transrectal prostatic biopsy, 11.04.17 - Adenocarcinoma, Gleason 3+4 = 7. Number of cores involved - 8 of 14. MDM Plan: Discussed at Urology MDM 20.04.17. Patient 12 has high risk prostate cancer. He should be seen in clinic and have a discussion with regard to curative treatment. Signee: If you have any queries or require further information, please do not hesitate to contact us.				
NICER	03/05/2017		Consultant Urologist	Letter to GP	Diagnosis: High risk non metastatic prostate cancer Outcome: Commence Bicalutamide 50mgs once a day, 28 day course Please commence Decapeptyl 11.25mg first dose to be given week commencing 15th May and continued every 12 weeks thereafter Isotope bone scan Refer to Oncology for consideration of radiotherapy in addition to androgen deprivation Patient 12 prostate biopsies have confirmed a high risk prostate cancer and radiologically on his MRI this would appear to be stage T3a with no nodal metastases. Given this the recommended treatment would be hormones and radiotherapy. I have outlined this to him. He does require a bone scan to complete his staging which I have arranged. I have commenced him on his Bicalutamide today and would be grateful if you could arrange his Decapeptyl as above. I have referred him to my Oncology colleagues				

Patient 137

Data Source	Date	Time	Professional Group	Key Facts	Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
NIECR	20/12/2016			CT Chest and abdo and pelvis with contrast	20/12/2016 11:28 CT Chest and abdo and pelvis with contrast At the posterior aspect of the RUL, there is a 42 x 21 x 21 mm irregular soft tissue abnormality with an air bronchogram, adjacent to the oblique fissure present. Minimal linear atelectasis in the right base and mild bilateral basal hypoventilation atelectatic changes. Several accentuated subcarinal lymph nodes measuring up to 12 mm. Normal both kidneys with mildly accentuated collecting system (likely of no clinical significance). In the left perirenal space, anterior to the upper pole of the kidney, there is a large (78 x 68 x 72 mm) well defined fatty tumour with some soft tissue component, abutting mildly thickened adrenal. Enlarged prostate. Normal liver, bile ducts, pancreas, right adrenal, spleen and urinary bladder. No sinister process of the imaged skeleton. Partial lumbarisation of S1. Two small sclerotic lesions within the L3 vertebral body (bony islands?). A small T12 vertebral body haemangioma. **Conclusion:** Right upper lobe pulmonary abnormality suggesting a dense consolidation. Please correlate with clinical features. Follow-up recommended. A large fatty tumour in the left perirenal space which may be in keeping with an angiomyolipoma with extrarenal growth. Differential diagnosis should include liposarcoma, adrenal teratoma or adrenal myelolipoma. Specialist referral is advised. Time Reported 20-Dec-2016 15:42							
NIECR	21/12/2016			Letter from respiratory physician to GP	Diagnosis: 1. Right upper lobe community acquired pneumonia. - CT chest 20/12/16, right upper lobe consolidation. 2. Left perirenal mass. - CT chest abdomen 20/12/16, large fatty tumour (78 mm) left perirenal space. 3. Left hydrocele repair 2012. 4. Hypertension. 5. Recurrent episodes of hiccups. Comment: This Personal Information redacted by the USI was reviewed at the Respiratory Clinic today following his recent discharge from hospital. His CT imaging is as detailed above. I reviewed the patient's CT imaging with Dr Clarke, Consultant Radiologist today. The left perirenal mass differential diagnosis includes an adrenal myelolipoma, atypical lipoma or a liposarcoma. Action: 1. I have explained the CT results and further management plan to the patient. 2. I would be grateful if you could provide this patient with 7 days of Amoxicillin and Clarithromycin as per handwritten note and telephone call to your surgery today. 3. Red flag referral to Urology Team, Craigavon Area Hospital has been arranged. 4. Repeat chest x-ray has been booked for 6 weeks' time. 5. No review is planned at the Respiratory Clinic.							
NIECR	21/12/2016			Red flag referral from respiratory physician to Urologist	I would be grateful for your urgent assessment of this Personal Information redacted by the USI who has been found to have a 78 mm left perirenal mass. Please find a copy of the most recent correspondence attached. Thank you for your help.							
NIECR	23/12/2016			MDT letter to chair of MDT from Consultant Urologist 2	We have received communication from the chest physician colleagues in the Erne re this Personal Information redacted by the USI [redacted] with pneumonia, but has had an incidental finding of a mass lesion in the left perirenal area. I don't think that this is renal in origin; I would agree with their sentiments that this could either be of adrenal origin, I suspect it would be difficult to biopsy. I would be grateful if his films could be reviewed. This would probably be beneficial before speaking to [redacted] Patient 137 himself							
NIECR	12/05/2017			GP letter	Reason for Referral/ History of Presenting Complaint Description: L renal mass Comment: Patient 137 has never had an appointment re this matter-- ? has referral been made and what are the ry arrangements							
NIECR	18/05/2017			OPD letter to GP from Consultant	Many thanks for your letter Patient 137 . Unfortunately it would appear that the referral to the Endocrine Team has not happened. I have done a referral which is attached and I would anticipate Patient 137 will hear from the Endocrine Team in due course.							
NIECR	18/05/2017			OPD letter to Endocrine consultant from Urology Consultant	I would be grateful if you could arrange for review of Patient 137 's imaging and clinical review with yourself. He was referred following a CT scan which was performed in December 2016 following an admission under the care of the General Physicians in South West Acute Hospital. Incidentally the CT scan showed an abnormality in the left peri-renal space. This was reviewed at the Urology MDM in Craigavon Hospital on 12th January where it was felt to represent an adrenal abnormality and referral to yourself was recommended. Unfortunately this referral does not appear to have occurred and a new letter was sent by [redacted] Patient 137 's GP today. The view of the Urology MDT was given that it would appear to be an adrenal abnormality and further management would be appropriate under your care. I would be grateful if you could arrange for review of your imaging at MDT and subsequent clinic review with yourself regarding further managem							

Personal Information redacted by the USI

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ED record	30/04/2017	14:06		Arrival at ED	Arrived ED by ambulance - alone							
ED record	30/04/2017	14:06	Nursing Hannah Donnelly	Triage	Shortness of Breath adults New abnormal pulse SOBAR today, denies CP feels otherwise well Pulse 109 BP 92/55, RR 28 temp 36.7 SaO2 94 Location resus							
ED record	30/04/2017	OA	Medical Gilbert Rice	Assessment	Personal Information generally unwell x2 episode vomit yesterday SOB, Øpyrexia, Ø cough BO 1/7 ago Sister stated vomiting ++ for 1/52 mild cognitive impairment 2o to stroke **PMH** DM type 2 ↑chol prev ICH HTN O/E HS 1+11+0 calves SNT Chest ↓A/E L base. Abdomen distended ++ non tender BS↓ Na 126, K5.7 Cl78, ur 14.4,cr 178 eGFR 25 (41) trop 43 (29) LFT N, wcc 14.3 CRP 39.3							
ED record	30/04/2017			Diagnosis	1. Acute Bowel obstruction 2. Hyperkalaemia 3. AKI							
NIECR	30/04/2017	15:42		Abdominal X-ray	30/04/2017 16:21 XR Abdomen, Author: McReynolds, Andrew There is marked dilatation of multiple small and large bowel loops. The colon appears oedematous and there is subtle intramural pneumatosis in the ascending colon. I note the subsequent CT report. AMcR/PFR							
NIECR	30/04/2017	15:42		Chest X-ray	30/04/2017 16:21 XR Chest, Author: Fourways, 4W Admin Radiology Report Date: 08/06/2017 19:10 Date: 30 April 2017 Examination: Chest x-ray Technique: AP Clinical Indications: Query bowel obstruction or lung lesion Findings: The heart size is normal both lungs are of normal volume. There is minimal subsegmental collapse at the left base but there is no free air under the hemidiaphragms to suggest perforation. There is no focal consolidation or collapse. No change is seen compared to previous films of February 2017.							
ED record	30/04/2017	16:00			Referred to surgical team							
ED record	30/04/2017		Nursing Hannah Donnelly		Prioritised in resus							
ED record					CXR→consolidation L Base AXR → Large dilated bowel loop							
NIECR		17:37		CT abdomen	NB! This is a change of a previously given preliminary report 30/04/2017 17:57 CT Abdomen and pelvis, Author: Hutchinson, Christopher Subsequently contrast was administered per rectum in an attempt to delineate the possible calibre change further. There is a 40mm long apple core tumour present in the recto sigmoid region. This is causing almost complete obstruction however a small amount of contrast has passed beyond it. No significant local or regional lymphadenopathy has been identified. Again pneumatosis intestinalis is present in the ascending and transverse colon. There is no evidence of portal venous gas. **Conclusions:** Obstructing lesion in the recto sigmoid region has appearances highly suspicious for malignancy. I am now informed the patient has had previous pelvic radiotherapy. A stricture secondary to this is possible but thought less likely given the degree of shouldering of the lesion. The continued lack of portal venous gas leads me to suspect that the pneumatosis intestinal is is secondary to obstruction rather than ischaemia. **Findings discussed directly with the referring team Reported on call by C Hutchinson St5** 30/04/2017 17:57 CT Abdomen and pelvis, Author: Hutchinson, Christopher **Indication:** Personal Information redacted by the USI with PMHx traumatic brain injury. A/w 1/52 intermittent vomiting, 1/7 of acute abdo distension and 1/7 no BO. On presentation to ED hypotensive, abdomen tense and distended. lactate 13.2. WCC 14, CRP 40 **Technique:** Due to renal function, non contrast CT abdomen and pelvis. **Findings**: The large bowel is distended and filled with fluid and faeces until an abrupt calibre change in the recto sigmoid region. This is adjacent to the suture material from the frevious hysterectomy. The is significant pneumatosis in the ascending and transverse colon to the splenic flexure. There is no portal venous gas. Being non contrast, it has not been possible to assess the mesenteric arteries. There is some calcification of the aorta but non of the mesenteric vessels. The small bowel and stomach is distended and fluid filled. Within the limitations of this non contrast study, there is no significant abnormality of the liver, pancreas spleen or adrenals. Gallstones noted. There is no free fluid or gas.							
ED record		19:30	J Anderson		Urinary catheter inserted aseptically							
ED record		18:45	E Jones		Attended for CT abdo. Placed in 4 North but returned to Resus after scan ABG repeated							
NIECR		19:37			Clinical Info From Order 1/7 distended abdomen + No BO. Vomitting 1/52. Lactate 13. CTAP - distended LB loops ?adhesional LBO ?pseudoobstruction Time Reported 04-May-2017 10:31							
ED record		20:10	E Jones		For further CT scan with contrast. Surgical Dr to acompany. Not for wrd until result of scan as may need to go to theatre							
ED record					Admit to ward - Theatre							
ED record				Discharge obs	P 120, BP 121/56, resp 18, tmp 36, SPO2 99% intubated							

ED record		22:10			Left department							
ED record continuation		22:10	E Jones		Retrospective note Pt brought to CT scan for further CT abdo with rectal contrast. Accompaied by surgical Dr IV access tissued on route to scan. IV fluids stopped. When on scanner pt had rectal catheter inserted and Dr began to give contract. Monitored throughout. Obs stable. Shortly after contract started pt began to vomit profusely. Suctioned while on scanner, became very cyanosed. O2 therapy applied. Assisted airway. Colour remained poor and became more unresponsive crash team called as peri arrest call. Anaesthetic team also contacated. NG tube inserted and pt intubated and ventilated. Proceeded with CT scan as planned. Taken to theatre to await report may need laparotomy tonight. Surgical reg spoke with sister and updated her. Family decided to go home phone numbers given. I will hand over to theatre staff to update family as and when needed							
Medical notes		22:15	I Soric Surgical reg		Pt waas taken to CT ???rectal contrast. Vomited during the procedure and became very hypoxic and unresponsive. Anaesthetic team got involved. Pt was intubated in CT. CT verbal report→Stricturing lesion upper rectum- most likely neoplastic →large bowel obstruction D/W with sister Personal Information redacted by the USI the situation. Explained the situation deteriorated dramatically and our expectations are very guarded. Personal Information redacted by the USI aware very understanding and they saw a decline in Personal Informati condition over latst 2/52 and news was not entirely unexpected to them. Explained that after conversation with consultant on call Mr Hewitt and anaesthetic team we feel the best next step is surgery to remove the obstructed large bowel. Personal Information redacted by the USI agreed with the plan and totally understood that Perso nal may not survive the operation or immediate postoperative period. Family ???? to be informed of further changed in Personal condition							
Southern Trust Acute Surgical Admission			HO/Soric		**Presenting Complaint** Abdominal distension **History of presenting complaint** Vague historian. Patient states that she had an episode of collapse yesterday Sister states patient had been vomiting for 1/52 Last BO yest. Abdomen ↑distension over 1/7 Denise any abdo pain **Past medical/surgical history** TBI →SAH 1997 T2BM, HTN, Endometrial CA - TAH 2006 **Abdomina**l Grossly distended & tense. Non peritonitis **Bloods** HB 127, WBC 14.3, PLT 639, CRP 39, NA 126, K 5.7, CL 78, Urea 14.4, Creat 128, eGFR 25 TP 69, ALb 43, Bili 13.2, ALP 83, AST 22, ALT 20 GGT 33 **Imaging** CTAP dilated LB ? pneumatosis ? adhesions LBO ? pseudo-obstruction **Problem list/differentials** Adhesional LBO vs pseudo-obstruction AKI **Management plan** Resuscitation Gastrografin n enema with CTAP →if contrast pass throught →conservative management v caecum flex sig →if blockage of contradt → ? laparotomy Waiting **Senior Review** Personal Information redacted by the USI . Very unwell. Abod distension ? large bowel obstruction on CT ? pneumatosis caecum and ascending colon D/W Mr Hewitt →suggested to do a CT with Gastrografin enema to confirm the presentation of large bowel obstruction. Mr Hewitt happy with the plan							
Southern Trust Acute Surgical Admission			Anaesthetist		Neurological Diwson, Moore, ST anaes 2116 30/4/17 Fast asleep to CT @20:44 on immediate arrival A -? copious vomit B -SpO2 ~60%/cyanosed partially obstructed RR ~18 C -P144 no BP possible no IV access D -AV P U Actions 10 Access tibia (2 failed ???in side) M'son C NGT - 500mls drained RSI ??50 ? ROC 100mg McGrath CT pass 7.5 coexPropofol 100mls/hr 16# ESR Handed over to the night team and D?W R McKee							
Medical notes			CT 2		Written in retrospect Patient transferred to CT scanner by myself, ED nurse and porter at 20:20. Stable pre-transfer, normotensive, communicative X comfortable. Platient lay on right lateral position for insertionof catheter PR & contract injection. During instillation of PR contract patient aspirated with acute destauration. Mouth suction but unable to protect the airway. Cardiac arrest team & anaesthetics fast bleeped to CT scanner. Patient cnscious throughout with no loss of output. NG inserted by SPR Soric. 10 access obtained. Patient intubated via RSI, Following discussion between surgical & anaesthetic team, dicision made to perform CT scan as anaesthetic team in attendance. CT scan R/V by SpR Soric & D/W on call radiologist & Mr Hewitt. Given CT findings, blood results & patients clinical stable, decision made to perform laparotomy. Anaesthetic team in agreement. Family informed of events							
Operative notes			Soric & Crawford		Midline laparotomy **Finding**- Grossly distended large bowel. Impeding perforation caecum and transverse colon. Obstructing lesion upper rectum ……..							
NIECR	Personal Information			Chest X-ray	Date: 1 May 2017 Examination: Chest x-ray Technique: AP Clinical Indications: Query line placement query pneumothorax query aspiration **Findings:** The heart size is within normal limits. The ET tube and right internal jugular line are in a good position with no pneumothorax. There is marked consolidation within the right lung compatible with infection. These changes have markedly worsened compared to 30 April 2017.							
NIECR	Personal Information			Letter to GP	I regret to inform you of the death of Personal Information redacted . She attended Craigavon ED on 30/4/17 with vomiting and abdominal distension. CT showed bowel. obstruction due to a rectosigmoid tumour and she proceeded to laparotomy for a subtotal colectomy. She was transferred to ICU post-op and had high inotrope and ventilator requirements. She also had haemodialysis. However, despite maximal treatment, she continued to deteriorate. After discussions with her family, care was withdrawn on the afternoon of Personal Information she passed away peacefully at 15:50. Her MCCD was completed as follows: 1) a) Multi-organ failure b) Small bowel obstruction c) Recto-sigmoid tumour 2) Chronic Kidney disease, Diabetes Mellitus							

Personal Information redacted by the USI

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ED record	19/11/2015	11:23			Presented to ED with GP letter							
ED record	19/11/2015	11:24		Triage	Abdominal pain in adults Mod pain Abdo pain for 4/7 no D/V treated fro UTI HX kidney stones BP 137/89 RR18 temp 36 SaO2 97 ALert Pain score 6							
ED record	19/11/2015	11:30	Doctor 1	Assessment	Personal HX pain RIF Gradual onset. Constant pain worse on movement 6/10 severity. Associated anorexia. No nausea/vomiting . Sweating at night no temps. No bowel movement from Sunday until this morning - usually regular. No urinary symptoms O?E Pt looks well RR 18, SpO2 97%RA Temp 36.0 BP 137/89 HR 90 HS 1+11+0 Chest clear CRP 324, WCC 15.6 neut 84.4 PLT 341 Amylase 36 LFTs N U&E N RIF tenderness with guarding fullness R side Plan AXR, urinalysis Bloods							
NIECR	19/11/2015	12:46		XR Abdomen	No abnormal bowel dilatation seen. Calcific opacity seen in the right lumbar region. Degenerative changes seen in the spine. Vascular calcification noted. Time Reported 20-Nov-2015 10:18							
NIECR	19/11/2015	16:00		CT Abdomen and pelvis with contrast	Technique: Volume scan of the abdomen and pelvis following IV and oral contrast. **Findings:** A tubular structure exits the posterior aspect of the caecum, believed to represent a retrocaecal appendix. This is significantly enlarged with a maximum axial diameter of approximately 1.7 cm and it displays mural thickening and hyperenhancement. A small bleb of extraluminal gas is noted posterior to the appendix and there is a focal collection of fluid measuring approximately 5 cm in maximum axial diameter adjacent to this. Inflammatory stranding and subcentimeter lymphadenopathy is present in the surrounding fat of the right iliac fossa. Overall appearances are thought to represent acute retrocaecal appendicitis with localised perforation and formation of a focal fluid collection. The collection is thin walled but displays some peripheral rim enhancement. Of note, there is soft tissue thickening present at the base of the appendix/tip of the caecum. Further assessment is advised in this area. Scattered diverticula are noted throughout the entire colon. Within the limitations of an unenhanced study, the small and large bowel are otherwise unremarkable. No other intraperitoneal air or fluid. Two sub centimetre foci of ill-defined low attenuation are present within the right lobe of liver. These are essentially too small to categorise accurately. No other significant liver pathology demonstrated. A cortical cyst is present within the lower pole of each kidney, larger on the right side than the left. Both display foci of peripheral calcification and will require follow-up. A 1 cm calculus is present in the upper pole of the right kidney. The kidneys are otherwise unremarkable. The gallbladder, pancreas, spleen and adrenal glands are normal. Calcified mesenteric abdominal lymph nodes are present which may represent previous granulomatous disease. The visualised lung bases are clear. Degenerative changes are present in the visualised thoracolumbar spine. Lucent lesions within the L2-L5 vertebral bodies are fat attenuation and are most likely to represent incidental haemangiomas. **Conclusion: 1.** Appearances in the right iliac fossa are thought to represent an acute retrocaecal appendicitis with localised perforation and formation of a focal fluid collection. The collection is thin walled but diplays peripheral enhancement. Soft tissue thickening is present at the base of the appendix/tip of the caecum and evaluation of this region is advised in due course to exclude other pathology. **2.** Sub-centimetre foci of low attenuation in the right lobe of liver are essentially too small to characterise. A 3 month interval US scan is advised to ensure no progression. In the presence of a known sinister pathology these might be viewed with more suspicion and MRI should then be considered. **3.** Bilateral renal cysts which display peripheral calcification and require follow-up. A repeat CT of kidneys is advised in 1 year. **4**. Other incidental findings as discussed. Result discussed with surgical registrar on call at time of report. Time Reported 20-Nov-2015 10:18							
ED record	19/11/2015	16:00			Discharge observations P 86 HR 153/74, resp 18, temp 37.8 SpO2 96% GCS 15/15 Left dept at 15:05 to ward							
Person Cenred Nursing Assessment and Plan of Care	19/11/2015				Admitted to MSW Abdominal Pain							
NIECR	27/11/2015			Medical Hospital Discharge letter	RIF pain Initial Diagnosis ?appendicitis ?walled-off appendix ?malignancy Method of Admission Emergency Patient Receiving Palliative Care? No Principle Discharge Diagnosis Perforated appendix - conservatively managed Investigations Bloods on admission: Hb 129, WCC 15.6, Plt 9.8, Na 137, K 4.9, Urea 9, Creat 100, eGFR >60. CRP 324. LFTs normal. Amylase 36. Urine MSSU - no growth (16/11/15) ECG - AF with old RBBB Echo - sinus rhythm. LVF is low normal with EF approx 55%. Mild bi-latrial dilation. Mild aortic valve stenosis. AVA 1.9m2 Operations/Procedures/Radiology CT A/P - acute retrocaecal appendicitis with localised perforation and formation of a fluid collection. Collection thin walled with peripheral enhancement. Soft tissue thickening at base of appendix/tip of caecum. Evaluation of this region advised to exclude other pathology. Suc-centimetre foci of low attentuation in right lobe of liver too small to characterise. 3 month interval US scan advised to ensure no progression. Additional Information for GP Past Medical/Surgical History CVA Drinks alcohol socially - 1 glass wine per day Non smoker. Walks 6 miles/week. Changes to Medications - Start/Stop To complete a total of 14 days of antibiotics Started on Apixaban for AF Clinical Information/Comments Personal . Presented to ED with RIF pain. No other symptoms. 1/52 hx of pain on the right side. Pain unchanged during that week. No urinary symptoms. Last BO the same morning of presentation. No diarrhoea, no PR bleeding. No weight loss. No temperatures. OE, fullness and tenderness in RIF. No guarding. BS present. Patient was admitted for CT abdomen, kept fasting, given IV fluids. CT AP performed. CT findings - as above. Decision made to treat conservatively with antibiotics. Inflammatory markers continued to improve during treatment with antibiotics. During admission, new onset AF discovered on ECG. Patient asymptomatic of same. Impression was of AF secondary to sepsis. Reviewed by medical team - echo performed (result as above), advised to treat AF with apixaban due to CHADS score of 4 (for age and hx of CVA). Clinical impression on 27/11/2015 was that Pers was improving and fit for discharge with completion of a 14 day course of antibiotics (switched to co-amoxiclav). Had 9 days IV Abx. He is for repeat CT in 3/52. Colonoscopy in 8-10/52. To attend SAU level 3 DHH on Monday 7th Dec at 10am for repeat routine bloods. He is to be given the telephone number of Mr Gilpin's secretary in case of problems and has been strongly advised to seek medical advice should he feel unwell. Did the patient receive a blood transfusion? No							
Person Cenred Nursing Assessment and Plan of Care	01/12/2015				Patient had appointment at SAU today. Was admitted to ward query appendix abscess/mass							
NIECR	02/12/2015	16:15		CT Abdomen and pelvis	CT abdomen and pelvis performed following oral and intravenous contrast. Comparison made with previous CT scan examination of 19/11/2015. **Findings** 10x10 x 5.5 cm collection seen in the right iliac fossa. The posterior wall of the cecum is markedly thick walled. Two illdefined hypodense lesion seen in the segment V of the liver meauring upto 8.8mm. Gallbladder, spleen and pancreas appear normal. 8.3 mm calculus seen in the right kidney with no obstructive changes. 4.3 cm cyst also seen in the right kidney anteriorly. 13 mm hypodense lesions seen in the left kidney. Normal urinary bladder. Atherosclerotic calcification of the aorta and its branches seen. Degenerative changes are seen in the spine. There is suggestion of haemangioma in L3 vertebral body. **Conclusion** 10x10 cm collection in the right iliac fossa region. Thickening of the posterior ceacal wall which is highly concerning for neoplastic lesion. Two ill-defined hypodense lesion in the liver. These are too small to characterise however the differential diagnosis include metastasis. Ultrasound/MRI suggested for further evaluation. 13mm hypodense lesion in the left kidney. Follow up suggested. Time Reported 03-Dec-2015 10:18							

NIECR	04/12/2015	11:00		CT Guided drainage abdomen	04/12/2015 14:23 CT Guided drainage abdomen Procedure: Written informed consent obtained. Using CT guidance and aseptic technique a 12-French pigtail catheter was positioned within the previously described right-sided collection. Sample provided for microbiology. No immediate complication. The patient was returned to the ward for post procedural observations.Time reported 04-Dec-2015 15:18							
NIECR	04/12/2015			Medical hand over	Admitted recently with acute appendicitis and a mass. He was already on Plavix at that time so was treated conservatively. He was readmitted with further sepsis. CT scan confirms an abscess which is for radiological drainage today. The CT scan also suggests that there may be an underlying lower pole caecal carcinoma.							
NIECR	08/12/2015	10:11		CT Abdomen and pelvis	08/12/2015 11:14 CT Abdomen and pelvis Comparison made with previous examinations. **Findings** Mild right-sided pleural effusion with posterior basal consolidation. The collection in the right iliac fossa now measure 9.5x9.7x 6.2 cm and show septation/loculation. The drain tube is in the superolateral part of the collection. Rest of the abdominal findings reported on the previous examinations are unchanged. Time Reported 09-Dec-2015 08:54							
Medical notes	09/12/2015				Open drainage of appendix abscess							
Medical notes	10/12/2015			Ward round	Day 1 post I+D Δ appendix abcess NEWS 2 score on O2 Patient off 02 currently, pain improved from yesterday BO Plan Dietician, Bloods Switch to antibiotics- septrin + metronidazole							
NIECR	16/12/2015			Medical Hospital Discharge letter	Patient's Description of Their Complaint Abdominal pain Initial Diagnosis Appendiceal mass Method of Admission Emergency Patient Receiving Palliative Care? No Principle Discharge Diagnosis Appendiceal abscess Investigations Comparison with CT 19/11/2015: 10x10 cm collection in the right iliac fossa region. Thickening of the posterior ceacal wall which is highly concerning for neoplastic lesion. Two ill-defined hypodense lesion in the liver. These are too small to characterise however the differential diagnosis include metastasis. Ultrasound/MRI suggested for further evaluation. 13mm hypodense lesion in the left kidney. Follow up suggested. Operations/Procedures/Radiology CT-guided drain insertion Incision and drainage of appendiceal abscess: E coli and bacteriodes from wound culture Additional Information for GP Past Medical/Surgical History AF (apixaban) Stroke 2014 (right basal ganglia infarct) Hypercholesterolaemia Ex-smoker Changes to Medications - Start/Stop Start fortisip compact, pro-cal shots and forceval Clinical Information/Comments This Personal Information presented with abdominal pain and general malaise. Recently discharged following conservative treatment of perforated appendix. Is a/w Colonoscopy with Mr Gilpin as thickened caecum noted on previous CT. Commenced on antibiotics and analgesia. Underwent CT-guided drainage of appendiceal mass. Underwent incision and drainage of same. Seen by physio, OT and dietician. Reviewed by cardiology for AF. Currently bloods and symptoms improved. Obs stable. Surgically fit for discharge. Many thanks for continuing this patient's care. Did the patient receive a blood transfusion? No							
NIECR	18/12/2015			OPD letter surgical to GP	This Personal Information presented at the unit for review. He is presently systemically well and apyrexic. He has a history of open drainage of an appendix abscess on the 9 December 2015. On examination the wound site is healing satisfactorily the staples have been removed today from the main wound. No dehiscence of wound following removal of staples. There is no evidence of any surrounding overt erythema underlying collection or discharge. The wound has been redressed and we will review him again in the Surgical Assessment Unit on the 23 December 2015. Bloods for FBP, U&E and CRP have been sent off.							
NIECR	23/12/2015			SAU letter to GP	This Personal Information presented at the unit for review. He is presently systemically well, apyrexic and is feeling a lot better than before. His appetite is improving, bowels are moving, waterworks NAD. He has a history of appendix abscess with open drainage on the 9 December 2015. On examination the abdomen was soft and non-tender. RIF wounds are healing satisfactorily. Superior larger wound is healing well by primary intention. Infer lateral smaller wound shows some scant serous discharge but is otherwise healthy. The wound site has been redressed and he is to have regular dressings via the district nurse. He is presently awaiting a colonoscopy via the DPU. No further review has been planned in the Surgical Assessment Unit but if the need arises we shall be more than happy to see him again.							
ED record	30/01/2016	11:04			Self referral to ED @11:04							
ED record	30/01/2016	11:10		Triage	Wounds ? Infection Had appendectomy 6/52 ago drain in place prior pain and redness overnight lower abdomen Hand written note IVF 957/0(35 On amoxicillin form yesterday . ???red around old drain site BP137/71, RR16, temp 36 SaO2 97 A Pain score 6 65.5kg							
ED record	30/01/2016			Assessment	Appendectomy ?? RIF→???..... Tazocin 4.5g IV prescribed 14:15 administered 14:30							
Person Cenred Nursing Assessment and Plan of Care	30/01/2016				Admitted to FSW ward Pelvic abscess							
NICER	31/01/2016	09:00		CT Abdomen and pelvis with contrast	31/01/2016 12:11 CT Abdomen and pelvis with contrast The clinical history was noted. The history states the patient has had an appendicectomy. I see no evidence of appendicular histopathology in "lab centre". Please clarify clinical history. **Comparison** was made to the CT from 8 December 2015. There has been considerable reduction in the amount of abscess present in the right iliac fossa. A small right iliac fossa collection remained between the lateral aspect of the psoas muscle, anterior to the iliac muscle and extending to and involving the anterior abdominal wall with a low density tract seen extending to the skin. On maximal axial dimensions the liquefied portion of the intra-abdominal component to the abscess measures only 4.2 cm x 1.5 cm. This area was adjacent to an enlarged and abnormal looking appendix. Excess cecal pole mass was also present. Has the patient had a colonoscopy to exclude cecal pole mass? No small bowel dilatation. Elsewhere, the remainder of the abdominal findings were as described on the recent CT reports (particular reference was made to the CT report from the 2/12/15) . **Conclusion**. Ongoing right iliac fossa inflammatory abnormality with appendicitis. Overall there has been considerable reduction in size of the abscess when directly compared to initial CT scans. A small residual abscess communicating with the base of the appendix and extending laterally to the anterior abdominal wall with an associated entero-cutaneous fistula remained. Comment. At some stage colonoscopy of the cecal pole will be required in order to exclude cecal pole mass/tumour (if not already performed). Possible caecal pole mass may be contributing to the ongoing inflammatory process as the appendix does appear distended and may be obstructed at the base. A prominant ileocaecal valve area is considered and is possible but there is not much fat in this abnormal area. Please see selected images.Time Reported 31-Jan-2016 13:07							
Endoscopy day cae person centred nursing record	04/02/2016				Colonoscopy							
NIECR	04/02/2016				CLINICAL DETAILS Appendix/ caecal mass on CT. Biopsied irregular mucosa in caecum. Caecal pole biopsies PATHOLOGIST'S REPORT The specimen consists of multiple pieces of tissue processed in two cassettes (A & B) Histology show colonic mucosa with a villous architecture. There is a spectrum of low grade and high grade dysplasia. In one fragment dysplastic glands elicit a desmoplastic response and there is disruption of the muscularis mucosa and dysplastic glands adjacent to large sub-mucosal type blood vessels. A few small fragments of detached non-dysplastic mucosa are present. The appearances are those of an adenocarcinoma. There is a background of low and high grade dysplasia CAECAL MUCOUS MEMBRANE ADENOCARCINOMA Reported 12-Feb-2016 16:42							
NIECR	05/02/2016			Medical hand over	This man was admitted a couple of months ago with right iliac fossa pain and CT scan shows an appendix mass. It was initially treated conservatively. He then developed an appendix abscess which was drained percutaneously. Then he was taken to theatre for open drainage without an appendectomy. His sepsis settled after draining of the abscess and IV antibiotics. He was readmitted again last weekend with discharging sinus in his anterior abdominal wall and small abscess which was drained in theatre. He had a repeat CT scan which showed a small collection around his cecum and possible cecal lesion. I done a colonoscopy today down to his cecum and there is a small lesion in his cecal pole. This was biopsied today and he remains on IV antibiotics and we are awaiting results of his cecal biopsies. I have explained the likelihood of cecal carcinoma to him and his wife and he will need to be discussed at MDT.							

NIECR	07/02/2016			Medical Hospital Discharge letter	Initial Diagnosis Deep abdominal collection Method of Admission Emergency Patient Receiving Palliative Care? No Principle Discharge Diagnosis Discharging anterior abdominal wall sinus and small abscess Small collection at caecum and ?small lesion at caecal pole ?caecal malignancy Operations/Procedures/Radiology CT abdomen : Ongoing right iliac fossa inflammatory abnormality with appendicitis. Overall there has been considerable reduction in size of the abscess when directly compared to initial CT scans. A small residual abscess communicating with the base of the appendix and extending laterally to the anterior abdominal wall with an associated entero-cutaneous fistula remained. Possible caecal pole mass may be contributing to the ongoing inflammatory process as the appendix does appear distended and may be obstructed at the base. A prominant ileocaecal valve area is considered and is possible but there is not much fat in this abnormal area. Colonoscopy: diverticula around the sigmoid, caecal lesion, ?neoplastic ?inflammatory. Biopsies taken. Additional Information for GP Past Medical/Surgical History AF - on apixaban CVA Changes to Medications - Start/Stop No change Clinical Information/Comments This gentleman was recently discharged from Daisy Hill with abdominal pain. CT scan showed an appendix mass which was initially treated conservatively but later required drainage. He was readmitted with a three day history of exudate from his wound and feeling sweaty. He had no respiratory or urinary symptoms and his bowels were opening normally. On examination he was apyrexic, obs stable, abdomen soft and non-tender with a small superficial fluctuant swelling in the RIF with surrounding erythema. WCC 10 and CRP 56. Impression was of an abdominal abscess or collection. He was commenced on IV tazocin and gentamicin and the wound was opened and drained. A CT scan was carried out which showed a reduction in size of the collection, enlarged and abnormal appendix, caecal pole mass and entero-cutaneous fistula. An eakin bag was in place which drained serrous fluid. Colonscopy showed a caecal lesion which has been biopsied ?malignancy. Coloscopy findings have been discussed with the patient and family. For discussion at MDM next week.							
NIECR	07/02/2016			Consultant 4 to Consultant 3 referral	Many thanks for agreeing to see this Personal Information for consideration of right hemicolectomy as per the outcome of the MDT today. Personal as you know has caecal cancer proven on biopsy and on CT scan. He initially presented with an appendix abscess which was drained percutaneously back in December. This was followed by open drainage under general anaesthetic of the abscess as it had reoccurred. His op note states that his appendix was removed at the same time, but on checking his chart his appendix is still intact. I have contacted him today via the phone and explained to him the diagnosis and the fact that he will require a right hemicolectomy. He is on Apixaban for previous stroke and he will need to stop this prior to his surgery. I will leave that in your hands. Yours sincerely							
NIECR	07/02/2016			Consultant 4 to GP letter	Further to this gentleman's recent colonoscopy as an inpatient, caecal biopsies have confirmed the diagnosis of adenocarcinoma of the caecum. He was recently discussed at our colorectal MDT, and the plan is to proceed to a right hemicolectomy under Mr McKay. I have contacted the patient and informed him of the results of the biopsy and the outcome of the MDT discussion.							
NICER	11/02/2016	10:40		US Abdomen	11/02/2016 11:06 US Abdomen There are two small echogenic areas in the right lobe of liver which appear similar in size to previous CT (31/1/16). They measure 8.1mm and 8.2mm and are suggestive of haemangiomas. Due to patient history it is recommended to repeat scan of liver in 3 months to check for stability. Right kidney BPD measures 9.8 cm. There is a calculus in the upper pole and a cyst with fine septation in the lower pole(3.4cm) Left kidney BPD measures 10.5 cm. No hydronephrosis. The spleen is normal in size and texture. The pancreas is obscured with bowel gas. The aorta and IVC are normal in calibre. Time Reported 11-Feb-2016 11:13							
NIECR	18/02/2016			MDM Update:	Mr 1 Personal Information , h/o appendix abscess which was drained on 4/12/2015; 3 day h/o tenderness at drain site - noted to have small fluctuant abscess. This was incised and drained; however pus noted to be emerging through wound from deeper abscess. ?deeper collection. CT 31/01/16 Abd/Pel 31/01/16 - At some stage colonoscopy of the cecal pole will be required in order to exclude cecal pole mass/tumour (if not already performed). Possible caecal pole mass may be contributing to the ongoing inflammatory process as the appendix does appear distended and may be obstructed at the base. A prominant ileocaecal valve area is considered and is possible but there is not much fat in this abnormal area. Colonoscopy 04/02/16. Pathology - adenocarcinoma. Dear Dr XX On 18/02/2016. This patient was discussed at the Lower GI MDM @ The Southern Trust Consultant Surgeon Mr 2Yours sincerely, Discussed at Colorectal MDM 18/02/16. Patient to be referred to Mr 3 for surgery. If you have any queries or require further information, please do not hesitate to contact us.							
NIECR	29/02/2016			OPD letter consultant 3 to GP	I assessed Pers today. John has got a caecal cancer he unfortunately presented with perforation, either of the caecum itself or more likely a perforated obstructed appendix secondary to the tumour. He has had a difficult time with multiple trips in and out of hospital and his family were somewhat unhappy today with the care that he has received. In any case he has now been referred to the colorectal team. He requires a right hemicolectomy. He has not yet had a CT chest and we will book this for him a couple of weeks post-surgery given that he is for theatre on Wednesday. I have explained the risks and benefits of the procedure to him including the risks of infection, bleeding, DVT, PE, anastomotic leak rate, risk of mortality and so on. He is keen to proceed and we will admit him on Wednesday morning. He is off his Apixaban and we will restart it when it is safe post-operatively. He previously had a stroke but his exercise tolerance is excellent with approximately 3 miles he can walk at present. He is not diabetic and I hope he will do well.							
Medical notes	02/03/2017				Admitted for Right hemicolectomy							
NIECR	02/03/2017			Histology result	Final REPORT CLINICAL DETAILS Right hemicolectomy, perforated caecal cancer, extended resection - right hemicolectomy+abdominal wall+roof of abscess cavity. Macroscopic R0 PATHOLOGIST'S REPORT GROSS DESCRIPTION Specimen dissected by: Dr Karel Dedic Type of specimen: right hemicolectomy Site of tumour: caecum Length of specimen: terminal ileum 35 mm, caecum and ascending colon 150 mm Maximum tumour diameter: 35 mm Nature of tumour: Polypoid Tumour perforation: Yes - retroperitoneal Distance of tumour from nearest cut end: 50 mm from proximal limit HISTOLOGY Histological type: Adenocarcinoma Differentiation: Moderate Local invasion: pT4b (in colonic carcinoma, involvement of abdominal wall or adjacent loops of bowel equates to pT4b) Maximum distance of spread beyond muscularis propria: 4 mm Lymphovascular invasion: No Venous invasion: Extramural Lymph nodes: Number of lymph nodes identified = 20 Number infiltrated by tumour = 0 Apical node: Not involved Peritoneal involvement: None Proximal margin: Not involved Distal margin: Not involved Non-peritonealised circumferential margin: Not involved Histological measurement from tumour to non-peritonealised margin 5 mm pathology: None Pre-operative therapy given: Unknown Histologically confirmed metastatic disease: No Pathological staging: Dukes' B (growth beyond m. propria, nodes negative) pTNM staging: pT4bN0 Complete resection: Yes (R0) Mismatch repair IHC and KRAS: not performed; if required, couldbe performed on block C Diagnosis: Colon Adenocarcinoma lymph node negative for tumor cells							
NIECR	08/03/2016			Medical Hospital Discharge letter	Admission Reason Elective Admission for Right Hemicolectomy Patient Receiving Palliative Care? No Principle Discharge Diagnosis Caecal Adenocarcinoma Operations/Procedures/Radiology Right hemicolectomy Additional Information for GP Changes to Medications - Start/Stop as below Clinical Information/Comments Personal admitted for Right hemicolectomy following diagnosis of caecal adenocarcinoma. Well post op. On one occasion HR increased to 136. Treated with a stat of oral bisoprolol. Discussed with Cardiology. As HR usually 70-80 bpm, advised OP 24hour tape to assess whether or not rate control is suitable. Fit for discharge 08/03/2016.							
NIECR	09/03/2016			Letter from consultant 3 to patient	Your follow up CT chest has not shown any increase in the size of this little lung nodule, whch is good news, and means it is very unikely to be of any concern whatsoever. I will review you in outpatients.							
NIECR	10/03/2016			MDM Update:	Diagnosis: Carcinoma of caecum CONSULTANT: MR 3 Personal Information , h/o appendix abscess which was drained on 4/12/2015; 3 day h/o tenderness at drain site - noted to have small fluctuant abscess. This was incised and drained; however pus noted to be emerging through wound from deeper abscess. ?deeper collection. CT 31/01/16 Abd/Pel 31/01/16 - At some stage colonoscopy of the cecal pole will be required in order to exclude cecal pole mass/tumour (if not already performed). Possible caecal pole mass may be contributing to the ongoing inflammatory process as the appendix does appear distended and may be obstructed at the base. A prominant ileocaecal valve area is considered and is possible but there is not much fat in this abnormal area. Colonoscopy 04/02/16. Pathology - adenocarcinoma. Right Hemi 02/03/16. Pathology - adenocarcinoma, pT4b N0 R0, no LVI, Extramural Venous Invasion present, 0/20 nodes involved, Dukes B. MDM Update: Dear Dr On 10/03/2016. This patient was discussed at the Lower GI MDM @ The Southern Trust MDM Plan: Yours sincerely, Discussed at Colorectal MDM 10/03/16. Consultant to discuss chemotherapy with patient. If you have any queries or require further information, please do not hesitate to contact us.							
NICER	18/03/2016	13:45		CT Chest with contrast	18/03/2016 13:45CT chest with contrast. **Findings** Lung emphysema. 6mm pleural base triangular opacity seen in the right base laterally. Band opacity seen in the anterior segment of the right upper lobe. There is no hilar or mediastinal lymphadenopathy. Multiple thoracic vertebrae show slight anterior wedging. **Conclusion** No thoracic metastasis seen. Nonspecific small pleural based triangular opacity in the right base laterally. Follow up noncontrast CT of the chest in six months time suggested. Time Reported 20-Mar-2016 10:11							

NIECR	25/04/2016			Letter from consultant 3 to patient	I reviewed Pers today. He is keeping very well. He is getting back to pretty much all normal activities since his open right hemicolectomy for a T4b N0 adenocarcinoma of the caecum, which had previously locally perforated. He is still on iron tablets. I see his last haemoglobin is still on 95, so we have rechecked his full blood count and iron studies today, he certainly should continue on iron until these have improved. He is going to start playing golf again. There is no strong indication for adjuvant chemotherapy in his case and we will adopt a watchful waiting approach. I have checked his CEA today and we will see him again in four months' time							
	12/09/2016	13:30		CT Chest	12/09/2016 13:21 CT Chest CT chest without contrast. Comparison made with previous examination 18/03/2016. **Findings** The pleural based opacity in the right base laterally show no inerval increase in size. Time Reported 28-Sep-2016 20:02							
				OPD letter consultant 3 to GP	I reviewed Pers today. He is keeping really very well. He had a right hemi colectomy with abdominal wall resection of perforated caecal cancer in March of this year of this year. He has made a very good recovery. He is back playing gold. He does have a bit of a new facial twitch but I think he has been referred for a CT scan of brain and neurology opinion. From my point of view he is doing very well. I have booked a CT scan of his chest, abdomen and pelvis for follow up. I have also organised a follow up colonoscopy for him and checked his CEA today.							
	19/12/2016	10:00		CT Chest and abdo and pelvis with contrast	19/12/2016 10:05 CT Chest and abdo and pelvis with contrast **Indication**: Perforated caecal cancer operated in March 2016. Query metastasis. Technique: Arterial phase chest and portal venous phase abdomen pelvis volume scans with oral contrast. Comparison is made to the previous recent CT scans. **Findings**: The thoracic findings are stable with no convincing evidence of metastatic disease. A sub centimetre hypodensity inferiorly in the right lobe of the liver is also stable. Postinflammatory / surgical change in the right iliac fossa appears be resolving with no definite evidence of local recurrence. The right kidney has a 12 mm caliceal stone and an unchanged (4 cm diameter) slightly complex Bosniak class two cyst. A 10 mm low density lesion arising from the inter polar region of the left kidney has attenuation higher than a simple cyst, and although too small to accurately characterise is suggestive of at least a complex cyst and should be kept under surveillance with subsequent routine CTs. The adrenal glands, spleen and pancreas are unremarkable. The aorta has normal calibre, and there is no significant lymphadenopathy or destructive osseous lesion. **Conclusion**: No convincing evidence of disease recurrence. Time Reported 29-Dec-2016 18:13							
Endoscopy day care person centred nursing record	27/01/2017				Colonoscopy							
NIECR	22/05/2017			OPD letter consultant 3 to GP	I reviewed Pers today. He has been keeping well apart from some discomfort in the right iliac fossa. I had a look back at his CT scan that was performed earlier in December and just asked radiology to review the images from it to see if there was any concern. They certainly did not report any significant thickening of the anastomosis and he has had a subsequent colonoscopy to the anastomosis which was okay. I have rechecked his CEA today. We will wait until we hear back from radiology and if the CEA is raised we will rebook a quicker CT than we previously planned. Otherwise he himself looks well and is getting on with his life as normal. We will see how he gets on from here. Yours sincerely							

Received from Trudy Reid on 16/05/2023. Annotated by the Urology Services Inquiry.

Stinson, Emma M

From: Reid, Trudy [redacted]
Sent: 07 July 2017 19:13
To: Boyce, Tracey
Subject: FW: Screening
Attachments: Time line [redacted].xlsx; Time line [redacted].xlsx; Time line [redacted].xlsx; Time line [redacted].xlsx; Time line [redacted].xlsx

Tracey if Ronan and Colin want to screen the hard copy files are in the cupboard 3rd shelf down sitting horizontally, I have extra copies of the time line in the files

Trudy

Trudy Reid
Acute Clinical and Social Care Governance Coordinator
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ
Telephone [redacted]
Mobile [redacted]

From: Reid, Trudy
Sent: 07 July 2017 18:26
To: Carroll, Ronan
Cc: Boyce, Tracey
Subject: Screening

Dear Ronan please see attached time lines for screening, Tracey has agreed to screen the urology cases if Colin has time, if not I can do them following my leave

SEC	[redacted]	Fall in MSW - Contusional brain damage in both frontal lobes. Extracerebral collection overlying the right frontal lobe. Subarachnoid haemorrhage in the suprasellar cistern and pontine cistern. Cerebellar haemorrhage on the left. Left occipital bone fracture
SEC	[redacted]	Delay in diagnosis and treatment of prostate cancer
sec	[redacted]	Delay in diagnosis and management of prostate cancer
SEC	[redacted]	Delay in diagnosis and treatment of prostate cancer

SEC	Patient 137	Not referred from urology MDM to endocrine

Regards,

Trudy

Trudy Reid
Acute Clinical and Social Care Governance Coordinator
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ
Telephone Personal Information redacted by the USI
Mobile Personal Information redacted by the USI

Patient 11

Data Source	Date	Time	Professional Group	Key Facts	Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
NICER	17/07/2016		GP	GP referral to urology	Reason for Referral/ History of Presenting Complaint Description: overactive bladder Comment: This Personal Information is having increased problems in recent months with storage and voiding LUTS. I have commenced him on Oxybutinon, but would value a full bladder assessment from the Continence Service in SWAH, whom he has attended in the past. Many thanks.		IEAP					
NICER	28/07/2016		GP	GP referral to urology	Reason for Referral/ History of Presenting Complaint Description: Elevated PSA. Comment: This Personal Information redacted by the USI has mixed symptoms of overactive bladder and prostatism. Recent MSU and urinalysis were normal, but PSA was 5.6. On examination he has a moderately enlarged smooth prostate. I have commenced him on Oxybutynin recently and he has felt some improvement in his LUTS. Please see and advise regarding further management of his elevated PSA. I have also referred this man to the Continence Service for bladder studies.		IEAP					
NICER	18/01/2017		Consultant Urologist	Letter to patient	Dear Patient 11 I am following up a referral your GP sent in July 2016. At the time of this referral your prostate blood test was elevated slightly above normal range. I would be grateful if you could arrange to have repeat of this blood test checked with your GP at your earliest convenience using the enclosed blood test request form. Once a result is available I will be making arrangements to review in clinic.							
NICER	21/01/2017 reported 27/01/2017			Histology report	REPORT CLINICAL_DETAILS Right colonic biopsies - diarrhoea PATHOLOGISTS_REPORT Sections of the 3 white tissue fragments received show normal colonic mucosa with no evidence of inflammation, dysplasia or malignancy. DIAGNOSIS: COLONIC MUCOSA NO PATHOLOGIC DIAGNOSIS							
NICER	20/02/2017		Consultant Urologist	Letter to GP	Diagnosis: Elevated PSA with LUTS Outcome: MRI prostate and TRUS biopsy Trial of Tamsulosin I reviewed Patient 11 today who has had a two year history of frequency of urination and some stinging inside which is relieved by urination. He also feels he has intermittent incomplete emptying. He previously had marked symptoms of urgency which have improved since starting Oxybutynin and this was on the background of having previous urodynamics several years ago that did describe an overactive bladder however I could not find these results today, this information was from the patient. He describes no haematuria but does have nocturia up to 6 times at night, some hesitancy and terminal dribbling. There is no history of incontinence. His weight is stable and his appetite is good. His PSA in July 2016 was 5.6 and January 2017 5.5 ng/ml. On PR examination the base was smooth but I was unable to access the top of the prostate. He underwent flow and post void residual today which showed a post void residual of 7mls and a maximum flow of 16.2mls. His urinalysis was negative. His kidneys were normal. His prostate was identified as having a volume of 31cc with some areas of focal calcification. In view of his elevated PSA and smaller prostate and evidence of calcification this gentleman would benefit from further investigation to rule out any malignancy of his prostate and in light of this I have arranged an MRI of his prostate then TRUS biopsies. I have given him a trial of Tamsulosin today to see if this will improve some of his symptoms and have suggested that should he not see symptom Patient 11							
NICER	20/02/2017		Consultant Urologist	Letter to Pt	Dear Patient 11 Further to your recent clinic attendance I have seen the result of your MRI scan. As you are aware this was performed to further assess the raised prostate blood test. The MRI scan does show a small area of abnormality in the left side of the prostate. I believe arrangements have been made for you to have biopsies of the prostate and this will include some additional biopsies of this area of abnormality on the left side.							
NICER	27/02/2017	16:10			MRI pelvis and prostate							

NICER	06/03/2017	09:21	Radiology	Urology MRI report	27/02/2017 17:10 MRI Pelvis prostate, Author: RRO, Regional Admin MRI PROSTATE CLINICAL HISTORY PSA 5.5. 30 cc. Calcification on ultrasound.? Prostatic malignancy FINDINGS Prostate volume 28 mL. There is an area of decreased T2 W signal in the left peripheral zone measuring 17 x 14 x 25 mm (PI-RADS 5). DWI is been degraded by the THRs. Normal seminal vesicles. No enlarged pelvic lymph nodes. Small focus of decreased T1 W signal in the left ilium of equivocal significance. No other bony lesions. CONCLUSION T2, N0, M0 left peripheral zone carcinoma. (Assumed ilial lesion to be benign but bone scintigraphy recommended). This report of an unexpected significant finding has been notified to the imaging department using the agreed protocol.							
	04/04/2017 reported 11/04/2017			Histology report	CLINICAL DETAILS Recent MRI - area of abnormality left side. PSA: 5.5. Prostate Vol: 27.8 cc. Specimen - Prostate. PATHOLOGIST'S REPORT GROSS DESCRIPTION NATURE OF SPECIMEN: Needle core biopsy SITE: 1. Right base - Three cores measuring 5 mm, 6 and 5 mm along with fragments. (Clinically two cores, on slides fragmented) SITE: 2. Right mid - Three cores easuring 17, 9 and 7 mm along with fragment. (Clinically two cores, on slides fragmented) SITE: 3. Right apex - Two cores measuring 16 and 15 mm. SITE: 4. Left base - Three cores measuring 19, 18 and 12 mm. SITE: 5. Left mid - Four cores measuring 16, 5, 12 and 7 mm alongwith fragment. (Clinically three cores on slides fragmented) SITE: 6. Left apex - Four cores measuring 10, 6, 9 and 4 mm along with fragment. (Clinically two cores on slides fragmented) HISTOLOGY HISTOLOGICAL TYPE: Adenocarcinoma DIFFERENTIATION/GLEASON SUM SCORE: Overall 3+3 = 6 NUMBER OF CORES/CHIPS INVOLVED: 7 of 19 Right base - No tumour identified. Right mid - No tumour identified. Right apex - No tumour identified. Left base - 3 of 3 cores, Gleason 3+3, 11.2 mm max length, 75-80% of tissue. Left mid - 3 of 4 cores, Gleason 3+3, 35-40% of tissue. Left apex -1 of 4 cores, Gleason 3+3, <5% of tissue. INVASION INTO: Seminal vesicle: No Extracapsular fat: No PERINEURAL INVASION: Yes LYMPHOVASCULAR INVASION: No FURTHER COMMENTS: Within 7 of the 19 prostatic core biopsies there are infiltrates of Gleason 3+3 adenocarcinoma. This occupies approximately 20% of the overall tissue examined. There is perineural invasion but no lymphovascular invasion of extracapsular extension. DIAGNOSIS: PROSTATE CORE BIOPSIES							
NICER	04/04/2017		Nurse specialist	Letter to GP	Patient 11 attended Thorndale Unit on 4th April. Written consent was obtained. Local anaesthetic inserted and following guidance from his recent MRI scan a total of 14 core biopsies of prostate were collected. Patient 11 found the procedure somewhat uncomfortable but recovered quickly when the probe was removed. He was provided with a 3 day course of prophylactic antibiotics and discharged home care of a family member. His histology results will be discussed at urology MDM and reviewed by Mr Haynes thereafter. Yours sincerely dictated but not signed							
NICER	04/04/2017			US Guided biopsy prostate transrectal	Report 04/04/2017 09:46 US Guided biopsy prostate transrectal, Author: Radiology, Admin This examination was performed by the Urologist. Please see patient notes.							
NICER	10/04/2017		Medical	SWAH discharge letter for admission 6/4/17 to 10/4/17	This Personal Information redacted by the USI was admitted with pyrexia following a recent prostate biopsy two days previous. He reported feeling generally unwell with aches as well as complaining of ongoing urinary frequency and hesitancy. Patient continued to spike temperatures while in hospital and blood cultures were taken. This gentleman was discussed with urology in CAH where he underwent the biopsy who advised starting Patient 11 on Ciprofloxacin and Gentamicin to which he responded well. CRP peaked at 221.1 but is now improving. Patient 11 is feeling well, he is apyrexic and is surgically fit for discharge with further 7 days of oral Ciprofloxacin. Many thanks for your ongoing care of this gentleman.							

NICER	03/05/2017		Consultant Urologist	Letter to GP	Diagnosis: Low risk prostate cancer Outcome: Bone scan and subsequent outpatient review Patient 11 prostate biopsies have shown a gleason 3+3=6 prostate cancer. His presenting PSA is 5.5 and on MRI scan his local staging would be T2 N0. A bone scan has been arranged to complete his staging. I would anticipate this to be satisfactory given the low risk nature of his disease. His treatment options are either proceeding to treatment with curative intent with either radical surgery, external beam radiotherapy or brachytherapy or alternatively proceeding to active surveillance. He has been given written information regarding prostate cancer and information regarding each of these treatment options. I plan to review him in clinic after his bone scan to discuss these further. Yours sincerely							
NICER	18/05/2017	12:00 reported 18 :26	Radiology	NM bone whole body	Report 18/05/2017 16:14 NM Bone whole body, Author: Vallely, Stephen No evidence of bony metastatic disease. Bilateral hip replacements noted							

Received from Trudy Reid on 16/05/2023. Annotated by the Urology Services Inquiry.

Patient 14

Data Source	Date	Time	Professional Group	Key Facts	Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
NICER	03/06/2016		GP	GP referral	Reason for Referral/ History of Presenting Complaint Description: Raised PSA Comment: Many thanks for seeing this patient - Small rise in PSA noted on routine testing earlier in year - had returned to Normal on repeat testing but mot recent test raised again (5.63) . Few LUTS and nil overt on clinical examination . Please see and advise regards further investigation .		IEAP					
NICER	07/02/2017		Consultant urologist	letter to pt	Dear Patient 14 I am writing to you with the results of your recent MRI. I am pleased to say there are no significant abnormalities of your prostate. There are however some changes within a small area of the prostate so we cannot completely exclude a tumour. Given that your PSA remains raised for your age I would like to offer you a prostate biopsy that is performed under local anaesthetic in the Thorndale outpatients. I will arrange for you to have biopsies and you will be sent an appointment in due course, however if you don't wish to proceed with biopsies at the present time or wish to discuss this further we would be more than happy to hear from you. If you have any queries please contact us on the number above, otherwise I will see you with your biopsy results							
NICER	07/02/2017		Consultant urologist	letter toGP	Thank you for referring this Personal Information redacted by the USI who has a raised PSA of 5.63. Prior to that it had been 4.4 and 5.5. On questioning Patient 14 reports no troublesome lower urinary tract symptoms. He has some occasional hesitancy however he is very happy with his waterworks at present. On examination his abdomen was soft and non-tender and he has a non-palpable bladder. The area revealed moderately enlarged and generally firm but benign feeling prostate. Given that it has been 8 months since his last PSA I have repeated this today at clinic. If it remains elevated or has risen further I will proceed with an MRI of his prostate as he has no contra-indications to this. If however his PSA remains stable I think it is reasonable to continue with 6 monthly surveillance PSA. I will be in touch with his results when they are available. Yours sincerelyThank you for referring this Personal Information redacted by the USI who has a raised PSA of 5.63. Prior to that it had been 4.4 and 5.5. On questioning Patient 14 reports no troublesome lower urinary tract symptoms. He has some occasional hesitancy however he is very happy with his waterworks at present.							
NICER	07/02/2017		Consultant urologist	letter to pt	Dear Patient 14 I am writing to inform you of your latest PSA prostate blood test result. Your PSA has dropped slightly to 5.5 from 5.6 last year. Overall this is reassuring. Given that it remains slightly elevated for your age I will proceed with booking an MRI scan of your prostate as discussed at clinic. You will receive an appointment in due course.							
NICER	24/02/2017	08:20			MRI Pelvis prostate							
NICER	06/03/2017	19:21	Radiology	MRI report	Report 24/02/2017 09:05 MRI Pelvis prostate, Author: Williams, Marc Prostate volume of 37cc. There is a small volume of reduced T2 and ADC signal change related to the posterolateral peripheral zone of the left apex to mid gland. No overt restricted diffusion. The appearances are therefore of equivocal significance and may represent a small focus of tumour. Extension to but not definitively beyond the prostatic capsule. Non specific minor reduced T2 and ADC signal changes within the posterolateral and peripheral zones of both sides of the mid gland to base. Within the limitations of transition zone assessment, no definite transition zone tumour is identified. The seminal vesicles appear unremarkable.5mm utricular cyst. No pelvic lymphadenopathy. Probable degenerative change at L5/S1. An 11mm low T1 signal focus within the right femoral neck is not thought to be significant. CONCLUSION: There is no definite radiological evidence of significant prostate tumour. A small volume of signal change within the posterolateral peripheral zone of the left apex to mid gland is regarded as suspicious. Mild signal change elsewhere within the peripheral zone as described is equivocal. If biopsies are being considered, you may wish to consider additional biopsies of the left apex to mid gland peripheral zone. If tumour should be present, the appearances are thought to represent organ confined disease.							
NICER	28/03/2017			US Guided biopsy prostate transrectal	Report Final 28/03/2017 10:36 US Guided biopsy prostate transrectal, Author: Newell, Denise This examination was performed by the Urologist. Please see patient notes.							
NICER	28/03/2017		Nurse specialist	letter toGP	Patient 14 attended Thorndale Unit today. Written consent was obtained, local anaesthetic inserted and following guidance from his recent MRI scan a total of 15 core biopsies of prostate were obtained. He was provided with a 3 day course of prophylactic antibiotics and discharged home care of a family member. His histology results will be discussed at the urology MDM and he will be reviewed by Mr O'Donoghue thereafter.							

NICER	28/03/2017 reported 5/4/2017			Histology report	CLINICAL DETAILS Recent MRI. SPECIMEN - Prostate. PATHOLOGIST'S REPORT GROSS DESCRIPTION : NATURE OF SPECIMEN: needle core biopsy. SITE: 1. Right base - 2 cores and fragments the longest measuring 18 mm. SITE: 2. Right mid - 2 cores the longest measuring 20 mm. SITE: 3. Right apex - 4 cores the longest measuring 8 mm. SITE: 4. Left base - 2 cores the longest measuring 16 mm. SITE: 5. Left mid - 4 cores the longest measuring 20 mm. SITE: 6. Left apex - 3 cores the longest measuring 19 mm. HISTOLOGY HISTOLOGICAL TYPE: Adenocarcinoma. DIFFERENTIATION/GLEASON SUM SCORE: 3+3=6 NUMBER OF CORES/CHIPS INVOLVED: Right base - Not involved. Right mid -Not involved. Right apex - 1 of 2 cores involved. Gleason 3+3. 40% tissue. Left base - 2 of 2 cores involved. Gleason 3+3. 50% tissue. 6.5mm max length Left mid - 1 of 4 cores. Gleason 3+3. 1% tissue Left apex - 3 of 3 cores involved. Gleason 3+3. 20% tissue. INVASION INTO: Seminal vesicle: No. Extracapsular fat: No. PERINEURAL INVASION: No. LYMPHOVASCULAR INVASION: No. Prostatic adenocarcinoma of overall Gleason sum score 3 + 3 = 6 is present in 7 of 17 cores with a maximum tumour length of 6.5 mm. The tumour occupies approximately 15% of the total tissue volume. DIAGNOSIS PROSTATE NEEDLE CORE BIOPSY ADENOCARCINOMA						
NICER	06/04/2017		Chair MDM	MDM letter to GP	This patient was discussed at the Urology MDM @ The Southern Trust On 06/04/2017. Diagnosis: Prostate cancer Gleason Score 3 + 3 MDM Update: CONSULTANT MR O'DONOGHUE: This Personal Information redacted by the USI who has a raised PSA of 5.63ng/ml. Prior to that it had been 4.4ng/ml and 5.5ng/ml. He reports no troublesome lower urinary tract symptoms, he has some occasional hesitancy. The area revealed moderately enlarged and generally firm but benign feeling prostate. MRI, 24.02.17 - There is no definite radiological evidence of significant prostate tumour. A small volume of signal change within the posterolateral peripheral zone of the left apex to mid gland is regarded as suspicious. Transrectal prostatic biopsy, 28.03.17 - Prostatic adenocarcinoma of Gleason score 3 + 3 = 6, is present in 7 of 17 cores with a maximum tumour length of 6.5mm. The tumour occupies approximately 15% of the total tissue volume. MDM Plan: Discussed at Urology MDM 06.04.17, Patient 14 has low risk, organ confined prostate cancer. For review with Mr O'Donoghue to discuss all treatment options. Signee: If you have any queries or require further information, please do not hesitate to contact us.						
NICER	19/04/2017		Consultant urologist	letter toGP	This gentleman as you know recently had prostate biopsies for a PSA of 5.63ng/ml. The histology has come back showing adenocarcinoma of the prostate Gleason score 3+3=6 in 7 of 17 cores. The tumour occupied approximately 15% of the total tissue. His MRI showed no definite radiological evidence of a significant prostate tumour. There was a small volume of signal change within the posterolateral peripheral zone of the left apex to mid-gland which was regarded as suspicious. As per MDT I have went through the various options for treatment with this low risk organ confined prostate cancer with Patient 14. We discussed radical radiotherapy, radical surgery and active surveillance and he wishes to pursue a period of active surveillance. I will see him in 4 months' time with a PSA 1 week beforehand and in 1 years' time I will re-biopsy his prostate. Yours sincerely						

Patient 12

Data Source	Date	Time	Professional Group	Key Facts	Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
NICER	08/09/2016		GP	Referral to urology	Reason for Referral/ History of Presenting Complaint Description: lower urinary tract symptoms and elevated PSA. Comment: Dear Urologist Please may I have your advice on this Personal Information redacted by the USI with lower urinary tract symptoms and elevated PSA. This man has previously been reviewed in regards to an elevated PSA. He complains of increasing lower urinary tract symptoms of frequency and nocturia. He denies any haematuria or dysuria. He decided to stop his combodart due to erectile dysfunction. He denies any erectile dysfunction while taking Contiflo. His PSA has had a slow general increase over the last number of years and is now 7.34. I would appreciate your opinion on biopsy of his prostate.		IEAP					
NICER	30/01/2017		GP	Referral to urology	Reason for Referral/ History of Presenting Complaint Description: elevated PSA Comment: Please find attached my previous referral in regards to this Personal Information redacted by the USI. I have repeated his PSA at a reasonable interval and it has elevated to 9.43. I would appreciate it if you could upgrade his referral to red flag.		IEAP					
NICER	06/02/2017		LAT3 in Urology	Letter to GP	Diagnosis: Raised PSA Plan: MRI prostate Thank you for referring this Personal Information redacted by the USI who has a rising PSA. Over the last 12 months it has gone from 7.3 to 6.9 and subsequently 9.43 in January 2017. I note that he has had previous investigations including a TRUS biopsy in 2008 which was benign. He reports some urgency and occasional dribbling but is not overly troubled with his lower urinary tract symptoms. He has had no haematuria, UTIs or weight loss. Of note he had previously been on Combodart however he discontinued this due to erectile dysfunction. He is now only on Contiflo. On examination this gentleman has a moderately enlarged but benign feeling prostate. There is a nodule present just left of the midline however I note that this was present in 2007 as documented in an outpatient letter at that time. I have discussed the options with Patient 12 and we have agreed to proceed with an MRI of his prostate. If this shows any abnormalities we will carry out a TRUS biopsy. I will be in touch with the result of his scan in due course.							
NICER	14/02/2017				MRI performed							
NICER	01/03/2017			MRI report	14/02/2017 09:42 MRI Pelvis prostate, Author: RRO, Regional Admin. MRI prostate Oncology report CLINICAL HISTORY Rising PSA 9.4 from 6.9 last year, left lobe nodule on rectal examination FINDINGS Prostate volume 60 mL. There is a 1 cm nodule seen in the left posterior peripheral zone bulge in the capsule, with restricted diffusion (PIRADS 5) and also a possible lesion seen in the right anterior lobe and some PIRADS 3 changes in the right peripheral zone posteriorly. The seminal vesicles collapsed but grossly normal. Normal visualised rectum and bladder. No significantly enlarged lymph nodes or bony deposit in the pelvis CONCLUSION If biopsy-proven, at most, T3a N0, MX							
NICER	07/03/2017		Consultant Urologist	Letter to Pt	Dear Patient 12 I am writing to you with results of your recent MRI. The scan has detected some changes within your prostate which require further investigation. As we discussed at clinic, the next step is to perform a biopsy of the prostate. This can be performed under local anaesthetic at our outpatient unit. I will arrange this and will be in touch with appointment details in the near future.							

NICER	11/04/2017			Histology report	REPORT CLINICAL DETAILS Total cores taken 14. ?? abnormality left mid - base on MRI. PSA 9.43 ng/ml. Prostate volume 31.8. Medication Combodart. SPECIMEN - Prostate. PATHOLOGIST'S REPORT GROSS DESCRIPTION NATURE OF SPECIMEN: Needle core biopsy SITE: 1. Right base - 2 cores measuring 15 and 6 mm along with fragment. SITE: 2. Right mid - 2 ragged cores measuring 14 and 13 mm. SITE: 3. Right apex - 1 core measuring 14 mm. SITE: 4. Left base - 2 ragged cores measuring 18 and 12 mm. SITE: 5. Left mid - 6 cores measuring 11, 10, 14, 12, 5 and 3 mm along with fragments. SITE: 6. Left apex - 1 core measuring 10 mm along with fragment. HISTOLOGY HISTOLOGICAL TYPE: Adenocarcinoma OVERALL GLEASON SUM SCORE: 3+4 = 7 (Grade Group 2) NUMBER OF CORES INVOLVED: 8 of 14 Right base - No tumour identified. Right mid - 2 of 2 cores, Gleason 3+3, < 5% of tissue. Right apex - No tumour identified. Left base - No tumour identified. Left mid - 6 of 6 cores, Gleason 3+4, 6.3 mm max length, 20-25% of tissue. Left apex - No tumour identified. INVASION INTO: Seminal vesicle: No Extracapsular fat: No PERINEURAL INVASION: No LYMPHOVASCULAR INVASION: No FURTHER COMMENTS: The macroscopically described 2 cores within the block 5C got fragmented into 5 small bits, two of which show neoplastic glands. It is difficult to be certain but would be best regarded as 2 of 2 cores involved. Within 8 of the 14 prostatic core biopsies there are infiltrates of Gleason 3+3 and 3+4 adenocarcinoma. This occupies approximately 5% of the overall examined material. There is no perineural invasion, lymphovascular invasion or extracapsular extension. Selected slides (5B, 5C) were discussed with Dr G McClean. DIAGNOSIS PROSTATE CORE BIOPSIES ADENOCARCINOMA				
NICER	20/04/2017		Chair of MDM	MDM meeting letter to GP	This patient was discussed at the Urology MDM @ The Southern Trust On 20/04/2017. Diagnosis: Prostate cancer Gleason Score 3 + 4 MDM Update: CONSULTANT MR HAYNES: This Personal Information redacted by the USI has had a rising PSA it had gone from 7.3ng/ml to 6.9ng/ml and subsequently 9.43ng/ml in January 2017. He has had previous investigations including a TRUS biopsy in 2008 which was benign. He reports some urgency and occasional dribbling but is not overly troubled with his lower urinary tract symptoms. On examination he has a moderately enlarged but benign feeling prostate. MRI, 14.02.17 - If biopsy-proven, at most, T3a N0, MX Transrectal prostatic biopsy, 11.04.17 - Adenocarcinoma, Gleason 3+4 = 7. Number of cores involved - 8 of 14. MDM Plan: Discussed at Urology MDM 20.04.17. Patient 12 has high risk prostate cancer. He should be seen in clinic and have a discussion with regard to curative treatment. Signee: If you have any queries or require further information, please do not hesitate to contact us.				
NICER	03/05/2017		Consultant Urologist	Letter to GP	Diagnosis: High risk non metastatic prostate cancer Outcome: Commence Bicalutamide 50mgs once a day, 28 day course Please commence Decapeptyl 11.25mg first dose to be given week commencing 15th May and continued every 12 weeks thereafter Isotope bone scan Refer to Oncology for consideration of radiotherapy in addition to androgen deprivation Patient 12 prostate biopsies have confirmed a high risk prostate cancer and radiologically on his MRI this would appear to be stage T3a with no nodal metastases. Given this the recommended treatment would be hormones and radiotherapy. I have outlined this to him. He does require a bone scan to complete his staging which I have arranged. I have commenced him on his Bicalutamide today and would be grateful if you could arrange his Decapeptyl as above. I have referred him to my Oncology colleagues				

Patient 137

Data Source	Date	Time	Professional Group	Key Facts	Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
NIECR	20/12/2016			CT Chest and abdo and pelvis with contrast	20/12/2016 11:28 CT Chest and abdo and pelvis with contrast At the posterior aspect of the RUL, there is a 42 x 21 x 21 mm irregular soft tissue abnormality with an air bronchogram, adjacent to the oblique fissure present. Minimal linear atelectasis in the right base and mild bilateral basal hypoventilation atelectatic changes. Several accentuated subcarinal lymph nodes measuring up to 12 mm. Normal both kidneys with mildly accentuated collecting system (likely of no clinical significance). In the left perirenal space, anterior to the upper pole of the kidney, there is a large (78 x 68 x 72 mm) well defined fatty tumour with some soft tissue component, abutting mildly thickened adrenal. Enlarged prostate. Normal liver, bile ducts, pancreas, right adrenal, spleen and urinary bladder. No sinister process of the imaged skeleton. Partial lumbarisation of S1. Two small sclerotic lesions within the L3 vertebral body (bony islands?). A small T12 vertebral body haemangioma. **Conclusion:** Right upper lobe pulmonary abnormality suggesting a dense consolidation. Please correlate with clinical features. Follow-up recommended. A large fatty tumour in the left perirenal space which may be in keeping with an angiomyolipoma with extrarenal growth. Differential diagnosis should include liposarcoma, adrenal teratoma or adrenal myelolipoma. Specialist referral is advised. Time Reported 20-Dec-2016 15:42							
NIECR	21/12/2016			Letter from respiratory physician to GP	Diagnosis: 1. Right upper lobe community acquired pneumonia. - CT chest 20/12/16, right upper lobe consolidation. 2. Left perirenal mass. - CT chest abdomen 20/12/16, large fatty tumour (78 mm) left perirenal space. 3. Left hydrocele repair 2012. 4. Hypertension. 5. Recurrent episodes of hiccups. Comment: This Personal Information redacted by the USI was reviewed at the Respiratory Clinic today following his recent discharge from hospital. His CT imaging is as detailed above. I reviewed the patient's CT imaging with Dr Clarke, Consultant Radiologist today. The left perirenal mass differential diagnosis includes an adrenal myelolipoma, atypical lipoma or a liposarcoma. Action: 1. I have explained the CT results and further management plan to the patient. 2. I would be grateful if you could provide this patient with 7 days of Amoxicillin and Clarithromycin as per handwritten note and telephone call to your surgery today. 3. Red flag referral to Urology Team, Craigavon Area Hospital has been arranged. 4. Repeat chest x-ray has been booked for 6 weeks' time. 5. No review is planned at the Respiratory Clinic.							
NIECR	21/12/2016			Red flag referral from respiratory physician to Urologist	I would be grateful for your urgent assessment of this Personal Information redacted by the USI who has been found to have a 78 mm left perirenal mass. Please find a copy of the most recent correspondence attached. Thank you for your help.							
NIECR	23/12/2016			MDT letter to chair of MDT from Consultant Urologist 2	We have received communication from the chest physician colleagues in the Erne re this Personal Information [redacted] with pneumonia, but has had an incidental finding of a mass lesion in the left perirenal area. I don't think that this is renal in origin; I would agree with their sentiments that this could either be of adrenal origin, I suspect it would be difficult to biopsy. I would be grateful if his films could be reviewed. This would probably be beneficial before speaking to Patient 137 himself							
NIECR	12/05/2017			GP letter	Reason for Referral/ History of Presenting Complaint Description: L renal mass Comment: Patient 137 has never had an appointment re this matter-- ? has referral been made and what are the rv arrangements							
NIECR	18/05/2017			OPD letter to GP from Consultant	Many thanks for your letter Patient 137. Unfortunately it would appear that the referral to the Endocrine Team has not happened. I have done a referral which is attached and I would anticipate Patient 137 will hear from the Endocrine Team in due course.							

NIECR	18/05/2017			OPD letter to Endocrine consultant from Urology Consultant	I would be grateful if you could arrange for review of Patient 137 's imaging and clinical review with yourself. He was referred following a CT scan which was performed in December 2016 following an admission under the care of the General Physicians in South West Acute Hospital. Incidentally the CT scan showed an abnormality in the left peri-renal space. This was reviewed at the Urology MDM in Craigavon Hospital on 12th January where it was felt to represent an adrenal abnormality and referral to yourself was recommended. Unfortunately this referral does not appear to have occurred and a new letter was sent by Patient 137 's GP today. The view of the Urology MDT was given that it would appear to be an adrenal abnormality and further management would be appropriate under your care. I would be grateful if you could arrange for review of your imaging at MDT and subsequent clinic review with yourself regarding further managem							

Received from Trudy Reid on 16/05/2023. Annotated by the Urology Services Inquiry.

Personal Information redacted by the USI

Data Source	Date	Time	Professional Group	Key Facts	Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
ED RECORD	07/06/2017	18:20			GP referral to ED history of binge drinking/depression.							
Medical Admission Booklet	07/06/2017	23:15	Medical		[redacted]. Alcohol misuse referred from GP. Woke up today- nose bleed or mouth, unsure?. First episode over face and pillow. Went to GP- they noted ascites & advised ED. Loss of 3 stone from Christmas. Poor appetite for 10 weeks. ↑abdominal sweling. No abd pain. Urine dark bowels black approx a fortnight- not on iron. Vomiting today- bile - rthen noticed fresh blood -no clots after taking a cup of coffee. Mood low xxx poor sleep. Stressors-ex wife ↑alcohol use would drink in am. Denies previous DVTs. Wishing to Detox.Past Medical History. Alcohol excess Depression, Circle of Wills, Aneurysm →Previous coiling & SAH. Carrier for haemacromotosis H63D heterocygosity HFt gene. Admitted MSW DHH.							
Nursing Record	08/06/2017	04:00	Nursing	Admission	Admission Nursing assessment Unsteady when walking on admission. Prior to admission: Unsteady on feet ass x1 whilst walking and transferring.							
Nursing Record	08/06/2017	04:40	Nursing		patient unsteady on his feet ass x 1 pt needing referrals to disciplines patient states he hasn't been sleeping.							
Nursing Record	**not dated**			**Falls risk assessment**	Falls (Risk assessment) signed but not dated Does patent have a history of falling or has fallen since admission? NO Does the patient have a fear of falling? NO							
Nursing Record	08/06/2017				Referred to Physio and OT 8/6/17.							
Nursing Record	08/06/2017	11:30	Nursing		Assisted x 1 to mobilize, remains unsteady on feet. Patient uses walking aid at home, not with patient on ward.							
Nursing Record	08/06/2017	19:30	Nursing		Remains unsteady on feet, using crutches to mobilize. Physio unable to assess, will assess tomorrow.							
Nursing Record	09/06/2017	00:15	Nursing		[redacted] in bathroom advised to use call bell as unsteady with stick. Assisted into bed.							
Nursing Record	10/06/2017	11:30	Nursing		Unsteady on feet. Advised to not walk too far from bed.							
Nursing Record	11/06/2017	19:05	Nursing		Supervised whilst mobilizing as unsteady gait.							
Nursing Record	12/06/2017	21:10	Nursing		Mobilizing out to toilet under supervision with aid of ZF.							
Nursing Record	13/06/2017	12:30	Nursing		Mobilizing under supervision							
Nursing Record	14/06/2017	14:35	Nursing		Assisted out to bathroom							
Nursing Record	15/06/2017	12:20	Nursing		Out to bathroom with zimmer x1 staff							
Nursing Record	16/06/2017	01:30	Nursing		Assisted out to toilet with 1 member of staff + comode.							
Nursing Record	17/06/2017	08:00	Nursing		Up to sit at bedsisde and walked to toilet with aid of zimmer and 2 nurses							
Nursing Record	17/06/2017		Nursing	Falls Assessment	Moving and Handling Plan: Bed to chair, Walking Dependency 1-2. Aids: Z Frame. Patient orientiated to the ward. Call bell given. Pt unsteady ass x 1. Pt's mobility is not great. Ass x 1 very unsteady gait							
Nursing Record	19/06/2017	02:30			[redacted] complaining about sickness- ondanstron 4 mg PO given @02:15. Change again for faecal incontinence. [redacted] state he want to sit in chair, asisted with same. States he is not comfortable in the bed.							
Nursing Record	19/06/2017	05:30	Nursing	**Falls risk assessment**	Page 17 Nursing Booklet. Fall @ward. Patient orientiated to ward. Medical review after fall. GCS 14/15 then 15?15 within an hour. Call bell within reach and explained.[redacted] slightly confused right after fall but GCS back @ 15/15. Moving and handling assessment completed. Ass x 2 out of bed. Zimmer frame. Medical review done after fall		Nursing admission assessment	??				
Medical Record	19/06/2017	05:50	Medical		ATSP re Fall on ward. Arrived to find patient lying on his back in MSW Ward 2. In attendance Bedmanager Angela, SN Maria and Health Care Assistant (P).[redacted] was conscious, had slipped in urine and fell to floor hitting head. Bleeding from posterior head, left forehead and left nostril. C/O pain in head. Able to move all 4 limbs while on ground. Following commands. Pain free CSP ROM. No deformity felt at CSP therefore rolled patient onto side and mobilized patient safely on to chair and back to bed. O/GCS 14/15- confused, not orientiated to time /place/person. Considered swelling at posterior/occipital region of head + abrasion at forehead + dry blood in left nostril. PEARL Double vision with all eye movements. CN grossly intact. Able to move all 4 limbs pain free. No focal neurology. No other obvious injuries. RR18 Sats 95%RA Temp 36 BP 140/70 HR 102. xxx (Alert). Plan Caog screen deranged ++. →CT Brain - discussed + confirmed. CNS obs, Analgesia.							
Medical Record	19/06/2017		Medical		Continued. Episode of haematemesis post fall. Small volume in kidney dish. Plan. A/W CT report							
NIECR	19/06/2017	06:33	Radiology	**CT Brain**	Time Performed 19-Jun-2017 06:33 Time Reported 19-Jun-2017 07:06 CT BRAIN. CLINICAL NOTES: Decompensated liver disease head injury abnormal clotting. FINDINGS: There is a shallow extracerebral collection overlying the right frontal lobe and some contusional damage to the underlying brain in both cerebral hemispheres. There is the subarachnoid haemorrhage in the suprasellar cistern. There is evidence of previous surgery with a right-sided craniotomy and surgical clip in the sylvian fissure. Haemorrhage is present in the left cerebellar hemisphere and subarachnoid haemorrhage is present in the cerebellar folia. There is some haemorrhage in the pontine cistern..There is there occipital bone fracture on the left side. **CONCLUSION:Contusional brain damage in both frontal lobes. Extracerebral collection overlying the right frontal lobe. Subarachnoid haemorrhage in the suprasellar cistern and pontine cistern. Cerebellar haemorrhage haemorrhage on the left. Left occipital bone fracture**							
Medical Record	19/06/2017	06:55	Medical		Seen by doctor. History noted. O/E Large occipital haematoma. CNS 12 Intact. Both pupils reactive. Eye movements Normal, Visual fields Normal. CT result phoned through to Dr McCreesh.→ Bifrontal confusing →Extracerebral collection Right frontal lobe →SAH Suprasellar cistern + positive cistern →Cerebellar haemmorrhage on the left. Left occipital bone #. D/W Drv Magee (Cons on Call) → Advises contacting Neurosurgery and Haematology.→ On way in to hospital, will be present in 15-20 mins. D/W Neurosurgical Registrar (Jonathan Poots) → Given poor prognosis regarding liver disease, deranged Coag and low platlets he would not be a surgical candidate. → Advises haematology advice. D/W Haematology Consultant (Dr Bily Cons) → Advises giving 3000 units Octaplex, 2 Units Plts, 1g Transexamic acid TID (8hrly) for 3-4/7- Daily FBC + coag							
Nursing Record	19/06/2017	07:00			...Assisted to chari and back to bed x 2[redacted] has taken short naps overnight .....At 05:30[redacted] has unwitnessed fall.[redacted] had disconnected both his iv drips independentl and got out of bed, found lying on his back, appear to have hit his head- bleeding from back of his head, also nose bleed. Clinical observations recorded, no LOC, responsive, slightly confused. FY1 Dr xxx contacted who comes to see[redacted] @ 05:35							
Medical Record	19/06/2017	07:35	Medical		W/R Dr Magee. Fell early am. (approx 05:50) Pt thinks he slipped on something on floor. Hit back of head. ◦ LOC. C/O pain at back of head. Speech slurred/difficult to make out. (◦ change as per N/S). Episode of haematemesis post fall. O/E pupils reactive ; small. Blood around mouth. Platlets ↓↓ Chest clear RR 19 Sats 95% RA HR 110 BP 140/80 Temp 36.5 c. Explained to pt findings of CT; # skull and area of bleeding. We will try to correct the bleeding problem with medications. - Needs escalated as Serious adverse incident, - contact family,- CNS Obs, -Correct caog as per haematology.							
Medical Record	19/06/2017	08:10	Medical		Octaplex requested. 2 Units platlets requested.							
Medical Record	19/06/2017		Medical		WR Hillemand. Events overnight discussed and current plan noted. Patient c/o some headache, is alert and rousable. BP 153/84 HR 104 SaO2 94% (RA). Day 6 Terlipressin/albumin. Stop pabrinex, check U&E today - K ›3.5. 2 hrly CNS obs then 4 hrly in evening if stable.							

<table>
<tr><td>Medical Record</td><td>19/06/2017</td><td>21:10</td><td>Medical</td><td></td><td>Harity SHO. GCS subsequently deterioriated - now 3/15. Snoring, vomiting x 1. Unsafe airway- unsuitable for transfer currently. D/W Consultant on call Shambul. Advised of above. Ceiling of care estabilished- not for Resus/intubation given unstable airway and potential to loose airway in scanner, advised not for scan @ present. Reconsider scan in event of GCS improving given GCS currently, comfort measures @ present. D/W family RE above, happy, no further questions @ present.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Medical Record</td><td>19/06/2017</td><td></td><td>Medical</td><td></td><td>CT1 Medical. Xx R/V. Events noted. Rapid decline in GCS now 3/15. Care has been discussed with Dr Shamboal, Consultant on call. Not for scanning or further intervention. Family in attendance. Pt appears comfortable at rest. Snoring evident. No aggitation/confusion. No spouse to xxxx touch. Family happy with current care. xxxx and comfort only. PRN midazolam. Diamorphine prescribed in event he becomes agitated but not requiring at present. If GCS improves, rediscussion with Sr Shamboal and consider now if airway patent.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Medical Record</td><td>20/06/2107</td><td>09:18</td><td>Medical</td><td></td><td>Personal Information admitted 7/6/17. Alcohol excess, decom ALD. Temp spikes- USS cholrcystitis →treated with Teic + Gent+ Metro. →switched to Aztreonam, Linezolid, Metronidazole. Multifactorial AKL. Fall on ward : CT - SAH- Cerebellar haemorrhage.→D/W Neurosurgey → not a surgical candidate. Note events overnight. ↓GCS 3/15 DW Dr Shamboal Consultant on call. Obs at 4am RR16 Sats 93 Aprexic BP 153/71 HR 120.Personal information redacted in attendance this am. Family agree with comfort measures. GCS 5/15 at present. HS 1=11-0 rapid. Appears comfortable. Plan PRN midazolam + diamorphine. I will update Dr Hillemand on events in past 2hr.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Nursing Record</td><td>19/06/2107- 20/06/2107</td><td>05:30-21:00</td><td>Nursing</td><td>NEWS CHART</td><td>
<table>
<tr><td>Time</td><td>05:30</td><td>05:45</td><td>06:00</td><td>06:15</td><td>07:55</td><td>08:10</td><td>08:30</td><td>08:45</td><td>09:00</td><td>09:10</td><td>10:00</td><td>12:00</td><td>14:00</td><td>17:00</td><td>19:15</td><td>21:00</td></tr>
<tr><td>GCS</td><td>14/15</td><td>14/15</td><td>15/15</td><td>15/15</td><td>15/15</td><td>15/15</td><td>15/15</td><td>15/15</td><td>15/15</td><td>15/15</td><td>15/15</td><td>15/15</td><td>15/15</td><td>14/15</td><td>6/ 15</td><td>3/ 1</td></tr>
<tr><td>Limb power</td><td>Normal</td><td>Normal</td><td>Normal</td><td>Normal</td><td>Normal</td><td>Normal</td><td>Normal</td><td>Normal</td><td>Normal</td><td>Normal</td><td>Normal</td><td>Normal</td><td>Normal</td><td>Mild weakness arms</td><td>-</td><td>-</td></tr>
<tr><td>Pupils</td><td>3 equal & reacting</td><td>3 equal & reacting</td><td>3 equal & reacting</td><td>3 equal & reacting</td><td>2 equal & reacting</td><td>2 equal & reacting</td><td>2 equal & reacting</td><td>2 equal & reacting</td><td>2 equal & reacting</td><td>2 equal & reacting</td><td>3 equal & reacting</td><td>2 equal & reacting</td><td>2 equal & reacting</td><td>2 equal & reacting</td><td>R =3</td><td></td></tr>
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</td><td></td><td>Post falls observations</td><td>???</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Nursing Record</td><td>19/06/2017</td><td>12:00-21:00</td><td>Nursing</td><td>CI Obs Chart</td><td>
<table>
<tr><th colspan="7">Clinical observations</th></tr>
<tr><td>Date</td><td>19/06/2017</td><td>19/06/2017</td><td>19/06/2017</td><td>19/06/2017</td><td>19/06/2017</td><td>19/06/2017</td></tr>
<tr><td>Time</td><td>12:00</td><td>14:00</td><td>14:10</td><td>17:00</td><td>19:15</td><td>21:00</td></tr>
<tr><td>Resp</td><td>18</td><td>16</td><td>17</td><td>16</td><td>14</td><td>16</td></tr>
<tr><td>Spo2 %</td><td>95%</td><td>91%</td><td>91%</td><td>91%</td><td>91%</td><td>93%</td></tr>
<tr><td>Temp</td><td>36.5</td><td>37.4</td><td>37.3</td><td>36.8</td><td>37.3</td><td></td></tr>
<tr><td>Blood Pressure</td><td>158/70</td><td>150/74</td><td>151/72</td><td>140/71</td><td>152/71</td><td>160/76</td></tr>
<tr><td>HR</td><td>112</td><td>111</td><td>100</td><td>117</td><td>120</td><td>120</td></tr>
<tr><td>Level of Consciousness</td><td>A</td><td>A</td><td>A</td><td>A</td><td>P</td><td>U</td></tr>
<tr><td>NEWs</td><td>2</td><td>5</td><td>4</td><td>3</td><td>8</td><td>7</td></tr>
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</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Medical Record</td><td>20/06/2017</td><td>14:55</td><td>Medical</td><td></td><td>Lee Marshall F1. Confirmation of life extinct. ⊖ heart sounds ⊖ central pulse ⊖ respiratory effort/breath sounds. Pupils fixed + dilated ⊖ response to pain. <u>Time of death</u>Perso Personal <u>Family</u> (Personal Information redacted by the USI) in attendance. Asked me to extend thanks to Dr Hillemand & the rest of his team..</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Medical Record</td><td>20/06/2017</td><td>15:48</td><td>Medical</td><td></td><td>D/W Coroners office, They advised 1 (a) Subarachnoid haemorrhage (b) Fall 2. Decompensated alcohol liver disease. To fax an unsigned copy to coroners office and a clinical summary.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>20/06/2017</td><td>Perso</td><td>Medical</td><td>Personal inform redact</td><td>Time of Death Personal</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>No date</td><td></td><td>Medical</td><td>Letter Ref No : 1917-17</td><td>Dear Coroner's Team, History of Personal Information redacted by the USI . Admitted 7/6/17 Personal Information redacted by the USI Decompensated Alcohol Liver Disease. Back ground : Alcohol excess, depression, circle of willis, aneurysm with previous coiling and SAH 1992. 8/6 : US Abdo : Gallbladder contains sludge. Gallbladder wall oedematous. Appearance of acute cholecystitis. Ascetic tap : not indicitative of SBP. Commenced on antibiotics for cholecystitis. Subsequently developed acute kidney injury. Coagulation deranged. On the 19th of June he fell unwitnessed where he slipped on his urine @ 05:50am. On the Personal @ 19:40pm hid GCS decreased to 3/15. He died Personal His care was D/W Neurosurgery given CT scan result → Contusional brain damage in both frontal lobes. Extracerebellar collection overlying the R frontal lobe. SAH in the supracellar cistern and positve cistern. Cerebellar haem on left. Occipital bone #. Any queries, contact # 4514. Many Thanks. Elizabeth Finnan FY2.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

Stinson, Emma M

From: Reid, Trudy [redacted]
Sent: 18 July 2017 09:20
To: Carroll, Ronan
Subject: FW: Screening
Attachments: Time line [redacted].xlsx; Time [redacted]xlsx; Time line [redacted].xlsx; Time line [redacted].xlsx; Time line [redacted].xlsx

Dear Ronan please see attached time lines for screening, happy to work round your and Colin's availability

SEC	[redacted]	Fall in MSW - Contusional brain damage in both frontal lobes. Extracerebral collection overlying the right frontal lobe. Subarachnoid haemorrhage in the suprasellar cistern and pontine cistern. Cerebellar haemorrhage on the left. Left occipital bone fracture
SEC	[redacted]	Delay in diagnosis and treatment of prostate cancer
sec	[redacted]	Delay in diagnosis and management of prostate cancer
SEC	[redacted]	Delay in diagnosis and treatment of prostate cancer
SEC	[redacted]	Not referred from urology MDM to endocrine

Regards,

Trudy

Trudy Reid
Acute Clinical and Social Care Governance Coordinator
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ
Telephone [redacted]
Mobile [redacted]

Patient 11

Data Source	Date	Time	Professional Group	Key Facts	Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
NICER	17/07/2016		GP	GP referral to urology	Reason for Referral/ History of Presenting Complaint Description: overactive bladder Comment: This Personal Information is having increased problems in recent months with storage and voiding LUTS. I have commenced him on Oxybutinon, but would value a full bladder assessment from the Continence Service in SWAH, whom he has attended in the past. Many thanks.		IEAP					
NICER	28/07/2016		GP	GP referral to urology	Reason for Referral/ History of Presenting Complaint Description: Elevated PSA. Comment: This Personal Information redacted by the USI has mixed symptoms of overactive bladder and prostatism. Recent MSU and urinalysis were normal, but PSA was 5.6. On examination he has a moderately enlarged smooth prostate. I have commenced him on Oxybutynin recently and he has felt some improvement in his LUTS. Please see and advise regarding further management of his elevated PSA. I have also referred this man to the Continence Service for bladder studies.		IEAP					
NICER	18/01/2017		Consultant Urologist	Letter to patient	Dear Patient 11 I am following up a referral your GP sent in July 2016. At the time of this referral your prostate blood test was elevated slightly above normal range. I would be grateful if you could arrange to have repeat of this blood test checked with your GP at your earliest convenience using the enclosed blood test request form. Once a result is available I will be making arrangements to review in clinic.							
NICER	21/01/2017 reported 27/01/2017			Histology report	REPORT CLINICAL_DETAILS Right colonic biopsies - diarrhoea PATHOLOGISTS_REPORT Sections of the 3 white tissue fragments received show normal colonic mucosa with no evidence of inflammation, dysplasia or malignancy. DIAGNOSIS: COLONIC MUCOSA NO PATHOLOGIC DIAGNOSIS							
NICER	20/02/2017		Consultant Urologist	Letter to GP	Diagnosis: Elevated PSA with LUTS Outcome: MRI prostate and TRUS biopsy Trial of Tamsulosin I reviewed Patient 11 today who has had a two year history of frequency of urination and some stinging inside which is relieved by urination. He also feels he has intermittent incomplete emptying. He previously had marked symptoms of urgency which have improved since starting Oxybutynin and this was on the background of having previous urodynamics several years ago that did describe an overactive bladder however I could not find these results today, this information was from the patient. He describes no haematuria but does have nocturia up to 6 times at night, some hesitancy and terminal dribbling. There is no history of incontinence. His weight is stable and his appetite is good. His PSA in July 2016 was 5.6 and January 2017 5.5 ng/ml. On PR examination the base was smooth but I was unable to access the top of the prostate. He underwent flow and post void residual today which showed a post void residual of 7mls and a maximum flow of 16.2mls. His urinalysis was negative. His kidneys were normal. His prostate was identified as having a volume of 31cc with some areas of focal calcification. In view of his elevated PSA and smaller prostate and evidence of calcification this gentleman would benefit from further investigation to rule out any malignancy of his prostate and in light of this I have arranged an MRI of his prostate then TRUS biopsies. I have given him a trial of Tamsulosin today to see if this will improve some of his symptoms and have suggested that should he not see symptom Patient 11							
NICER	20/02/2017		Consultant Urologist	Letter to Pt	Dear Patient 11 Further to your recent clinic attendance I have seen the result of your MRI scan. As you are aware this was performed to further assess the raised prostate blood test. The MRI scan does show a small area of abnormality in the left side of the prostate. I believe arrangements have been made for you to have biopsies of the prostate and this will include some additional biopsies of this area of abnormality on the left side.							
NICER	27/02/2017	16:10			MRI pelvis and prostate							

NICER	06/03/2017	09:21	Radiology	Urology MRI report	27/02/2017 17:10 MRI Pelvis prostate, Author: RRO, Regional Admin MRI PROSTATE CLINICAL HISTORY PSA 5.5. 30 cc. Calcification on ultrasound.? Prostatic malignancy FINDINGS Prostate volume 28 mL. There is an area of decreased T2 W signal in the left peripheral zone measuring 17 x 14 x 25 mm (PI-RADS 5). DWI is been degraded by the THRs. Normal seminal vesicles. No enlarged pelvic lymph nodes. Small focus of decreased T1 W signal in the left ilium of equivocal significance. No other bony lesions. CONCLUSION T2, N0, M0 left peripheral zone carcinoma. (Assumed ilial lesion to be benign but bone scintigraphy recommended). This report of an unexpected significant finding has been notified to the imaging department using the agreed protocol.							
	04/04/2017 reported 11/04/2017			Histology report	CLINICAL DETAILS Recent MRI - area of abnormality left side. PSA: 5.5. Prostate Vol: 27.8 cc. Specimen - Prostate. PATHOLOGIST'S REPORT GROSS DESCRIPTION NATURE OF SPECIMEN: Needle core biopsy SITE: 1. Right base - Three cores measuring 5 mm, 6 and 5 mm along with fragments. (Clinically two cores, on slides fragmented) SITE: 2. Right mid - Three cores easuring 17, 9 and 7 mm along with fragment. (Clinically two cores, on slides fragmented) SITE: 3. Right apex - Two cores measuring 16 and 15 mm. SITE: 4. Left base - Three cores measuring 19, 18 and 12 mm. SITE: 5. Left mid - Four cores measuring 16, 5, 12 and 7 mm alongwith fragment. (Clinically three cores on slides fragmented) SITE: 6. Left apex - Four cores measuring 10, 6, 9 and 4 mm along with fragment. (Clinically two cores on slides fragmented) HISTOLOGY HISTOLOGICAL TYPE: Adenocarcinoma DIFFERENTIATION/GLEASON SUM SCORE: Overall 3+3 = 6 NUMBER OF CORES/CHIPS INVOLVED: 7 of 19 Right base - No tumour identified. Right mid - No tumour identified. Right apex - No tumour identified. Left base - 3 of 3 cores, Gleason 3+3, 11.2 mm max length, 75-80% of tissue. Left mid - 3 of 4 cores, Gleason 3+3, 35-40% of tissue. Left apex -1 of 4 cores, Gleason 3+3, <5% of tissue. INVASION INTO: Seminal vesicle: No Extracapsular fat: No PERINEURAL INVASION: Yes LYMPHOVASCULAR INVASION: No FURTHER COMMENTS: Within 7 of the 19 prostatic core biopsies there are infiltrates of Gleason 3+3 adenocarcinoma. This occupies approximately 20% of the overall tissue examined. There is perineural invasion but no lymphovascular invasion of extracapsular extension. DIAGNOSIS: PROSTATE CORE BIOPSIES							
NICER	04/04/2017		Nurse specialist	Letter to GP	Patient 11 attended Thorndale Unit on 4th April. Written consent was obtained. Local anaesthetic inserted and following guidance from his recent MRI scan a total of 14 core biopsies of prostate were collected. Patient 11 found the procedure somewhat uncomfortable but recovered quickly when the probe was removed. He was provided with a 3 day course of prophylactic antibiotics and discharged home care of a family member. His histology results will be discussed at urology MDM and reviewed by Mr Haynes thereafter. Yours sincerely dictated but not signed							
NICER	04/04/2017			US Guided biopsy prostate transrectal	Report 04/04/2017 09:46 US Guided biopsy prostate transrectal, Author: Radiology, Admin This examination was performed by the Urologist. Please see patient notes.							
NICER	10/04/2017		Medical	SWAH discharge letter for admission 6/4/17 to 10/4/17	This Personal Information redacted by the USI was admitted with pyrexia following a recent prostate biopsy two days previous. He reported feeling generally unwell with aches as well as complaining of ongoing urinary frequency and hesitancy. Patient 11 continued to spike temperatures while in hospital and blood cultures were taken. This gentleman was discussed with urology in CAH where he underwent the biopsy who advised starting Patient 11 on Ciprofloxacin and Gentamicin to which he responded well. CRP peaked at 221.1 but is now improving. Patient 11 is feeling well, he is apyrexic and is surgically fit for discharge with further 7 days of oral Ciprofloxacin. Many thanks for your ongoing care of this gentleman.							

NICER	03/05/2017		Consultant Urologist	Letter to GP	Diagnosis: Low risk prostate cancer Outcome: Bone scan and subsequent outpatient review Patient 11 prostate biopsies have shown a gleason 3+3=6 prostate cancer. His presenting PSA is 5.5 and on MRI scan his local staging would be T2 N0. A bone scan has been arranged to complete his staging. I would anticipate this to be satisfactory given the low risk nature of his disease. His treatment options are either proceeding to treatment with curative intent with either radical surgery, external beam radiotherapy or brachytherapy or alternatively proceeding to active surveillance. He has been given written information regarding prostate cancer and information regarding each of these treatment options. I plan to review him in clinic after his bone scan to discuss these further. Yours sincerely							
NICER	18/05/2017	12:00 reported 18 :26	Radiology	NM bone whole body	Report 18/05/2017 16:14 NM Bone whole body, Author: Vallely, Stephen No evidence of bony metastatic disease. Bilateral hip replacements noted							

Received from Trudy Reid on 16/05/2023. Annotated by the Urology Services Inquiry.

Patient 14

Data Source	Date	Time	Professional Group	Key Facts	Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
NICER	03/06/2016		GP	GP referral	Reason for Referral/ History of Presenting Complaint Description: Raised PSA Comment: Many thanks for seeing this patient - Small rise in PSA noted on routine testing earlier in year - had returned to Normal on repeat testing but mot recent test raised again (5.63) . Few LUTS and nil overt on clinical examination . Please see and advise regards further investigation .		IEAP					
NICER	07/02/2017		Consultant urologist	letter to pt	Dear Patient 14 I am writing to you with the results of your recent MRI. I am pleased to say there are no significant abnormalities of your prostate. There are however some changes within a small area of the prostate so we cannot completely exclude a tumour. Given that your PSA remains raised for your age I would like to offer you a prostate biopsy that is performed under local anaesthetic in the Thorndale outpatients. I will arrange for you to have biopsies and you will be sent an appointment in due course, however if you don't wish to proceed with biopsies at the present time or wish to discuss this further we would be more than happy to hear from you. If you have any queries please contact us on the number above, otherwise I will see you with your biopsy results							
NICER	07/02/2017		Consultant urologist	letter toGP	Thank you for referring this Personal Information redacted by the USI who has a raised PSA of 5.63. Prior to that it had been 4.4 and 5.5. On questioning Patient 14 reports no troublesome lower urinary tract symptoms. He has some occasional hesitancy however he is very happy with his waterworks at present. On examination his abdomen was soft and non-tender and he has a non-palpable bladder. The area revealed moderately enlarged and generally firm but benign feeling prostate. Given that it has been 8 months since his last PSA I have repeated this today at clinic. If it remains elevated or has risen further I will proceed with an MRI of his prostate as he has no contra-indications to this. If however his PSA remains stable I think it is reasonable to continue with 6 monthly surveillance PSA. I will be in touch with his results when they are available. Yours sincerelyThank you for referring this Personal Information redacted by the USI who has a raised PSA of 5.63. Prior to that it had been 4.4 and 5.5. On questioning Patient 14 reports no troublesome lower urinary tract symptoms. He has some occasional hesitancy however he is very happy with his waterworks at present.							
NICER	07/02/2017		Consultant urologist	letter to pt	Dear Patient 14 I am writing to inform you of your latest PSA prostate blood test result. Your PSA has dropped slightly to 5.5 from 5.6 last year. Overall this is reassuring. Given that it remains slightly elevated for your age I will proceed with booking an MRI scan of your prostate as discussed at clinic. You will receive an appointment in due course.							
NICER	24/02/2017	08:20			MRI Pelvis prostate							
NICER	06/03/2017	19:21	Radiology	MRI report	Report 24/02/2017 09:05 MRI Pelvis prostate, Author: Williams, Marc Prostate volume of 37cc. There is a small volume of reduced T2 and ADC signal change related to the posterolateral peripheral zone of the left apex to mid gland. No overt restricted diffusion. The appearances are therefore of equivocal significance and may represent a small focus of tumour. Extension to but not definitively beyond the prostatic capsule. Non specific minor reduced T2 and ADC signal changes within the posterolateral and peripheral zones of both sides of the mid gland to base. Within the limitations of transition zone assessment, no definite transition zone tumour is identified. The seminal vesicles appear unremarkable.5mm utricular cyst. No pelvic lymphadenopathy. Probable degenerative change at L5/S1. An 11mm low T1 signal focus within the right femoral neck is not thought to be significant. CONCLUSION: There is no definite radiological evidence of significant prostate tumour. A small volume of signal change within the posterolateral peripheral zone of the left apex to mid gland is regarded as suspicious. Mild signal change elsewhere within the peripheral zone as described is equivocal. If biopsies are being considered, you may wish to consider additional biopsies of the left apex to mid gland peripheral zone. If tumour should be present, the appearances are thought to represent organ confined disease.							
NICER	28/03/2017			US Guided biopsy prostate transrectal	Report Final 28/03/2017 10:36 US Guided biopsy prostate transrectal, Author: Newell, Denise This examination was performed by the Urologist. Please see patient notes.							
NICER	28/03/2017		Nurse specialist	letter toGP	Patient 14 attended Thorndale Unit today. Written consent was obtained, local anaesthetic inserted and following guidance from his recent MRI scan a total of 15 core biopsies of prostate were obtained. He was provided with a 3 day course of prophylactic antibiotics and discharged home care of a family member. His histology results will be discussed at the urology MDM and he will be reviewed by Mr O'Donoghue thereafter.							

NICER	28/03/2017 reported 5/4/2017			Histology report	CLINICAL DETAILS Recent MRI. SPECIMEN - Prostate. PATHOLOGIST'S REPORT GROSS DESCRIPTION : NATURE OF SPECIMEN: needle core biopsy. SITE: 1. Right base - 2 cores and fragments the longest measuring 18 mm. SITE: 2. Right mid - 2 cores the longest measuring 20 mm. SITE: 3. Right apex - 4 cores the longest measuring 8 mm. SITE: 4. Left base - 2 cores the longest measuring 16 mm. SITE: 5. Left mid - 4 cores the longest measuring 20 mm. SITE: 6. Left apex - 3 cores the longest measuring 19 mm. HISTOLOGY HISTOLOGICAL TYPE: Adenocarcinoma. DIFFERENTIATION/GLEASON SUM SCORE: 3+3=6 NUMBER OF CORES/CHIPS INVOLVED: Right base - Not involved. Right mid -Not involved. Right apex - 1 of 2 cores involved. Gleason 3+3. 40% tissue. Left base - 2 of 2 cores involved. Gleason 3+3. 50% tissue. 6.5mm max length Left mid - 1 of 4 cores. Gleason 3+3. 1% tissue Left apex - 3 of 3 cores involved. Gleason 3+3. 20% tissue. INVASION INTO: Seminal vesicle: No. Extracapsular fat: No. PERINEURAL INVASION: No. LYMPHOVASCULAR INVASION: No. Prostatic adenocarcinoma of overall Gleason sum score 3 + 3 = 6 is present in 7 of 17 cores with a maximum tumour length of 6.5 mm. The tumour occupies approximately 15% of the total tissue volume. DIAGNOSIS PROSTATE NEEDLE CORE BIOPSY ADENOCARCINOMA						
NICER	06/04/2017		Chair MDM	MDM letter to GP	This patient was discussed at the Urology MDM @ The Southern Trust On 06/04/2017. Diagnosis: Prostate cancer Gleason Score 3 + 3 MDM Update: CONSULTANT MR O'DONOGHUE: This Personal Information redacted by the USI who has a raised PSA of 5.63ng/ml. Prior to that it had been 4.4ng/ml and 5.5ng/ml. He reports no troublesome lower urinary tract symptoms, he has some occasional hesitancy. The area revealed moderately enlarged and generally firm but benign feeling prostate. MRI, 24.02.17 - There is no definite radiological evidence of significant prostate tumour. A small volume of signal change within the posterolateral peripheral zone of the left apex to mid gland is regarded as suspicious. Transrectal prostatic biopsy, 28.03.17 - Prostatic adenocarcinoma of Gleason score 3 + 3 = 6, is present in 7 of 17 cores with a maximum tumour length of 6.5mm. The tumour occupies approximately 15% of the total tissue volume. MDM Plan: Discussed at Urology MDM 06.04.17, Patient 14 has low risk, organ confined prostate cancer. For review with Mr O'Donoghue to discuss all treatment options. Signee: If you have any queries or require further information, please do not hesitate to contact us.						
NICER	19/04/2017		Consultant urologist	letter toGP	This gentleman as you know recently had prostate biopsies for a PSA of 5.63ng/ml. The histology has come back showing adenocarcinoma of the prostate Gleason score 3+3=6 in 7 of 17 cores. The tumour occupied approximately 15% of the total tissue. His MRI showed no definite radiological evidence of a significant prostate tumour. There was a small volume of signal change within the posterolateral peripheral zone of the left apex to mid-gland which was regarded as suspicious. As per MDT I have went through the various options for treatment with this low risk organ confined prostate cancer with Patient 14. We discussed radical radiotherapy, radical surgery and active surveillance and he wishes to pursue a period of active surveillance. I will see him in 4 months' time with a PSA 1 week beforehand and in 1 years' time I will re-biopsy his prostate. Yours sincerely						

Patient 12

Data Source	Date	Time	Professional Group	Key Facts	Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
NICER	08/09/2016		GP	Referral to urology	Reason for Referral/ History of Presenting Complaint Description: lower urinary tract symptoms and elevated PSA. Comment: Dear Urologist Please may I have your advice on this Personal Information redacted by the USI with lower urinary tract symptoms and elevated PSA. This man has previously been reviewed in regards to an elevated PSA. He complains of increasing lower urinary tract symptoms of frequency and nocturia. He denies any haematuria or dysuria. He decided to stop his combodart due to erectile dysfunction. He denies any erectile dysfunction while taking Contiflo. His PSA has had a slow general increase over the last number of years and is now 7.34. I would appreciate your opinion on biopsy of his prostate.		IEAP					
NICER	30/01/2017		GP	Referral to urology	Reason for Referral/ History of Presenting Complaint Description: elevated PSA Comment: Please find attached my previous referral in regards to this Personal Information redacted by the USI. I have repeated his PSA at a reasonable interval and it has elevated to 9.43. I would appreciate it if you could upgrade his referral to red flag.		IEAP					
NICER	06/02/2017		LAT3 in Urology	Letter to GP	Diagnosis: Raised PSA Plan: MRI prostate Thank you for referring this Personal Information redacted by the USI who has a rising PSA. Over the last 12 months it has gone from 7.3 to 6.9 and subsequently 9.43 in January 2017. I note that he has had previous investigations including a TRUS biopsy in 2008 which was benign. He reports some urgency and occasional dribbling but is not overly troubled with his lower urinary tract symptoms. He has had no haematuria, UTIs or weight loss. Of note he had previously been on Combodart however he discontinued this due to erectile dysfunction. He is now only on Contiflo. On examination this gentleman has a moderately enlarged but benign feeling prostate. There is a nodule present just left of the midline however I note that this was present in 2007 as documented in an outpatient letter at that time. I have discussed the options with Patient 12 and we have agreed to proceed with an MRI of his prostate. If this shows any abnormalities we will carry out a TRUS biopsy. I will be in touch with the result of his scan in due course.							
NICER	14/02/2017				MRI performed							
NICER	01/03/2017			MRI report	14/02/2017 09:42 MRI Pelvis prostate, Author: RRO, Regional Admin. MRI prostate Oncology report CLINICAL HISTORY Rising PSA 9.4 from 6.9 last year, left lobe nodule on rectal examination FINDINGS Prostate volume 60 mL. There is a 1 cm nodule seen in the left posterior peripheral zone bulge in the capsule, with restricted diffusion (PIRADS 5) and also a possible lesion seen in the right anterior lobe and some PIRADS 3 changes in the right peripheral zone posteriorly. The seminal vesicles collapsed but grossly normal. Normal visualised rectum and bladder. No significantly enlarged lymph nodes or bony deposit in the pelvis CONCLUSION If biopsy-proven, at most, T3a N0, MX							
NICER	07/03/2017		Consultant Urologist	Letter to Pt	Dear Patient 12 I am writing to you with results of your recent MRI. The scan has detected some changes within your prostate which require further investigation. As we discussed at clinic, the next step is to perform a biopsy of the prostate. This can be performed under local anaesthetic at our outpatient unit. I will arrange this and will be in touch with appointment details in the near future.							

NICER	11/04/2017			Histology report	REPORT CLINICAL DETAILS Total cores taken 14. ?? abnormality left mid - base on MRI. PSA 9.43 ng/ml. Prostate volume 31.8. Medication Combodart. SPECIMEN - Prostate. PATHOLOGIST'S REPORT GROSS DESCRIPTION NATURE OF SPECIMEN: Needle core biopsy SITE: 1. Right base - 2 cores measuring 15 and 6 mm along with fragment. SITE: 2. Right mid - 2 ragged cores measuring 14 and 13 mm. SITE: 3. Right apex - 1 core measuring 14 mm. SITE: 4. Left base - 2 ragged cores measuring 18 and 12 mm. SITE: 5. Left mid - 6 cores measuring 11, 10, 14, 12, 5 and 3 mm along with fragments. SITE: 6. Left apex - 1 core measuring 10 mm along with fragment. HISTOLOGY HISTOLOGICAL TYPE: Adenocarcinoma OVERALL GLEASON SUM SCORE: 3+4 = 7 (Grade Group 2) NUMBER OF CORES INVOLVED: 8 of 14 Right base - No tumour identified. Right mid - 2 of 2 cores, Gleason 3+3, < 5% of tissue. Right apex - No tumour identified. Left base - No tumour identified. Left mid - 6 of 6 cores, Gleason 3+4, 6.3 mm max length, 20-25% of tissue. Left apex - No tumour identified. INVASION INTO: Seminal vesicle: No Extracapsular fat: No PERINEURAL INVASION: No LYMPHOVASCULAR INVASION: No FURTHER COMMENTS: The macroscopically described 2 cores within the block 5C got fragmented into 5 small bits, two of which show neoplastic glands. It is difficult to be certain but would be best regarded as 2 of 2 cores involved. Within 8 of the 14 prostatic core biopsies there are infiltrates of Gleason 3+3 and 3+4 adenocarcinoma. This occupies approximately 5% of the overall examined material. There is no perineural invasion, lymphovascular invasion or extracapsular extension. Selected slides (5B, 5C) were discussed with Dr G McClean. DIAGNOSIS PROSTATE CORE BIOPSIES ADENOCARCINOMA				
NICER	20/04/2017		Chair of MDM	MDM meeting letter to GP	This patient was discussed at the Urology MDM @ The Southern Trust On 20/04/2017. Diagnosis: Prostate cancer Gleason Score 3 + 4 MDM Update: CONSULTANT MR HAYNES: This [Personal Information redacted by the USI] has had a rising PSA it had gone from 7.3ng/ml to 6.9ng/ml and subsequently 9.43ng/ml in January 2017. He has had previous investigations including a TRUS biopsy in 2008 which was benign. He reports some urgency and occasional dribbling but is not overly troubled with his lower urinary tract symptoms. On examination he has a moderately enlarged but benign feeling prostate. MRI, 14.02.17 - If biopsy-proven, at most, T3a N0, MX Transrectal prostatic biopsy, 11.04.17 - Adenocarcinoma, Gleason 3+4 = 7. Number of cores involved - 8 of 14. MDM Plan: Discussed at Urology MDM 20.04.17. Patient 12 has high risk prostate cancer. He should be seen in clinic and have a discussion with regard to curative treatment. Signee: If you have any queries or require further information, please do not hesitate to contact us.				
NICER	03/05/2017		Consultant Urologist	Letter to GP	Diagnosis: High risk non metastatic prostate cancer Outcome: Commence Bicalutamide 50mgs once a day, 28 day course Please commence Decapeptyl 11.25mg first dose to be given week commencing 15th May and continued every 12 weeks thereafter Isotope bone scan Refer to Oncology for consideration of radiotherapy in addition to androgen deprivation Patient 12 prostate biopsies have confirmed a high risk prostate cancer and radiologically on his MRI this would appear to be stage T3a with no nodal metastases. Given this the recommended treatment would be hormones and radiotherapy. I have outlined this to him. He does require a bone scan to complete his staging which I have arranged. I have commenced him on his Bicalutamide today and would be grateful if you could arrange his Decapeptyl as above. I have referred him to my Oncology colleagues				

Patient 137

Data Source	Date	Time	Professional Group	Key Facts	Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
NIECR	20/12/2016			CT Chest and abdo and pelvis with contrast	20/12/2016 11:28 CT Chest and abdo and pelvis with contrast At the posterior aspect of the RUL, there is a 42 x 21 x 21 mm irregular soft tissue abnormality with an air bronchogram, adjacent to the oblique fissure present. Minimal linear atelectasis in the right base and mild bilateral basal hypoventilation atelectatic changes. Several accentuated subcarinal lymph nodes measuring up to 12 mm. Normal both kidneys with mildly accentuated collecting system (likely of no clinical significance). In the left perirenal space, anterior to the upper pole of the kidney, there is a large (78 x 68 x 72 mm) well defined fatty tumour with some soft tissue component, abutting mildly thickened adrenal. Enlarged prostate. Normal liver, bile ducts, pancreas, right adrenal, spleen and urinary bladder. No sinister process of the imaged skeleton. Partial lumbarisation of S1. Two small sclerotic lesions within the L3 vertebral body (bony islands?). A small T12 vertebral body haemangioma. **Conclusion:** Right upper lobe pulmonary abnormality suggesting a dense consolidation. Please correlate with clinical features. Follow-up recommended. A large fatty tumour in the left perirenal space which may be in keeping with an angiomyolipoma with extrarenal growth. Differential diagnosis should include liposarcoma, adrenal teratoma or adrenal myelolipoma. Specialist referral is advised. Time Reported: 20-Dec-2016 15:43							
NIECR	21/12/2016			Letter from respiratory physician to GP	Diagnosis: 1. Right upper lobe community acquired pneumonia. - CT chest 20/12/16, right upper lobe consolidation. 2. Left perirenal mass. - CT chest abdomen 20/12/16, large fatty tumour (78 mm) left perirenal space. 3. Left hydrocele repair 2012. 4. Hypertension. 5. Recurrent episodes of hiccups. Comment: This Personal Information redacted by the USI was reviewed at the Respiratory Clinic today following his recent discharge from hospital. His CT imaging is as detailed above. I reviewed the patient's CT imaging with Dr Clarke, Consultant Radiologist today. The left perirenal mass differential diagnosis includes an adrenal myelolipoma, atypical lipoma or a liposarcoma. Action: 1. I have explained the CT results and further management plan to the patient. 2. I would be grateful if you could provide this patient with 7 days of Amoxicillin and Clarithromycin as per handwritten note and telephone call to your surgery today. 3. Red flag referral to Urology Team, Craigavon Area Hospital has been arranged. 4. Repeat chest x-ray has been booked for 6 weeks' time. 5. No review is planned at the Respiratory Clinic.							
NIECR	21/12/2016			Red flag referral from respiratory physician to Urologist	I would be grateful for your urgent assessment of this Personal Information redacted by the USI who has been found to have a 78 mm left perirenal mass. Please find a copy of the most recent correspondence attached. Thank you for your help.							
NIECR	23/12/2016			MDT letter to chair of MDT from Consultant Urologist 2	We have received communication from the chest physician colleagues in the Erne re this Personal Information [redacted] with pneumonia, but has had an incidental finding of a mass lesion in the left perirenal area. I don't think that this is renal in origin; I would agree with their sentiments that this could either be of adrenal origin, I suspect it would be difficult to biopsy. I would be grateful if his films could be reviewed. This would probably be beneficial before speaking to Patient 137 himself							
NIECR	12/05/2017			GP letter	Reason for Referral/ History of Presenting Complaint Description: L renal mass Comment: Patient 137 has never had an appointment re this matter-- ? has referral been made and what are the rv arrangements							
NIECR	18/05/2017			OPD letter to GP from Consultant	Many thanks for your letter Patient 137. Unfortunately it would appear that the referral to the Endocrine Team has not happened. I have done a referral which is attached and I would anticipate Patient 137 will hear from the Endocrine Team in due course.							
NIECR	18/05/2017			OPD letter to Endocrine consultant from Urology Consultant	I would be grateful if you could arrange for review of Patient 137 's imaging and clinical review with yourself. He was referred following a CT scan which was performed in December 2016 following an admission under the care of the General Physicians in South West Acute Hospital. Incidentally the CT scan showed an abnormality in the left peri-renal space. This was reviewed at the Urology MDM in Craigavon Hospital on 12th January where it was felt to represent an adrenal abnormality and referral to yourself was recommended. Unfortunately this referral does not appear to have occurred and a new letter was sent by Patient 137 's GP today. The view of the Urology MDT was given that it would appear to be an adrenal abnormality and further management would be appropriate under your care. I would be grateful if you could arrange for review of your imaging at MDT and subsequent clinic review with yourself regarding further managem							

Personal Information redacted by the USI

Data Source	Date	Time	Professional Group	Key Facts	Core Detail	Intellegence gathered from staff	What policies/procedures are relevant	Were standards met	If care case management was less than it should have been and the lapses/ommissions ere not serious what is the local learning point and how is it going to be used for team improvement	Serious breeches s	For all serious breeches identify key areas of enquiry	Further investigation required
ED RECORD	07/06/2017	18:20			GP referral to ED history of binge drinking/depression.							
Medical Admission Booklet	07/06/2017	23:15	Medical		[redacted]. Alcohol misuse referred from GP. Woke up today- nose bleed or mouth, unsure?. First episode over face and pillow. Went to GP- they noted ascites & advised ED. Loss of 3 stone from Christmas. Poor appetite for 10 weeks. ↑abdominal sweling. No abd pain. Urine dark bowels black approx a fortnight- not on iron. Vomiting today- bile - rthen noticed fresh blood -no clots after taking a cup of coffee. Mood low xxx poor sleep. Stressors-ex wife ↑alcohol use would drink in am. Denies previous DVTs. Wishing to Detox.Past Medical History. Alcohol excess Depression, Circle of Wills, Aneurysm →Previous coiling & SAH. Carrier for haemacromotosis H63D heterocygosity HFt gene. Admitted MSW DHH.							
Nursing Record	08/06/2017	04:00	Nursing	Admission	Admission Nursing assessment Unsteady when walking on admission. Prior to admission: Unsteady on feet ass x1 whilst walking and transferring.							
Nursing Record	08/06/2017	04:40	Nursing		patient unsteady on his feet ass x 1 pt needing referrals to disciplines patient states he hasn't been sleeping.							
Nursing Record	**not dated**			**Falls risk assessment**	Falls (Risk assessment) signed but not dated Does patent have a history of falling or has fallen since admission? NO Does the patient have a fear of falling? NO							
Nursing Record	08/06/2017				Referred to Physio and OT 8/6/17.							
Nursing Record	08/06/2017	11:30	Nursing		Assisted x 1 to mobilize, remains unsteady on feet. Patient uses walking aid at home, not with patient on ward.							
Nursing Record	08/06/2017	19:30	Nursing		Remains unsteady on feet, using crutches to mobilize. Physio unable to assess, will assess tomorrow.							
Nursing Record	09/06/2017	00:15	Nursing		[redacted] in bathroom advised to use call bell as unsteady with stick. Assisted into bed.							
Nursing Record	10/06/2017	11:30	Nursing		Unsteady on feet. Advised to not walk too far from bed.							
Nursing Record	11/06/2017	19:05	Nursing		Supervised whilst mobilizing as unsteady gait.							
Nursing Record	12/06/2017	21:10	Nursing		Mobilizing out to toilet under supervision with aid of ZF.							
Nursing Record	13/06/2017	12:30	Nursing		Mobilizing under supervision							
Nursing Record	14/06/2017	14:35	Nursing		Assisted out to bathroom							
Nursing Record	15/06/2017	12:20	Nursing		Out to bathroom with zimmer x1 staff							
Nursing Record	16/06/2017	01:30	Nursing		Assisted out to toilet with 1 member of staff + comode.							
Nursing Record	17/06/2017	08:00	Nursing		Up to sit at bedsisde and walked to toilet with aid of zimmer and 2 nurses							
Nursing Record	17/06/2017		Nursing	Falls Assessment	Moving and Handling Plan: Bed to chair, Walking Dependency 1-2. Aids: Z Frame. Patient orientiated to the ward. Call bell given. Pt unsteady ass x 1. Pt's mobility is not great. Ass x 1 very unsteady gait							
Nursing Record	19/06/2017	02:30			[redacted] complaining about sickness- ondanstron 4 mg PO given @02:15. Change again for faecal incontinence. [redacted] state he want to sit in chair, asisted with same. States he is not comfortable in the bed.							
Nursing Record	19/06/2017	05:30	Nursing	**Falls risk assessment**	Page 17 Nursing Booklet. Fall @ward. Patient orientiated to ward. Medical review after fall. GCS 14/15 then 15?15 within an hour. Call bell within reach and explained.[redacted] slightly confused right after fall but GCS back @ 15/15. Moving and handling assessment completed. Ass x 2 out of bed. Zimmer frame. Medical review done after fall		Nursing admission assessment	??				
Medical Record	19/06/2017	05:50	Medical		ATSP re Fall on ward. Arrived to find patient lying on his back in MSW Ward 2. In attendance Bedmanager Angela, SN Maria and Health Care Assistant (P). [redacted] was conscious, had slipped in urine and fell to floor hitting head. Bleeding from posterior head, left forehead and left nostril. C/O pain in head. Able to move all 4 limbs while on ground. Following commands. Pain free CSP ROM. No deformity felt at CSP therefore rolled patient onto side and mobilized patient safely on to chair and back to bed. O/GCS 14/15- confused, not orientiated to time /place/person. Considered swelling at posterior/occipital region of head + abrasion at forehead + dry blood in left nostril. PEARL Double vision with all eye movements. CN grossly intact. Able to move all 4 limbs pain free. No focal neurology. No other obvious injuries. RR18 Sats 95%RA Temp 36 BP 140/70 HR 102. xxx (Alert). Plan Caog screen deranged ++. →CT Brain - discussed + confirmed. CNS obs, Analgesia.							
Medical Record	19/06/2017		Medical		Continued. Episode of haematemesis post fall. Small volume in kidney dish. Plan. A/W CT report							
NIECR	19/06/2017	06:33	Radiology	**CT Brain**	Time Performed 19-Jun-2017 06:33 Time Reported 19-Jun-2017 07:06 CT BRAIN. CLINICAL NOTES: Decompensated liver disease head injury abnormal clotting. FINDINGS: There is a shallow extracerebral collection overlying the right frontal lobe and some contusional damage to the underlying brain in both cerebral hemispheres. There is the subarachnoid haemorrhage in the suprasellar cistern. There is evidence of previous surgery with a right-sided craniotomy and surgical clip in the sylvian fissure. Haemorrhage is present in the left cerebellar hemisphere and subarachnoid haemorrhage is present in the cerebellar folia. There is some haemorrhage in the pontine cistern..There is there occipital bone fracture on the left side. **CONCLUSION:Contusional brain damage in both frontal lobes. Extracerebral collection overlying the right frontal lobe. Subarachnoid haemorrhage in the suprasellar cistern and pontine cistern. Cerebellar haemorrhage haemorrhage on the left. Left occipital bone fracture**							
Medical Record	19/06/2017	06:55	Medical		Seen by doctor. History noted. O/E Large occipital haematoma. CNS 12 Intact. Both pupils reactive. Eye movements Normal, Visual fields Normal. CT result phoned through to Dr McCreesh.→ Bifrontal confusing →Extracerebral collection Right frontal lobe →SAH Suprasellar cistern + positive cistern →Cerebellar haemmorrhage on the left. Left occipital bone #. D/W Drv Magee (Cons on Call) → Advises contacting Neurosurgery and Haematology.→ On way in to hospital, will be present in 15-20 mins. D/W Neurosurgical Registrar (Jonathan Poots) → Given poor prognosis regarding liver disease, deranged Coag and low platlets he would not be a surgical candidate. → Advises haematology advice. D/W Haematology Consultant (Dr Bily Cons) → Advises giving 3000 units Octaplex, 2 Units Plts, 1g Transexamic acid TID (8hrly) for 3-4/7- Daily FBC + coag							
Nursing Record	19/06/2017	07:00			...Assisted to chari and back to bed x 2 [redacted] has taken short naps overnight .....At 05:30 [redacted] has unwitnessed fall. [redacted] had disconnected both his iv drips independentl and got out of bed, found lying on his back, appear to have hit his head- bleeding from back of his head, also nose bleed. Clinical observations recorded, no LOC, responsive, slightly confused. FY1 Dr xxx contacted who comes to see [redacted] @ 05:35							
Medical Record	19/06/2017	07:35	Medical		W/R Dr Magee. Fell early am. (approx 05:50) Pt thinks he slipped on something on floor. Hit back of head. ◦ LOC. C/O pain at back of head. Speech slurred/difficult to make out. (◦ change as per N/S). Episode of haematemesis post fall. O/E pupils reactive ; small. Blood around mouth. Platlets ↓↓ Chest clear RR 19 Sats 95% RA HR 110 BP 140/80 Temp 36.5 c. Explained to pt findings of CT; # skull and area of bleeding. We will try to correct the bleeding problem with medications. - Needs escalated as Serious adverse incident, - contact family,- CNS Obs, -Correct caog as per haematology.							
Medical Record	19/06/2017	08:10	Medical		Octaplex requested. 2 Units platlets requested.							
Medical Record	19/06/2017		Medical		WR Hillemand. Events overnight discussed and current plan noted. Patient c/o some headache, is alert and rousable. BP 153/84 HR 104 SaO2 94% (RA). Day 6 Terlipressin/albumin. Stop pabrinex, check U&E today - K ›3.5. 2 hrly CNS obs then 4 hrly in evening if stable.							

<table>
<tr><td>Medical Record</td><td>19/06/2017</td><td>21:10</td><td>Medical</td><td></td><td>Harity SHO. GCS subsequently deterioriated - now 3/15. Snoring, vomiting x 1. Unsafe airway- unsuitable for transfer currently. D/W Consultant on call Shambul. Advised of above. Ceiling of care estabilished- not for Resus/intubation given unstable airway and potential to loose airway in scanner, advised not for scan @ present. Reconsider scan in event of GCS improving given GCS currently, comfort measures @ present. D/W family RE above, happy, no further questions @ present.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Medical Record</td><td>19/06/2017</td><td></td><td>Medical</td><td></td><td>CT1 Medical. Xx R/V. Events noted. Rapid decline in GCS now 3/15. Care has been discussed with Dr Shamboal, Consultant on call. Not for scanning or further intervention. Family in attendance. Pt appears comfortable at rest. Snoring evident. No aggitation/confusion. No spouse to xxxx touch. Family happy with current care. xxxx and comfort only. PRN midazolam. Diamorphine prescribed in event he becomes agitated but not requiring at present. If GCS improves, rediscussion with Sr Shamboal and consider now if airway patent.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Medical Record</td><td>20/06/2107</td><td>09:18</td><td>Medical</td><td></td><td>Personal information redacted admitted 7/6/17. Alcohol excess, decom ALD. Temp spikes- USS cholrcystitis →treated with Teic + Gent+ Metro. →switched to Aztreonam, Linezolid, Metronidazole. Multifactorial AKL. Fall on ward : CT - SAH- Cerebellar haemorrhage.→D/W Neurosurgey → not a surgical candidate. Note events overnight. ↓GCS 3/15 DW Dr Shamboal Consultant on call. Obs at 4am RR16 Sats 93 Aprexic BP 153/71 HR 120.Personal Information redacted in attendance this am. Family agree with comfort measures. GCS 5/15 at present. HS 1=11-0 rapid. Appears comfortable. Plan PRN midazolam + diamorphine. I will update Dr Hillemand on events in past 2hr.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Nursing Record</td><td>19/06/2107- 20/06/2107</td><td>05:30-21:00</td><td>Nursing</td><td>NEWS CHART</td><td>
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<tr><td>Time</td><td>05:30</td><td>05:45</td><td>06:00</td><td>06:15</td><td>07:55</td><td>08:10</td><td>08:30</td><td>08:45</td><td>09:00</td><td>09:10</td><td>10:00</td><td>12:00</td><td>14:00</td><td>17:00</td><td>19:15</td><td>21:00</td></tr>
<tr><td>GCS</td><td>14/15</td><td>14/15</td><td>15/15</td><td>15/15</td><td>15/15</td><td>15/15</td><td>15/15</td><td>15/15</td><td>15/15</td><td>15/15</td><td>15/15</td><td>15/15</td><td>15/15</td><td>14/15</td><td>6/ 15</td><td>3/ 1</td></tr>
<tr><td>Limb power</td><td>Normal</td><td>Normal</td><td>Normal</td><td>Normal</td><td>Normal</td><td>Normal</td><td>Normal</td><td>Normal</td><td>Normal</td><td>Normal</td><td>Normal</td><td>Normal</td><td>Normal</td><td>Mild weakness arms</td><td>-</td><td>-</td></tr>
<tr><td>Pupils</td><td>3 equal & reacting</td><td>3 equal & reacting</td><td>3 equal & reacting</td><td>3 equal & reacting</td><td>2 equal & reacting</td><td>2 equal & reacting</td><td>2 equal & reacting</td><td>2 equal & reacting</td><td>2 equal & reacting</td><td>2 equal & reacting</td><td>3 equal & reacting</td><td>2 equal & reacting</td><td>2 equal & reacting</td><td>2 equal & reacting</td><td>R =3</td><td></td></tr>
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</td><td></td><td>Post falls observations</td><td>???</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Nursing Record</td><td>19/06/2017</td><td>12:00-21:00</td><td>Nursing</td><td>CI Obs Chart</td><td>
<table>
<tr><th colspan="7">Clinical observations</th></tr>
<tr><td>Date</td><td>19/06/2017</td><td>19/06/2017</td><td>19/06/2017</td><td>19/06/2017</td><td>19/06/2017</td><td>19/06/2017</td></tr>
<tr><td>Time</td><td>12:00</td><td>14:00</td><td>14:10</td><td>17:00</td><td>19:15</td><td>21:00</td></tr>
<tr><td>Resp</td><td>18</td><td>16</td><td>17</td><td>16</td><td>14</td><td>16</td></tr>
<tr><td>Spo2 %</td><td>95%</td><td>91%</td><td>91%</td><td>91%</td><td>91%</td><td>93%</td></tr>
<tr><td>Temp</td><td>36.5</td><td>37.4</td><td>37.3</td><td>36.8</td><td>37.3</td><td></td></tr>
<tr><td>Blood Pressure</td><td>158/70</td><td>150/74</td><td>151/72</td><td>140/71</td><td>152/71</td><td>160/76</td></tr>
<tr><td>HR</td><td>112</td><td>111</td><td>100</td><td>117</td><td>120</td><td>120</td></tr>
<tr><td>Level of Consciousness</td><td>A</td><td>A</td><td>A</td><td>A</td><td>P</td><td>U</td></tr>
<tr><td>NEWs</td><td>2</td><td>5</td><td>4</td><td>3</td><td>8</td><td>7</td></tr>
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</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Medical Record</td><td>20/06/2017</td><td>14:55</td><td>Medical</td><td></td><td>Lee Marshall F1. Confirmation of life extinct. ⊖ heart sounds ⊖ central pulse ⊖ respiratory effort/breath sounds. Pupils fixed + dilated ⊖ response to pain. <u>Time of death</u>Perso... Personal information redacted <u>Family</u> (Personal Information redacted by the HSI) in attendance. Asked me to extend thanks to Dr Hillemand & the rest of his team..</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Medical Record</td><td>20/06/2017</td><td>15:48</td><td>Medical</td><td></td><td>D/W Coroners office, They advised 1 (a) Subarachnoid haemorrhage (b) Fall 2. Decompensated alcohol liver disease. To fax an unsigned copy to coroners office and a clinical summary.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>20/06/2017</td><td>Perso...</td><td>Medical</td><td>Personal information redacted</td><td>Personal information redacted by HSI</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>No date</td><td></td><td>Medical</td><td>Letter Ref No : 1917-17</td><td>Dear Coroner's Team, History of Personal Information redacted by the HSI. Admitted 7/6/17 Personal information redacted Decompensated Alcohol Liver Disease. Back ground : Alcohol excess, depression, circle of willis, aneurysm with previous coiling and SAH 1992. 8/6 : US Abdo : Gallbladder contains sludge. Gallbladder wall oedematous. Appearance of acute cholecystitis. Ascetic tap : not indicitative of SBP. Commenced on antibiotics for cholecystitis. Subsequently developed acute kidney injury. Coagulation deranged. On the 19th of June he fell unwitnessed where he slipped on his urine @ 05:50am. On the Personal information redacted @ 19:40pm hid GCS decreased to 3/15. He died Personal information redacted His care was D/W Neurosurgery given CT scan result → Contusional brain damage in both frontal lobes. Extracerebellar collection overlying the R frontal lobe. SAH in the supracellar cistern and positive cistern. Cerebellar haem on left. Occipital bone #. Any queries, contact # 4514. Many Thanks. Elizabeth Finnan FY2.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
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Date	19/06/2017	19/06/2017	19/06/2017	19/06/2017	19/06/2017	19/06/2017	19/06/2017	19/06/2017	19/06/2017	19/06/2017	19/06/2017	19/06/2017	19/06/2017	19/06/2017
Time	06:00	06:15	07:55	08:10	08:30	08:45	09:00	09:10	10:00	12:00	14:00	17:00	19:15	21:00
GCS	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15	14/15	Jun-15	Mar-15
Limb power	Normal	Normal	Normal	Normal	Normal	Normal	Normal	Normal	Normal	Normal	Normal	Mild weakness arms	-	-
Pupils	3 equal & reacting	3 equal & reacting	2 equal & reacting	2 equal & reacting	2 equal & reacting	2 equal & reacting	2 equal & reacting	2 equal & reacting	3 equal & reacting	2 equal & reacting	2 equal & reacting	2 equal & reacting	R =3	

Clinical observations														
Date	19/06/2017	19/06/2017	19/06/2017	19/06/2017	19/06/2017	19/06/2017	19/06/2017	19/06/2017	19/06/2017	19/06/2017	19/06/2017	19/06/2017	19/06/2017	19/06/2017
Time	07:30	07:55	08:10	08:30	08:45	09:00	09:15	10:00	12:00	14:00	14:10	17:00	19:15	21:00
Resp	19	20	20	20	20	20	20	20	18	16	17	16	14	16
Spo2 %	95%	94%	95%	94%	95%	95%	94%	94%	95%	91%	91%	91%	91%	93%
Temp	36.5	36.5	36.5	36.5	36.5	36.5	36.5	36.5	36.5	37.4	37.3	36.8	37.3	
Blood Pressure	140/80	142/70	160/84	158/74	160/70	158/80	160/90	158/84	158/70	150/74	151/72	140/71	152/71	160/76
HR	110	102	108	104	104	100	100	108	112	111	100	117	120	120
Level of Consciousness	A	A	A	A	A	A	A	A	A	A	A	A	P	U
NEWs	3	2	1	2	1	1	1	2	2	5	4	3	8	7

Stinson, Emma M

From: Boyce, Tracey [redacted]
Sent: 29 June 2017 15:40
To: Reid, Trudy
Subject: RE: Screening

Hi
I am about the week of the 12th – could I sit in for you that week? – it would shave a couple of days off the timescales?

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy
[redacted]

Learn more about mental health medicines and conditions on the Choiceandmedication website http://www.choiceandmedication.org/hscni/

From: Reid, Trudy
Sent: 29 June 2017 14:55
To: Boyce, Tracey
Subject: FW: Screening

For discussion please see below this means the AOB cannot be screened until then and I am on leave to 16th July

Regards,

Trudy

Trudy Reid
Acute Clinical and Social Care Governance Coordinator
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ
Telephone [redacted]
Mobile [redacted]

From: Carroll, Ronan
Sent: 29 June 2017 13:19
To: Reid, Trudy
Cc: Haynes, Mark; Weir, Colin
Subject: RE: Screening

In cah tomorrow if I can get mark. Colin on AL to 10th july

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

From: Reid, Trudy
Sent: 29 June 2017 11:25
To: Carroll, Ronan
Subject: FW: Screening

Ronan just checking if you had a date for screening?

Regards,

Trudy

Trudy Reid
Acute Clinical and Social Care Governance Coordinator
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ
Telephone Personal Information redacted by the USI
Mobile Personal Information redacted by the USI

From: Reid, Trudy
Sent: 16 June 2017 10:31
To: Carroll, Ronan
Subject: FW: Screening

Ronan please see attached time lines for screening

SEC	Personal Information redacted by the USI	CT showed PE not actioned
SEC	Patient 12	Delay in diagnosis and treatment of prostate cancer

sec	Patient 14	Delay in diagnosis and management of prostate cancer
SEC	Patient 11	Delay in diagnosis and treatment of prostate cancer
SEC	Personal Information redacted by the USI	Delay in tumour management
SEC	Personal Information redacted by the USI	Not preped for CT scan - aspirated
SEC	Patient 137	Not referred from urology MDM to endocrine

Regards,

Trudy

Trudy Reid
Acute Clinical and Social Care Governance Coordinator
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ
Telephone Personal Information redacted by the USI
Mobile Personal Information redacted by the USI

Stinson, Emma M

To: Carroll, Ronan; Weir, Colin; McAloran, Paula
Cc: Boyce, Tracey
Subject: screening and notification forms for approval
Attachments: Screening form AM.doc; Screening Checklist template Patient 12 .doc; Screening Checklist Patient 14 .doc; Screening Checklist template Patient 11 .doc; Appendix 1 - Notification Form urology cases.docx; Screening form Patient 16 .doc

Good afternoon please see attached screening forms and SAI notification for the urology cases

Trudy Reid
Acute Clinical and Social Care Governance Coordinator
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ
Telephone Personal Information redacted by the USI
Mobile Personal Information redacted by the USI

MAJOR / CATASTROPHIC INCIDENT CHECKLIST [redacted]

Directorate:	**Acute Services**
Reporting Division:	**Acute**
Date of Incident:	**28/07/2016**
Incident (IR1) ID:	**Complaint requires datix to be completed**
Grade of Incident:	**Major**
Names / Designations of those considering Incident: *(Should include Director, Assistant Director, AMD & CSCG Coordinator)*	Mr R Carroll Mr C Weir Coordinator Mrs T Reid
If Incident involved the death of a service user, was the coroner informed:	**No**
Brief Summary of Incident:	[redacted] male referred to urology following an episode of haematuria on 28/07/2016, it appears the letter was not triaged and thus [redacted] was place on a routine waiting list. As part of an internal review [redacted] was upgraded to red flag referral and was reviewed at OPD, subsequent investigations diagnosed a pT4 TCC of bladder and prostate. MDM 09/03/2017 [redacted] has locally advance bladder cancer (G3T4a).
Summary of discussions re SAI / RCA/ major / catastrophic incident review:	The review team considered that the apparent lack of triage precipitated a delay in diagnosis.

Decision on Level Review Type AND rationale for this:	Level 1 SAI
Nominated Review Team: *(Consider need / benefit of independent external expertise)*	
Is it appropriate to inform the Medical Executive/Executive Directorate of Nursing?	☒ X ☐ **NO**
Contact for service user and / or designated relatives / carers: *(Either Lead Professional or Chair of Review)*	
Date and by whom service user and / or designated relatives / carers informed of review taking place*:(If there is an exceptional case where this is inappropriate rationale must be documented):*	
If case referred to the Coroner - Date and by whom coroner informed of SAI / Internal Review :	

(Corporate Governance Office / Litigation to complete) Date and by whom Trust Litigation Dept informed:	
Does this incident meet the DHSSPS Early Alert Criteria including rationale:	
POST REVIEW COMPLETION: Date and by whom and how Review is shared with the service user and / or designated relatives / carers: *(In exceptional cases where this is inappropriate, rationale should be documented)*	
Date and by whom and how Review is shared with the Coroner:	

MAJOR / CATASTROPHIC INCIDENT CHECKLIST **Name: -** [redacted]

Directorate:	**Acute Services**
Reporting Division:	**Acute**
Date of Incident:	**20/04/2017**
Incident (IR1) ID:	[redacted]
Grade of Incident:	**Major**
Names / Designations of those considering Incident: *(Should include Director, Assistant Director, AMD & CSCG Coordinator)*	**Mr R Carroll** **Mr C Weir** **Mrs P McAloran** **Mrs T Reid (Facilitator)**
If Incident involved the death of a service user, was the coroner informed:	**NA**
Brief Summary of Incident:	**Patient** [redacted] **was referred to Urology Outpatients on 8 Sept 2016 for assessment and advice on lower tract symptoms and elevated PSA. Referral was marked urgent by the GP. Referral was not triaged on receipt. As a result of a look-back exercise the referral was upgraded to red flag and was seen in clinic on day 151, on day 197 the patient had a confirmed cancer diagnosis**
Summary of discussions re SAI / RCA/ major / catastrophic incident review:	The review team considered that the apparent lack of triage precipitated a delay in diagnosis.

Decision on Level Review Type AND rationale for this:	Level 1 SEA
Nominated Review Team: *(Consider need / benefit of independent external expertise)*	Dr J Johnston Mr M Haynes Mrs K Robinson Mrs T Reid
Is it appropriate to inform the Medical Executive/Executive Directorate of Nursing?	☒ X ☐ **NO**
Contact for service user and / or designated relatives / carers: *(Either Lead Professional or Chair of Review)*	
Date and by whom service user and / or designated relatives / carers informed of review taking place*:(If there is an exceptional case where this is inappropriate rationale must be documented):*	
If case referred to the Coroner - Date and by whom coroner informed of SAI / Internal Review :	

(Corporate Governance Office / Litigation to complete) Date and by whom Trust Litigation Dept informed:	
Does this incident meet the DHSSPS Early Alert Criteria including rationale:	
POST REVIEW COMPLETION: Date and by whom and how Review is shared with the service user and / or designated relatives / carers: *(In exceptional cases where this is inappropriate, rationale should be documented)*	
Date and by whom and how Review is shared with the Coroner:	

MAJOR / CATASTROPHIC INCIDENT CHECKLIST **Name: -** [redacted] Patient 14 [redacted]

Directorate:	**Acute Services**
Reporting Division:	**Acute**
Date of Incident:	**06/04/2017**
Incident (IR1) ID:	Personal Information redacted by the USI [redacted]
Grade of Incident:	**Major**
Names / Designations of those considering Incident: *(Should include Director, Assistant Director, AMD & CSCG Coordinator)*	**Mr R Carroll** **Mr C Weir** **Mrs P McAloran** **Mrs T Reid (Facilitator)**
If Incident involved the death of a service user, was the coroner informed:	**NA**
Brief Summary of Incident:	Patient Patient 14 [redacted] was referred to Urology Outpatients on 3 June 2016 for assessment and advice raised PSA. Referral was marked urgent by the GP. Referral was not triaged on receipt. As part of an internal review the referral was upgraded to red flag and was seen in clinic on day 246, on day 304 the patient had a confirmed cancer diagnosis. There has been a resultant 10 month delay in OP review and recommendation of treatment for a prostate cancer. Patient is aware of diagnosis but not delay he has decided to opt for active surveillance treatment

Summary of discussions re SAI / RCA/ major / catastrophic incident review:	The review team considered that the apparent lack of triage precipitated a delay in diagnosis.
Decision on Level Review Type AND rationale for this:	Level 1 SEA
Nominated Review Team: *(Consider need / benefit of independent external expertise)*	Dr J Johnston Mr M Haynes Mrs K Robinson Mrs T Reid
Is it appropriate to inform the Medical Executive/Executive Directorate of Nursing?	☒ X ☐ **NO**
Contact for service user and / or designated relatives / carers: *(Either Lead Professional or Chair of Review)*	
Date and by whom service user and / or designated relatives / carers informed of review taking place*:(If there is an exceptional case where this is inappropriate rationale must be documented):*	
If case referred to the Coroner - Date and by whom coroner informed of SAI / Internal Review :	

(Corporate Governance Office / Litigation to complete) Date and by whom Trust Litigation Dept informed:	
Does this incident meet the DHSSPS Early Alert Criteria including rationale:	
POST REVIEW COMPLETION: Date and by whom and how Review is shared with the service user and / or designated relatives / carers: *(In exceptional cases where this is inappropriate, rationale should be documented)*	
Date and by whom and how Review is shared with the Coroner:	

MAJOR / CATASTROPHIC INCIDENT CHECKLIST **Name: -** Patient 11

Directorate:	**Acute Services**
Reporting Division:	**Acute**
Date of Incident:	**28/07/2016**
Incident (IR1) ID:	Personal Information redacted by the USI
Grade of Incident:	**Major**
Names / Designations of those considering Incident: *(Should include Director, Assistant Director, AMD & CSCG Coordinator)*	**Mr R Carroll** **Mr C Weir** **Mrs P McAloran** **Mrs T Reid (Facilitator)**
If Incident involved the death of a service user, was the coroner informed:	**NA**
Brief Summary of Incident:	Patient Patient 11 was referred to Urology Outpatients on 28 July 2016 for assessment and advice elevated PSA. Referral was marked urgent by the GP. Referral was not triaged on receipt. As a result of a look-back exercise the referral was upgraded to red flag and patient was seen in clinic on day 217, on day 270 the patient had a confirmed cancer diagnosis. There has been a resultant 9 month delay in OP review and recommendation of treatment for a prostate cancer. Patient is aware of diagnosis but not delay and has is currently thinking about his options for treatment.
Summary of discussions re SAI / RCA/	The review team considered that the apparent lack of triage precipitated a delay in

major / catastrophic incident review:	diagnosis.
Decision on Level Review Type AND rationale for this:	Level 1 SEA
Nominated Review Team: *(Consider need / benefit of independent external expertise)*	Dr J Johnston Mr M Haynes Mrs K Robinson Mrs T Reid
Is it appropriate to inform the Medical Executive/Executive Directorate of Nursing?	☒ X ☐ **NO**
Contact for service user and / or designated relatives / carers: *(Either Lead Professional or Chair of Review)*	
Date and by whom service user and / or designated relatives / carers informed of review taking place*:(If there is an exceptional case where this is inappropriate rationale must be documented):*	
If case referred to the Coroner - Date and by whom coroner informed of SAI / Internal Review :	

(Corporate Governance Office / Litigation to complete) Date and by whom Trust Litigation Dept informed:	
Does this incident meet the DHSSPS Early Alert Criteria including rationale:	
POST REVIEW COMPLETION: Date and by whom and how Review is shared with the service user and / or designated relatives / carers: *(In exceptional cases where this is inappropriate, rationale should be documented)*	
Date and by whom and how Review is shared with the Coroner:	

APPENDIX 1

Revised November 2016 (Version 1.1)

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

1. ORGANISATION: Southern Health and Social Care Trust	**2.** UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE **3.** ID Patient 13 Patient 12 Patient 14 Patient 11
4. HOSPITAL / FACILTY / COMMUNITY LOCATION Craigavon Area Hospital	**5.** DATE OF INCIDENT: Reported:
6. DEPARTMENT / WARD / LOCATION EXACT Urology Department	
7. CONTACT PERSON: Mrs Connie Connolly	**8.** PROGRAMME OF CARE: Acute Services

9. DESCRIPTION OF INCIDENT:

1. Patient 13 referred to urology following an episode of haematuria on 28 July 2016, it appears the letter was not triaged and the patient was placed on a routine waiting list on 30 September 16. As part of an internal review this patient's referral letter was upgraded to a red flag referral and was reviewed at OPD on 31/01/17. Subsequent investigations diagnosed a pT4 TCC of bladder and prostate. Patient has locally advance bladder cancer (G3T4a).
2. Patient 12 was referred to Urology Outpatients on 8 Sept 2016 for assessment and advice on lower tract symptoms and elevated PSA. Referral was marked urgent by the GP. Referral was not triaged on receipt. As part of an internal review the referral was upgraded to red flag and was seen in clinic on day 151, on day 197 the patient had a confirmed cancer diagnosis T3a with no nodal metastases

3. Patient 14 was referred to Urology Outpatients on 3 June 2016 for assessment and advice raised PSA. Referral was marked urgent by the GP. Referral was not triaged on receipt. As part of an internal review the referral was upgraded to red flag and was seen in clinic on day 246, on day 304 the patient had a confirmed cancer diagnosis. There has been a resultant 10 month delay in OP review and recommendation of treatment for a prostate cancer. Patient is aware of diagnosis but not delay he has decided to opt for active surveillance treatment

4. Patient 11 was referred to Urology Outpatients on 28 July 2016 for assessment and advice elevated PSA. Referral was marked urgent by the GP. Referral was not triaged on receipt. As part of an internal review the referral was upgraded to red flag and patient was seen in clinic on day 217, on day 270 the patient had a confirmed cancer diagnosis. There has been a resultant 9 month delay in OP review and recommendation of treatment for a prostate cancer. Patient is aware of diagnosis but not delay and has is currently thinking about his options for treatment.

The SHSCT wish to submit this incident as an SAI in order to establish any areas of learning relating to this incident.

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

D
(complete where relevant)

10. IS THIS INCIDENT A NEVER EVENT?				If 'YES' *provide further detail on which never event - refer to DoH link below* https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars
YES		NO	x	

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING		
STAGE OF CARE: *Checking and Oversight*	DETAIL: *(refer to Guidance Notes)*	ADVERSE EVENT: *(refer to Guidance Notes)*

11. IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE: Notified to the Medical Director on

12. CURRENT CONDITION OF SERVICE USER: *recuperating from initial surgery, awaiting further treatment*

13. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)*		NO	
14. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED? *(please specify where relevant)*	YES		

15. WHY IS THIS INCIDENT CONSIDERED SERIOUS?: *(please select relevant criteria below)*

serious injury to, or the unexpected/unexplained death of: - a service user (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit) - a staff member in the course of their work - a member of the public whilst visiting a HSC facility.	x
unexpected serious risk to a service user and/or staff member and/or member of the public	
unexpected or significant threat to provide service and/or maintain business continuity	
serious self-harm or serious assault *(including attempted suicide, homicide and sexual assaults)* by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service	
serious self-harm or serious assault *(including homicide and sexual assaults*) - on other service users, - on staff or - on members of the public by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	
suspected suicide of a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	
serious incidents of public interest or concern relating to: - any of the criteria above - theft, fraud, information breaches or data losses - a member of HSC staff or independent practitioner	

16. IS ANY IMMEDIATE REGIONAL ACTION RECOMMENDED: *(please select)*		NO

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

if 'YES' (*full details should be submitted*):

17. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI?	YES	DATE INFORMED: DD/MM/YY
	NO	*specify reason:*

18. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *(refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.) please specify where relevant*	YES	NO

if 'YES' (*full details should be submitted including the date notified*):

19. OTHER ORGANISATION/PERSONS INFORMED: *(please select)*	DATE INFORMED:	OTHERS: *(please specify where relevant, including date notified)*
DoH EARLY ALERT		
HM CORONER		
INFORMATION COMMISSIONER OFFICE (ICO)		
NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC)		
HEALTH AND SAFETY EXECUTIVE NORTHERN IRELAND (HSENI)		
POLICE SERVICE FOR NORTHERN IRELAND (PSNI)		
REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA)		
SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNI)		
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP)		

20. LEVEL OF REVIEW REQUIRED: *(please select)*	LEVEL 1		

* FOR ALL LEVEL 2 OR LEVEL 3 REVIEWS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6

21. I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (*delete as appropriate*)

Report submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

22. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION: *(refer to Guidance Notes)*

Additional information submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

Completed proforma should be sent to: [redacted]
and (*where relevant*) [redacted]

MAJOR / CATASTROPHIC INCIDENT CHECKLIST Patient 16

Directorate:	**Acute Services**
Reporting Division:	**Acute**
Date of Incident:	
Incident (IR1) ID:	**Complaint requires datix to be completed**
Grade of Incident:	**Major**
Names / Designations of those considering Incident: *(Should include Director, Assistant Director, AMD & CSCG Coordinator)*	Mr R Carroll Mr C Weir Coordinator Mrs T Reid
If Incident involved the death of a service user, was the coroner informed:	**No**
Brief Summary of Incident:	Patient 16 had a history of metastatic colorectal cancer, small volume lung metastases and a left pelvic mass associated with ureteric obstruction. Patient 16 was considered for palliative pelvic radiotherapy in July 2016, urology stents management was required prior to radiotherapy; there was a delay in the management of stents. In December 2016 radiotherapy was no longer considered an option for Patient 16. Patient 16 died Personal Information redacted by the USI
Summary of discussions re SAI / RCA/ major / catastrophic incident review:	The review team considered there was sufficient failings in systems and processes including communication within the urology department to require a SAI review.

Decision on Level Review Type AND rationale for this:	Level 1 SAI
Nominated Review Team: *(Consider need / benefit of independent external expertise)*	
Is it appropriate to inform the Medical Executive/Executive Directorate of Nursing?	☒ X ☐ **NO**
Contact for service user and / or designated relatives / carers: *(Either Lead Professional or Chair of Review)*	
Date and by whom service user and / or designated relatives / carers informed of review taking place*:(If there is an exceptional case where this is inappropriate rationale must be documented):*	
If case referred to the Coroner - Date and by whom coroner informed of SAI / Internal Review :	

(Corporate Governance Office / Litigation to complete) Date and by whom Trust Litigation Dept informed:	
Does this incident meet the DHSSPS Early Alert Criteria including rationale:	
POST REVIEW COMPLETION: Date and by whom and how Review is shared with the service user and / or designated relatives / carers: *(In exceptional cases where this is inappropriate, rationale should be documented)*	
Date and by whom and how Review is shared with the Coroner:	

Southern Health and Social Care Trust

DIRECTORATE OF ACUTE SERVICES

DIRECTOR OF ACUTE SERVICES WEEKLY GOVERNANCE MEETING

Date: Wednesday, 14th November 2018

1.0	**Present**:
2.0	**Governance Structure** – Update from finance in relation to Consultant PA's and band 5 and 6 posts SAI work load remains challenging in relation to capacity for reports and also engagement / response
3.0	**Hyponatraemia** • HYPONATRAEMIA- ○ Meeting with lead nurses on 8th -Training development ongoing for ED, Trauma and Gynae nursing staff ○ Audit results for Acute continue to have areas for improvement  Acrobat Document.pdf ○ **Oversight group** ○ Paper being developed for SMT regarding placement of children 14yrs to 16th birthday and patient choice ○ Clinical Recommendations 10-30 Trudy and Bernie to update ○ Dr Rooney coming to Trust SMT 28th November 2018 ○ John Simpson – coming to Trust on 4th December 2018
4.0	**Waiting lists risks**- awaiting outcome of screening and refining DATIX search to identify incidents
5.0	**Cervical screening** – Family meeting update 9th November 2018
6.0	Waiting list risks – discussed possible incidents now appearing regarding same, we are currently screening some cases including endoscopy
7.0	Screening – challenges remain with pressures regarding regular screening meetings, cases in screening attached  Screening 13 11 2018.xlsx
8.0	Homicide SAI review for discussion  Letter to CE SHSCT 13 Nov 18.doc

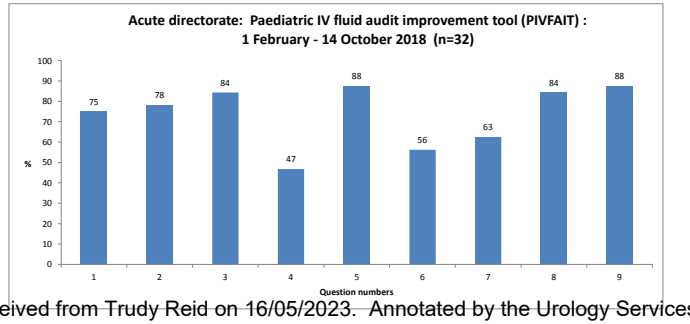
9.0	Internal Audit of S&G  Working Draft Mgt of Standards & Guideline Password is [redacted]
	Date of Next Meeting: Wednesday, 31st October 2018

Paediatric Intravenous Fluid Audit Implementation Tool

Child

Date	1/2/18 - 14/10/18	Ward/Dept	Acute

Q	1	2	3	4	5	6	7	8	9	Compliance %	Division	Ward
	Patient identification	**Glucose Monitoring**		**Cumulative input and output totalling and fluid balance.**	**Patient weight**	**DFBC calculation guidance completed.**		**Electrolyte monitoring**	**12 hour assessment.**			
	Are ALL the following **patient identifiers** provided on both sides of the DFBC? 1. Full Name 2. Date of birth 3. Hospital number	While the child is receiving IV fluids, is there a **Blood Glucose result** recorded on the DFBC (in accordance with the 2017 Paediatric Therapy Wallchart) i.e. at least 12 hourly?	Were ALL **Blood Glucose** measurements greater than 3mmol/L? If answer = No; Enter Hospital Number of those below 3mmol/L for Trust audit dept. to check for treatment.	Are ALL of the following amounts (in mls) recorded on the DFBC? 1. Oral/IV amounts, (all administered types of intake to be recorded). 2. Day and night totals. 3. Grand Total IN 4. Grand Total OUT 5. 24 hour Fluid Balance	Is there a **patient weight** in kgs, given on the DFBC?	Are the appropriate **calculation guidance** sections for the IV therapy completed?	Are there **coded indications** for the fluid administration provided?	Is there an **E&U result** recorded on the DFBC (in accordance with the 2017 Paediatric Therapy Wallchart)?	When IV fluids are administered for longer than 12 hours. is there a 12 hour **Reassessment box*** appropriately completed on the DFBC with an answer to the question: Is the infusion prescription still suitable - followed by a doctors signature? * Can be 10 - 14 hours			
Name or Number	*Record Yes = 1 , No = 0 (the only possible entries are e ther a 1 or a 0)*											
Personal Information redacted by the USI	1	1	1	1	1	0	1	1	1	89	ATICS	Theatre CAH
	1	1	1	0	0	0	1	1	1	67	ATICS	Theatre CAH
	1	1	1	0	1	0	0	1	1	67	ATICS	Theatre CAH
	0	1	1	1	1	0	1	1	1	78	ATICS	Theatre CAH
	1	1	1	0	1	0	1	1	1	78	ATICS	Theatre CAH
	1	1	1	0	1	1	1	1	1	89	S&EC	4 North
	0	1	1	1	1	1	1	1	0	78	S&EC	4 North
	1	1	1	1	1	1	1	1	0	89	S&EC	4 North
	1	1	1	0	1	1	0	1	0	67	S&EC	4 North
	1	1	1	0	1	1	1	1	1	89	M&UC	FMW
	0	0	1	0	1	1	0	1	1	56	M&UC	AMU
	1	0	0	0	1	1	0	1	1	56	M&UC	ED CAH
	1	1	1	1	1	1	1	1	1	100	M&UC	ED DHH
	1	1	1	0	1	1	1	1	1	89	M&UC	ED CAH
	1	0	0	0	1	0	0	0	1	33	M&UC	ED CAH
	1	1	1	1	1	1	1	1	1	100	M&UC	ED CAH
	1	1	1	0	1	1	0	1	1	78	M&UC	ED DHH
	0	0	0	0	0	0	0	0	1	11	S&EC	3 South
	1	1	1	1	1	1	1	1	1	100	ATICS	Theatre CAH
	0	0	1	1	1	1	0	0	1	56	ATICS	ICU
	1	1	1	1	1	0	1	1	1	89	ATICS	Theatre CAH
	1	1	1	0	0	1	0	1	1	67	ATICS	Theatre CAH
	0	0	0	0	0	0	0	0	0	0	ATICS	ICU
	1	1	1	0	1	0	1	1	1	78	ATICS	Theatre CAH
	1	1	1	1	1	0	1	1	1	89	ATICS	Theatre CAH
	1	1	1	1	1	0	1	1	1	89	ATICS	Theatre CAH
	1	1	1	1	1	1	1	1	1	100	M&UC	ED DHH
	0	1	1	1	1	1	1	1	1	89	ATICS	Theatre DHH
	1	0	0	0	1	0	1	0	1	44	M&UC	ED CAH
	0	1	1	1	1	1	0	1	1	78	M&UC	ED CAH
	1	1	1	1	1	0	0	1	1	78	ATICS	DSU CAH
	1	1	1	0	1	1	1	1	1	89	M&UC	ED CAH
	Total Audits Obs		**32**	Paediatric Version V0.13 July 2016			**Total number fully Compliant Com**			**4**		
Number of Charts completed	32	32	32	32	32	32	32	32	32			
Number of compliant cases	24	25	27	15	28	18	20	27	28			
	75	78	84	47	88	56	63	84	88			



Total number of charts completed	32
Total fully compliant	4

ED Screening				
Department	**Type**	**Name and H&C**	**Background**	**Screening update**
ED	SAI	Personal Information redacted by the USI	Internal discussion ongoing ED discharged returned OD - ICU Antrim -	24th August 2017 Meeting - Email doctor. Meeting with doctor cancelled to be reorganised – further information required – email consultant involved again review Wednesday. Not discussed 20/11/17. Need final decision re SAI 6.8.18 Paula provided S Gibson with timeline in order for him to provide information to Chair. 03/09/2018 – awaiting a chair 12/09/2018- reminder sent to S Gibson 12/09/2018- Dr Hampton requests this case is prioritised as urgent. A McVey emailed Simon Gibson 19/09/2018- 24/09/2018- Reminder to Simon Gibson for external chair for ED. 01/09/2018 Awaiting a chair 24/10/2018 Dr Murphy to email Simon Gibson for external chair 26.10.18 Simon emailed Trudy asking if she wished Dr Ahmed to approach S O'Reilly 5.11.18 Trudy emailed Simon happy with this approach
ED	M&M	Personal Information redacted by the USI	ED attendance x3 out of hospital arrest Coroner's report received 18.6.18 Cause of death: Hypoxic Ischaemic Necrosis of Brain & pneumonia due to Cardiac Arrest.	03/01/2018 – Reviewed by Dr Hampton- for full screening with Dr Murphy. 10/1/2018 Reviewed by Dr Murphy care appropriate for M&M discussion and PM feedback. 24/01/2018 Discussed with Dr Hampton & M Burke – Await further discussion with Dr Murphy following family letter – Dr Moan to review. ED M&M findings available 15/02/2018 for discussion Dec M&M findings ED- Deceased in ICU. General discussion was held regarding recording peak flow. Peak flow should recorded when the patient is well to assist with discharge planning. There were no issues with the ED management of the patient. Case to be discussed at CAH medical and ICU M&M. Learning point Have an adequate discharge plan. Action Case to be discussed at CAH medical and ICU M&M. Dr Moan is reviewing clinical information- 1/08/2018- Dr Murphy to confirm his nomination for meeting. ? need for ED rep. 6.8.18 – Dr P Murphy agreed to meet with family & Trudy. Dr Murphy said no need for ED rep. 03/09/2018 Meeting to be organised 12/09/2018- as above 19/09/2018- 24/09/2018- Meeting being arranged. 01/09/2018 Meeting being arranged 24/10/2018 Dr Murphy & Trudy Reid to agree a date for meeting 5.11.18 Trudy to discuss meeting the family with Dr Murphy
ED	SAI	Personal Information redacted by the USI	Blood gas issues?	10/1/2018 - Reviewed Dr Hampton wants to review in-depth. 17/01/2018 Reviewed by Dr Murphy probably SAI – for final review – needs discussed with Dr Wright. Discussed with Anne McVey. 24/01/2018 Further discussion with Dr Hampton & M Burke – will check blood gas machine time and signature -Await Dr Murphy discussion with Medical Director- Need a Notification form. 14/02/2018 RS email discussed Dr Murphy to discuss with Medical director 03/09/2018 Awaiting a chair 12/09/2018- Reminder sent to S Gibson 19/09/2018- 24/09/2018- Reminder to Simon Gibson for external chair for ED. 01/09/2018 Awaiting a chair 24/10/2018 Dr Murphy to email Simon Gibson for external chair 26.10.18 Simon emailed Trudy asking if she wished Dr Ahmed to approach S O'Reilly 5.11.18 Trudy emailed Simon happy with this approach
ED	Internal	Personal Information redacted by the USI	Sedation post spinal injury Internal	Need 3rd meeting organised (Erskine Holmes & Paul Smith) next Meeting 26/1/2018 24/01/2018 - Dr Hampton & M Burke updated – need to draft report and organise meeting with EH and doctor involved – email sent 18/4/18- Email to Dr L Robinson to be followed up re what information she gave to family 01/08/2018- Dr Hampton suggested a draft letter to Erskine Holmes for him to send to Dr Robinson requesting her statement. 6.8.18 – Paula Emailed Dr Holmes to get statement from Dr L Robinson 20/08/2018- 05/09/2018- Discuss Dr Robinson's request for information- Chair to decide way forward. 12/09/2018- Dr Hampton to discuss case with Dr E Holmes. ? do report without Dr Robinson response. 19/09/2018- Discussed with Dr Hampton at screening.Dr Hampton to discuss case with Dr E McCormick. (Sedation performa in Resus) Dr Robinson request for information to be provided. 26/09/2018- Email to be sent to Dr Robinson 01/09/2018 Email sent to Dr Robinson on 26 09 2018 as per Dr Murphy - same opened by Dr Robinson 24/10/2018 Discussed at screening. It was agreed for information Governance Team to be contacted before sending encrypted email (NHS email) with information to Dr Robinson 5.11.18 Paula to discuss at screening meeting what should be sent to Dr Robinson
ED	SAI	Personal Information redacted by the USI	DHH deterioration from ED to Ward	15/08/2018- Case not presented on Friday. Acknowledgement letter to family approved, needs signed and posted. HSCB advised case will be presented in September at Acute Governance Meeting 21/08/2018 Report finalised for presentation at September meeting 03/09/2018 – To be presented to ACG 10/09/2018- Passed for circulation to family and HSCB 19/09/2018- Discussed at screening- Close. 24/09/2018- Questions from family being reviewed. Letter to be sent to family to advise report is ready and offer a meeting. 24/10/2018 Final report being prepared. 5.11.18 Letter with Esther for signature 7.11.2018-Letter posted
ED MUSC	SAI	Personal Information redacted by the USI	CVA	21/08/2018 Meeting to review report, Dr McCormick updating report 03/09/2018 - Dr McCormick updating report 12/09/2018- report with Dr McCormick 24/09/2018- Reminder to Dr McCormick. 08/10/2018- reminder to Dr McCormick re report 24/10/2018 Report being finalised
ED SEC	Internal	Personal Information redacted by the USI	M&M outcome	Personal Information patient undergoing chemotherapy for myeloma presented to DHH ED at 14:02 with history of being unwell for 3/52, diarrhoea 1/52 poor mobility. 06:15 Cardiac arrest, 18 min CPR- PEA/asystole. Resuscitation stopped. Passed away 06:15 06:45 Verbal report of Ct abdomen available from Dr 6: multiple grossly small bowel loops with dilated transverse colon. 18/07/2018 INTERNAL REVIEW as per SEC – Dr McKay surgical rep, Linda Magowan ED rep-need medicine rep 8.8.18 Meeting arranged for 15.8.18. 20/08/2018- report to be drafted and circulated 05/09/2018- report being drafted 24/10/2018 as above 5.11.18 - Report being drafted

ED MUSC	SAI	Personal Information redacted by the USI	Patient transferred to theatre from resus for insertion of lines and stabilization prior to transfer to ICU. Patient arrested and time of death was called at Person Patient had a DNR in place.	06/03/2018- Email from Dr L Martin who suggests case needs to be discussed with ED/Medics to review the management prior to the arrest. 4/4/2018 Level 1 SAI 03/09/2018 – Update requested from Dr Moore 10/09/2018- waiting update from Dr Moore 18/09/2018- Meeting with Dr Moore. Letters to be sent to the 2 doctors involved to invite to a formal meeting. 24/09/2018- 01/10/2018 awaiting feedback re 2nd doctor 24/10/2018 email reminder to Dr Moore 7/11/2018
ED Radiology		Personal Information redacted by the USI	On 04/06/18 I was working as SHO in CAH ED. I saw a patient Perso who presented with hip pain. On reviewing her clinical notes and previous investigations it became apparent that she had a CT scan of her chest / abdomen / pelvis on 27/4/18. The clinical history on the request for this scan did not match those of the patient in question. It appears that it was requested and subsequently carried out in error.	07/06/2018 -The wrong patient had radiology investigation- will need informed of unnecessary radiology exposure. Possible checking issues at radiology in relation to patient age Investigation needs to take place of the inpatient that should have been scanned. Need to check that the right patient has been scanned. When ward/specialty identified to be discussed at appropriate screening meeting 15/06/2018 CT has not taken place for patient we think should have been referred Personal 18/06/2018- chart obtained for patient scan was intended. 2.7.18 To be discussed with Medicine 01/08/2018- Need initial referral?from?indication. Email to Denise Newell 01/08/2018- Need initial referral?from?indication. Email to Denise Newell response from email dated 2.8.18 “I cannot see a CT chest for this patient on date in question However, she had a request for a CT chest, abdomen and pelvis with contrast requested on 27/2/18Referral source: Gynae ward, Craigavon Referring clinician: Isam Yousif Clinical details23FAdmitted with unilateral headache/ rt shoulder pain/ rt arm and leg paraesthesia.Reported 10kg weight loss over 4 months - unplanned. Vasculitis screen negative Queried lymphoma on rheumatological review. For OP scan - patient has since been discharged Referral status: NHS. Referrer name: Niall Gallagher. Referrer grade: FYI 1-2. Referrer contact bleep detail: 1173. This examination was performed on 27.4.18” 03/09/2018 still no follow up of other patient, Dr Murphy will review if needed 05/09/2018- Trudy to discuss with Dr Murphy. 24/09/2018- Trudy to discuss with Dr Murphy 01/10/2018 notes with Dr Murphy 24/10/2018 Dr Murphy to send letter to patient's GP. CLOSE 5.11.18 Check with Dr Murphy if he sent to letter to patient
ED MUSC		Personal Information redacted by the USI	On 8/8/18 at 12.50 patient Per in Ward 2 North was confirmed as having Mycobacterium tuberculosis in a sputum sample. This patient initially presented to Daisy Hill ED on 31/7/18 with cough, pyrexia and abdominal pain. He was treated for pneumonia and admitted to Male Medical Ward. He developed increasing scrotal swelling and following discussion with the Urology team was transferred to CAH Ward 3 South for incision and drainage of a potential scrotal abscess on 3/8/18. He developed worsening hypoxia, consolidation, sepsis and a pleural effusion over the next few days and was transferred to Ward 2 north side room.	For screening & timeline. Obtain ED record & notes DHH&CAH 03/08/2018 - Time line to be completed- review screening for starting infliximab. Awaiting medical notes. 10/09/2018- Notes received. Timeline to be completed 01/10/2018 Time line to be completed Medical notes had been requested for clinics and Consultant request. Received 08/10/2018. 24/10/2018 Timeline reviewed. For referral to Medical M&M for guidance on commencement of biologics prior to treatment . Email sent to Dr Rory Convery and Dr John Harty 5.11.18 Timeline complete, Dr Convery " need a trust group to develop guidance for biologic treatment" Back to screening. Discussed at screening. Team members suggested to include representatives from GI team, Dr S Bhatt and Specialist Nurse, Rheumatology, Dr N Maiden
ED MUSC	Complaint now SAI	Personal Information redacted by the USI	(Complaint.) Personal attended ED CAH 16/03/2018 with limb problems. Moderate pain. Fast VE SOB- Nebulizer & GTN & Furosemide. Breathing relieved at triage. Fall on 7/03/2018 ? NOF. Patient’s wife and daughter drew attention to staff that he could not weight bear on left leg and that left leg was markedly cold from calf down. The foot was turning in and he was unable to straighten it. Patient was transferred to Older People’s assessment Unit where his daughter drew attention to the doctor to the left leg and expressed concern regarding the coldness and lack of mobility in the foot. Family also expressed concern of coldness of left foot to nursing staff. Patient was transferred on 18/03/2018 to RVH Belfast for above Personal Information redacted by the USI left leg.	03/09/2018-Medical notes requested for timeline 10/09/2018- Timeline in progress 18/09/2018-TIMELINE COMPLETE- For screening 24/09/2018- Discussed at screening. Confirmed SAI. Issues: Missed in ED, handover and post take ward round. Nominations for review team: AMcVey to ask Dr David Craig, Dr Mumtaz Hussan, ? ED rep and Nurse. AMcVey to discuss with Sandra Burns. 24/09/2018- Email sent to AMcVey. Timeline to be reviewed. Meeting TBA. Charts copied for review team. Notification to be completed. 01/10/2018 To be completed as SAI- Datix required 08/10/2018 Dr Polley to complete Datix, medical notes provided. 24/10/2018 A McVey to provide names for review team. 5.11.18 Paula emailed AMcV re review team
ED		Personal Information redacted by the USI	Patient attended ED DHH following a fall. Diagnosed multiple rib fractures, lung contusions, pelvic fractures and delay in transfer to RVH	24/10/2018 Discussed at screening. Dr Hampton to review medical notes and discuss with his colleagues.
ED			ROI patient transfer issue	Correspondence to go to staff - hold to ensure action is complete 17/10/18 Discussed when more information available send to M&M chairs 18/10/2018 Discussed with Brigid Quin email sent to Anne etc. 24/10/2018 Non UK resident guidance discussed. A McVey asked Trudy to liaise with Anita Carroll. Email sent to A Carroll.
ED CAH	Screening	Personal Information redacted by the USI	patient admitted with unwitnessed fall + head injury- arrived at 14:00 and obs complete again at 19:15, CTB requested at 17:15 and completed at 21:30. On taking over care of the patient, I attempted to contact CT and radiographers multiple times as did the doctor who had seen the patient. eventually we were able to get in touch with them but patients CTB was delayed significantly with a significant result requesting neuro surgeon input	Medical notes requested. 7.11.2018- Notes received. For screening
ED/ATICS	Internal M&M	Personal Information redacted by the USI	Intubated and ventilated in ED	Discussed with Dr Scullion and at ED screening, consider an external chair. Dr Hampton will be ED rep waiting a ATICS rep 22.10.18 Dr Scullion nominated Dr Nidhi Gupta, Dr Scullion has suggested chair should be a senior doctor eg Dr Neta Chada, Dr Shahid Tariq. Trudy to discuss with Dr Murphy. 23/10/2018 Discussed with Mr Carroll and Dr Scullion who agreed Dr Tariq should be asked to chair the review team. Email to be sent. 24/10/2018 Discussed at ED screening and review team agreed. Email sent to Dr Tariq request to chair review team. 5.11.18 Meeting being arranged
NIAS	Intertrust		NIAS attended a call in Newry on the 20th November 2017. When the call was received from NIFRS Control at 18:27 the nearest available resources were S123 an S121 in Armagh some thirty-three minutes away with S327 and S325 in Craigavon estimated as thirty-seven minutes away. There had been only one crew on duty in Newry on the day shift which was allocated to AS1 Irrelevant in Crossmaglen and had arrived on scene at 18:28. In response to this request, the Area Control Officer allocated S123 at 18:31. When it became clear this was not the usual “persons reported” incident that normally requires one resource initially the Control Officer contacted Daisyhill Emergency Department at 18:38 attempting to secure the release of S520 which had been held at their department on AS1 Irrelevant since 16:55 due to the number of patients in their department. The staff stated they would release the crew in five minutes despite being told of the nature of the call. The crew of S520 contacted Emergency Ambulance Control at 18:57 to advise they were assisting the NIFRS staff who had just arrived at Daisyhill. There was little initial information received regarding this call, it built up in subsequent calls, while Daisyhill were not able to assist NIAS in permitting a crew to be released to a 999 call which was five minutes from their department. Attempts were made to secure the release of an ambulance crew from Daisyhill ED while other resources were travelling to the scene. Daisyhill ED failed to release the crew. The local Station Officer was deployed to Daisyhill ED to assist with casualty clearing and to establish the injuries suffered by each patient. The Station Officer arrived at Daisyhill at 19:04. As a result of media enquiries on 21 November 2017 the NIAS Communications Officer was given a complete report on the occurrence. He then liaised with the NIAS Director of Operations who advised me this incident would require a Serious Adverse Incident report.	19/09/2018 - Discuss with Dr Hampton – Email sent to Paul Smyth for review
ED	Screening	Personal Information redacted by the USI	40 minute delay in anaesthetist attending ED	24/10/2018 Discussed at screening. For referral to Anaesthetics. Datix sent to Mr R Carroll and Dr D Scullion 06/11/2018- Discussed with Dr Sculliona nd Mr Carroll. ED records sent to Dr Scullion to review.
ED	Screening		Enoxaparin	24/10/2018- Discussed at screening. For round table discussion between ED, Dr K Boyd, Sr Sharon Holmes, Mr Imran Yousif. Meeting to be arranged.
ED	Screening		Ng tube inserted by anaesthetic SHO, without consultantion to CT scan and no report was available at the time. Ct scan showed base of skull fracture	5.11.18 For screening
ED	Screening		Patient presented to ED CAH on 28/10/2018 following a fall and head injury- alcohol taken and fell whie walking home. GCS 15 ON ARRIVAL. Pateint was sitting outside Triage 4 waiting for blood tests and ECG. Apparently informaed another patient that he was leaving and walked outside ED. Witnessed fall by NIAS- Head Injury sustained.	5.11.18 For screening
ED	Screening		Complaint ref Irreleva Patient attended ED CAH 24th,25th and 27th 29th July 2018. Admitted 30th July Severe abdominal pain and distension. Diagnosed sigmoid volvulus with necrotic bowel and had left hemicolectomy end colostomy and subsequent revision and reclipping.	12/11/2018 For screening as per Dr McGarry following M&M

MUSC Screening				
Department	**Type**	**Name and H&C**	**Background**	**Screening update**
ED MUSC	SAI	Personal Information redacted by the USI	CVA	21/08/2018 Meeting to review report, Dr McCormick updating report 03/09/2018 - Dr McCormick updating report 12/09/2018- report with Dr McCormick 24/09/2018- Reminder to Dr McCormick. 08/10/2018- reminder to Dr McCormick re report 5.11.18 - Report being finalised by Trudy
ED MUSC	SAI	Personal Information redacted by the USI	Patient transferred to theatre from resus for insertion of lines and stabilization prior to transfer to IC	06/03/2018- Email from Dr L Martin who suggests case needs to be discussed with ED/Medics to review the management prior to the arrest. 4/4/2018 Level 1 SAI 03/09/2018 – Update requested from Dr Moore 10/09/2018- waiting update from Dr Moore 18/09/2018- Meeting with Dr Moore. Letters to be sent to the 2 doctors involved to invite to a formal meeting. 24/09/2018- 01/10/2018 awaiting feedback re 2nd doctor 5.11.18 Paula emailed Dr moore on 24.10.18 re 2 doctor. Dr Moore on leave until 5.11.18 12/11/2018 Meeting being arranged with Dr Moore and Trudy
MUSC Radiology	SAI	Personal Information redacted by the USI	Arrest post midazolam	03/09/2018 Family meeting fed back to screening, email doctor involved and present at ACG 05/09/2108- Coroner has indicated this will not go to formal hearing 10/09/2018- Passed at ACG. Report with Dr and Simon Gibson has a copy for Medical Director. 24/09/2018 – Further meeting to be arranged to discuss family questions 01/10/2018 meeting planned to address family questions 19/10/2018 Dr Polley, Dr Hull, T Reid, Dr McConville, Dr Yousif and Ms Redpath also need cardiology rep 5.11.18 Finalising response to family
MUSC	Intertrust	Personal Information redacted by the USI	VSD post infarct	Patient presented with anterior STEMI-not fit for primary PCI, stabilised in CCU and underwent triple vessel PCI in CAH LVEF 40-45% at the time. Went home thereafter. Readmitted following acute deterioration with reduced O2 saturation. M&M Learning Point - Case discussed at cardiology M&M and subsequently with cardiac surgeons MDT. Patient should not have been discussed at theatre team meeting. Post infarction VSD is a surgical emergency and correct management is to discuss with the emergency cardiac surgeon on call who will advise on management by current recommendations is surgical repair pending patient suitability for theatre 29/01/2018 Discussed – as there has been regional and local learning via M&M and MDT – SAI review not required M&M report – 4/4/2018 available in chart 03/09/2018 – Update requested from Dr Moore 10/09/2018- as above 18/09/2018- Meeting with Dr Moore. Difference of opinion between CAH Cardiology team and RVH Cardiology Team. As per email 18/9/18- "I have discussed this case again with Dr McEneaney, Clinical Lead for Cardiology, and we feel that it is not a SAI trigger but there should be an Interhospital Datix." 18/09/2018-Email to Kay Carroll who was Clinical Lead Feb 2017 for Datix to be done 24/09/2018 – Spoke to K Carroll requested datix to be completed, to be sent to Belfast as an intertrust 01/10/2018 Kay to complete datix 15/10/18 Notes left with Denise for datix completion 5.11.18 Paula emailed reminder to Denise Nelson- on leave until 13/11/18
MUSC SEC	Complaint	Personal Information redacted by the USI	Crohns and Colitis treatment (Complaint) Subtotal colectomy May 2018	For discussion as per Dr Murphy email. 18/06/2018- Medical notes requested for timeline – received. 2.7.18 – Paula to do timeline. 23/07/2018-timeline to be done 30.7.18 – Acknowledgment for approval. Check with Dr Murphy the timeframe for SAI review 01/08/2018- Dr Murphy advises SEC to approve acknowledgement. Timeline to commence from 1st admission. 6.8.18 Acknowledgment approved by RC 8.8.18 – Timeline to be complete 03/09/2018 -1st meeting with Mr Epanomeritakis, 2nd meeting to be organised with Mr Bhatt 10/09/2018- meeting being organised 19/09/2018- Meting 19/09/2018 with Dr Bhatt 24/09/2018 – Report being drafted
MUSC	SAI	Personal Information redacted by the USI		6.8.18 – Response to family to be discussed at M&M 6.8.18 Dr P Murphy & M Burke said signed off. Paula to check with Trudy on her return. 05/09/2018- response approved and to be sent to family. 10/09/2018- report with DLS for approval 24/09/2018 – Reminder to E O'Neill in litigation regarding DLS approval of response to family 01/10/2018 awating DLS response, extra questions from Litigation to Anne and Philip 5.11.18 - DLS had additional queries re inquest. Trudy to meet with litigation

MUSC Dermatology		Personal Information redacted by the USI	Patient/ Personal Information was seen at Dermatology Clinic on 11/05/2017. Review was planned for 2-3 months. Patient did not receive review appointment. He was being treated for actinic keratosis on his nose. Whilst awaiting review lesion progressed and presented today with a large tumour in keeping with a squamous cell carcinoma. Today's appointment 16/08/2018, took place as patient phoned requesting urgent review.	For screening. Email sent to K. Robinson for information. See emails 20/08/2018- Discussed at screening. How are we managing Risk? What systems are in place? Need clear guidelines. Lisa is clarifying what is routine for AMcVey. 03/09/2018 – Complaint received – Screening team updated- Dr Murphy and Anne McVey to review waiting lists. 10/09/2018- Discussed at screening. SEA has taken place within Trust. Anne McVey to discuss with Kay Carroll. Dermatology to review forms/urgent/routine reviews. How we manage risk with long waiting times. Need to inform staff (doctors) re waiting times. ? SEA/SAI? 24/09/2018- Anne McVey to discuss with Kay Carroll 01/10/2018 Meeting with Mrs McVey, Dr Murphy and Lisa McAreavey to look at waiting lists has taken place - actions letter to be sent to all consultants re triage category - hold on report until actions complete 5.11.18 Acute to review datix incidents re dermatology. Examples of incidents to be obtained
ED MUSC		Personal Information redacted by the USI	On 8/8/18 at 12.50 patient Pers appl in Ward 2 North was confirmed as having Mycobacterium tuberculosis in a sputum sample. This patient initially presented to Daisy Hill ED on 31/7/18 with cough, pyrexia and abdominal pain. He was treated for pneumonia and admitted to Male Medical Ward. He developed increasing scrotal swelling and following discussion with the Urology team was transferred to CAH Ward 3 South for incision and drainage of a potential scrotal abscess on 3/8/18. He developed worsening hypoxia, consolidation, sepsis and a pleural effusion over the next few days and was transferred to Ward 2 north side room.	For screening & timeline. Obtain ED record & notes DHH&CAH 03/08/2018 - Time line to be completed- review screening for starting infliximab. Awaiting medical notes. 10/09/2018- Notes received. Timeline to be completed 01/10/2018 Time line to be completed Medical notes had been requested for clinics and Consultant request. Received 08/10/2018. 5.11.18 Timeline complete, Dr Convery " need a trust group to develop guidance for biologic treatment" Back to screening. 05/11/2018- Discussed at screening who should be on the group. GI specialist Dr and Nurse, Rheumatology Dr and Nurse, TB nurse. ? Dr R Forbes for Neurology. Dr Murphy suggested Dr Bhatt and Dr Maiden.
MUSC	SAI	Personal Information redacted by the USI	Datix re Missed bowel tumour	03/00/2018 Discussed at MUSC screening - Internal review in first instance as per SEC – Review team in agreement 10/09/2018- Meeting arranged for 17/09/2018- Mr K McElvanna and Dr S Bhatt 19/09/2018- Mr McElvanna to discuss with Mr McArdle. Dr Bhatt to discuss with Dr Hillemand and Dr S Murphy. 08/10/2018- Email to Mr McElvanna and Dr Bhatt for update 5.11.18 Report being drafted
ED MUSC	Complaint	Personal Information redacted by the USI	(Complaint.) Personal Information attended ED CAH 16/03/2018 with limb problems. Moderate pain. Fast VE SOB- Nebulizer & GTN & Furosemide. Breathing relieved at triage. Fall on 7/03/2018 ? NOF. Patient's wife and daughter drew attention to staff that he could not weight bear on left leg and that left leg was markedly cold from calf down. The foot was turning in and he was unable to straighten it. Patient was transferred to Older People's assessment Unit where his daughter drew attention to the doctor to the left leg and expressed concern regarding the coldness and lack of mobility in the foot. Family also expressed concern of coldness of left foot to nursing staff. Patient was transferred on 18/03/2018 to RVH Belfast for above Personal Information redacted by the USI left leg.	03/09/2018-Medical notes requested for timeline 10/09/2018- Timeline in progress 18/09/2018-TIMELINE COMPLETE- For screening 24/09/2018- Discussed at screening. Confirmed SAI. Issues: Missed in ED, handover and post take ward round. Nominations for review team: AMcVey to ask Dr David Craig, Dr Mumtaz Hussan, ? ED rep and Nurse. AMcVey to discuss with Sandra Burns. 24/09/2018- Email sent to AMcVey. Timeline to be reviewed. Meeting TBA. Charts copied for review team. Notification to be completed. 01/10/2018 To be completed as SAI- Datix required 08/10/2018 Dr Polley to complete Datix, medical notes provided. 16.10.18 Datix completed 5.11.18 Paula emailed AMcV re review team
MUSC	SAI	Personal Information redacted by the USI	Arrest in DHH post cardiac cath - Anaes and transfer issues	Discuss at screening. See email from Dr Scullion. 01/10/2018 Request notes and prepare a time line. Time line to be completed 15/10/2018 Discussed Dr Scullion views- still needs time line 22/10/2018 DHH Medical notes requested as CAH notes do not contain relevant information. 30/10/2018- Contacted Medical records- await medical notes ? in BCH ICU. 5.11.18 Notes received from Belfast. Timeline to be completed
MUSC	SAI	Personal Information redacted by the USI	Endoscopy screening waiting times	08/10/2018-Discussed at screening. For timeline. Medical notes requested. 15/10/18 Identify delays from specialites with incidents 5.11.18 timeline to be completed by Jane Scott, notes with Jane
MUSC			Patient with metastatic melanoma and known brain secondaries and bone secondaries admitted with increasing left arm pain and arm weakness and back pain. Seen by a number of professionals an I feel opportunities missed to diagnose spinal cord compression - which the patient was subsequently diagnosed with on 06/09/2018 Emergency MRI and emergency radiotherapy arranged and family and ward staff informed. Notes clearly documented and Barry Conway informed.	Notes needed for time line 29/10/2018. Medical notes received. 5.11.18 Paula to complete timeline
MUSC		Personal Information redacted by the USI	Pacing issues M&M SOM4	12/11/2018 DHH notes requested from Villa 3.
MUSC	SAI		Endoscopy screening waiting times Male patient Personal Information redacted by the USI referred for colonoscopy for investigation of iron deficiency anemia. Colonoscopy revealed mass in ascending colon (likely malignancy). Investigated for same in 2016 with colonoscopy when a polyp was removed from ascending colon (not retrieved due to poor bowel preparation) At that time recommendation was made for follow up colonoscopy in 12/12 as a safety measure due to poor bowel prep. This appears not to have happened. There was a new GP referral to OPD in Sep 2018 with anemia which was followed by a colonoscopy request from OPD.	5.11.18 Jane Scott to complete timeline - For screening.

MUSC	Screen	Personal Information redacted by the USI	Late upgrade of Red Flag referral A referral from Respiratory to Gastroenterology dictated on 06.09.18. Date Typed was 22.10.18. The referral was date stamped with 30.10.18 - Date received in RBC. It appears that referral was triaged on 31.10.18 and was marked as RF. This referral was then received into the Red Flag booking office on 02.11.18. Appointment was booked on 02.11.18 for 06.11.18. (61 Day wait from date of registration on PAS) The delay on this occasion appears to be with the typing of clinic.	

SEC Screening

Department	Type	Name and H&C	Background	Screening update
SEC	M&M Internal	Personal Information redacted by the USI	Personal Information redacted by the USI patient undergoing chemotherapy for myeloma presented to DHH ED at 14:02 with history of being unwell for 3/52, diarrhoea 1/52 poor mobility. Seen by Dr 1. Loose green stools. Reduced oral intake. Occasional mild general abdominal pain. One loose stool today, did not take chemo med. Worsening shortness of breath. No chest pain, on examination he was noted to be cachexic, frail. Bi-basal creps. Marked bilateral lower leg oedema. ECG Sinus rhythm, 2 BBB. BP 86/51 with fluids and legs raised. Distended abdomen query ascetic. Mild generalised tenderness, no masses felt, bowel sounds present Diagnoses: diarrhoea query secondary to chemo meds, associated dehydration and ?acute LVF. Seen by Dr 4 at 23:00- Distention for 1/12. One episode of vomiting. Just completed 4 cycles of chemo for multiple myeloma. ATSP re abdominal distention. Abdomen tympanic with generalised tenderness with some guarding. Bowel sounds scant. PR: external haemorrhoids ++. Will discuss with senior and review plain films. Will add to handover list and query review in am. Fast, NGT if vomiting continues. Stool chart. IVF and anti-emetics 02:04 Seen by Dr 5. History as above. On examination: abdomen firmly distended, tympanic. Mild generalised tenderness. AXR: gross bowel dilation in keeping with obstruction. Imp: bowel obstruction query underlying cause. 06:15 Cardiac arrest, 18 min CPR- PEA/asystole. Resuscitation stopped. 06:15 Passed away. 06:45 Verbal report of Ct abdomen available from Dr 6: multiple grossly small bowel loops with dilated transverse colon.	26/06/2018 Discussed with Mr Carroll and Dr Scullion – M&M January 2018 - Statement of Management to be provided: Medicine Statement of management: 3 - contained aspects that SHOULD² be improved (learning identified); the patient's eventual outcome was NOT 21/08/2018- Report to be drafted. Management of abdominal pain ED DHH Version 1(17April 2015) sent to Dr McKay and Dr Magowan 11/09/2018- Report in draft
SEC	Internal	Personal Information redacted by the USI	Patient admitted with? Diverticular perforation. CT Shows likely perforated tumour. Not reported by radiology. Discharged home. Delay in diagnosis significant.	Discrepancy meeting outcome - Discrepancy, cognition and perception. Abnormality was felt to be solid and represented malignancy as opposed to a diverticular abscess. 01/02/2018 with Discussed Dr Yousaf The initial request highlighted abdominal pain, diarrhoea, tender LIF, previous unremarkable endoscopy, CRP 200, WCC 14.9,? Diverticular abscess,? localised perforation- the reported stated … Briefly collection/inflammatory exudate along descending colon – sigmoid in LIF likely to be cause of symptoms and signs. Gold standard for diagnosis is endoscopy not CT. This case has been discussed at the discrepancy meeting Follow up endoscopy – on 23/11/2017 – haemorrhoids – GI registrar 16/01/2018 CT CAP showed …suggestive of locally advanced, perforated tumour of the distal descending colon/proximal sigmoid colon….. From Radiology perspective does not meet the criteria for SAI 16/01/2018 CT CAP showed …suggestive of locally advanced, perforated tumour of the distal descending colon/proximal sigmoid colon….. From Radiology perspective does not meet the criteria for SAI 11/09/2018- Meeting being arranged. 13.9.18 Meeting arranged for Monday 12 November

SEC	Internal	Personal Information redacted by the USI	? Delay in Diagnosis of Recto-sigmoid adenocarcinoma. Issued raised by Mr Mc Kay. Patient had a US Abdomen 7/4/17 – Conclusion - Fatty Liver; CT Abdomen & Pelvis with Contrast 22/7/17 – Conclusion - Severe sigmoid colitis with evidence of localised perforation	24/07/2018- email to I Yousuf on 13/7/18 + 24/07/18 re discrepancy report. Mr Carroll updated 31.7.18 Wait discrepancy report from Dr Yousuf. 21/08/2018 reminder to Dr Yousef 11/09/2018-as above 25/09/2018- still to be discussed at radiology discrepancy meeting 22.10.18 Trudy emailed Dr Imran Yousuf re CT Abdomen and Pelvis dated 22/07/2017) has been discussed at discrepancy yet. Gail Lindsey replied not discussed but will expedite it. 5.11.18 To be discussed at coming audit day, Friday, 16th November at the next discrepancy meeting.
SEC	Internal	Personal Information redacted by the USI	Delay in tumour management . Emergency admission with abdominal pain- initial CT 19/11/2015 showed retrocaecal appendicitis with localised perforation……soft tissue thickening is present at the base of the appendix/tip of the caecum and evaluation of this region is advised in due course to exclude other pathology- managed conservatively- Discharge letter noted RIF pain Initial Diagnosis ?appendicitis ?walled-off appendix ?malignancy. Following subsequent admission CT 2/12/2105 comment At some stage colonoscopy of the cecal pole will be required in order to exclude cecal pole mass/tumour (if not already performed). Possible caecal pole mass may be contributing to the ongoing inflammatory process as the appendix does appear distended and may be obstructed at the base. A prominent ileocaecal valve area is considered and is possible but there is not much fat in this abnormal area. Colonoscopy 4/2/2016 with subsequent pathology report stating 'The appearances are those of an adenocarcinoma. 07/02/2016 discussed at MDM for consideration of right hemicolectomy. Surgery on 08/03/2016	INTERNAL SEA – Need chair – wait for meeting minutes to be circulated then approach GH again minutes circulated request chair again 2/1/2018 - email sent requesting GH to chair 09/01/2018 - awaiting date for meeting 14/3/18 – Dr Haynes advised that Mr Hewitt to again be asked for a date for meeting if this is not provided he should be advised that a meeting will be scheduled in place of one of his theatre lists (in next 6 weeks). 6/4/18 – R Farrell to contact Mr Hewitt's sec re dates re dates for meeting 6/4/18 – T Reid email Mr Hewitt re dates re dates for meeting 26/06/2018 Mr Carroll update regarding no response from Mr Hewitt 13/07/2018 Mr Haynes has agreed to cancel elective surgery to allow Mr Hewitt to Chair the SEA report 11/09/2018- as above. wait response from Mr Hewitt. Email sent to W Clayton 25/09/2018- meeting scheduled for 03/10/2018. 22 10 2018 reschedule meeting 5.11.18 Meeting being arranged
SEC	Internal	Personal Information redacted by the USI	Following review at OP where new iron deficiency anaemia was diagnosed Personal was referred to for OGD and colonoscopy and subsequently CT abdomen and pelvis which was performed on 2/08/2016 and reported on 7/08/2016, there was an incidental finding of sub- segmental and segmental emboli seen in the R lung. 2/08/2016 reported 7/08/2016. This result was emailed to the referring consultant and a specialty doctor wrote to the consultant highlight this finding on 23/08/2016, Personal was also reviewed at a number of OP clinics where there was no documentation of CT findings CT showed PE not actioned	INTERNAL SEA – Need chair- wait for meeting minutes to be circulated then approach GH again minutes circulated request chair again 2/1/2018 - email sent requesting GH to chair 09/01/2018 - awaiting date for meeting 14/3/18 - Dr Haynes advised that Mr Hewitt to again be asked for a date for meeting if this is not provided he should be advised that a meeting will be scheduled in place of one of his theatre lists (in next 6 weeks). 6/4/18 – R Farrell to contact Mr Hewitt's sec re dates for meeting 6/4/18 – T Reid email Mr Hewitt re dates re dates for meeting 26/06/2018 Mr Carroll update regarding no response from Mr Hewitt 13/07/2018 Mr Haynes has agreed to cancel elective surgery to allow Mr Hewitt to Chair the SEA report 11/09/2018- wait response from Mr Hewitt. Email sent to W Clayton 25/10/2018- Meeting scheduled for 03/10/2018 09/10/2018- Mr Carroll updated meeting had taken place and report was in progress. 5.11.18 - Report being drafted