



Urology Services Inquiry

4. **Outline your relevant experience to the Inquiry addressing principally your employment history and the dates during which you served as a non-executive board member of the SHSCT.**

59. My employment history prior to joining the Trust Board is set out at above in response to Question 1.

60. I was appointed to the SHSCT Board on 15th February 2016.

61. I received broad general training on Trust policies, procedures and committees between 22nd September 2016 and 1st December 2016. I received specific training on MHPS via DLS on 22nd September 2016.

62. I was appointed as a designated NED in respect of the O'Brien MHPS on 19th January 2017.

5. **Outline any prior experience or knowledge you had of the MHPS framework & the Trust Guidelines before being appointed as the designated Board member for an investigation into concerns raised in relation to Mr Aidan O'Brien (Consultant Urologist).**

63. I had no other than knowledge of the MHPS and Trust Guidelines except that gained at training as outlined at Questions 4 and 6.

6. **Outline and provide documentation of any training or guidance you received with regard to the role of designated Board member with regard to:**

- I. **The MHPS framework;**
- II. **The Trust Guidelines; and**
- III. **The handling of performance concerns generally.**

- I. **MHPS framework**

64. I received broad general training on the MHPS framework from DLS during my induction period. This covered the generality of the framework. The role of the Designated NED was unclear and was highlighted as such by the trainer who on several occasions stated that the role was indistinct and that the



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Department of Health had been asked on several occasions for clarification but none had been provided. Throughout the course of the O'Brien case I asked on at least 2 occasions for assistance regarding role definition and clarification but this was not able to be provided for the reasons above.

65. Trust Guidelines

65. I think these were mentioned at the induction for MHPS but I have no clear recollection of specific guidance and training on them. Upon taking up the role of Designated NED I did not receive training on them either.

66. Handling of performance concerns generally

66. I do not believe I received training in this area nor had I received any relevant training from other jobs/roles I had prior to joining the SHSCT.

- 7. With specific regard to Section I paragraph 8 of MHPS and paragraph 2.10 of the Trust Guidelines, what purpose did you understand the designated Board member was to fulfil in the context of an investigation into concerns raised, at the point when you were appointed to the role?**

67. I understood that the role of the designated board member was to ensure that the momentum of the case was maintained and to consider any representation made from the practitioner. Therefore if the case was not being expedited quickly enough or if the process was operating outside specific guidelines then I would make representation to the Trust regarding these matters.

- 8. Outline how you understood the role of designated Board member was to relate to and engage with those of following individuals under the MHPS Framework and the Trust Guidelines:**

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

Comac, Jennifer

From: Wilkinson, John [Personal Information redacted by the USI]
Sent: 12 September 2016 21:09
To: Comac, Jennifer
Subject: RE: Training for Non-Executive Directors - Maintaining High Professional Standards - 22nd September 2016

Thanks Jennifer.
I've got this!
John

From: Comac, Jennifer
Sent: 12 September 2016 16:08
To: Graham, Edwin; Mahood, Elizabeth; McCartan, Hilary; Mullan, Eileen; Mullan, Raymond; Rooney, SiobhanNED; Wilkinson, John
Cc: Comac, Jennifer; Judt, Sandra; Mallagh-Cassells, Heather
Subject: Training for Non-Executive Directors - Maintaining High Professional Standards - 22nd September 2016

Dear colleagues

Re emails below – I just wanted to remind you that the Maintaining High Professional Standards training will take place on Thursday 22nd September 2016 at 2.30 pm in the Boardroom, Trust HQ.

Kind regards

Jennifer

On 13 Jun 2016, at 10:31, Comac, Jennifer [Personal Information redacted by the USI] wrote:

Dear colleagues – re below – please note this session has now been confirmed for 22nd September 2016 at 2.30 pm. Venue to be confirmed. Please confirm date/time in your diaries.

Kind regards

Jennifer

From: Comac, Jennifer
Sent: 01 June 2016 15:24
To: Graham, Edwin; Mahood, Elizabeth; McCartan, Hilary; Mullan, Eileen; Mullan, Raymond; Rooney, SiobhanNED; Wilkinson, John
Cc: Comac, Jennifer; Judt, Sandra
Subject: Training for Non-Executive Directors - Maintaining High Professional Standards

Dear colleagues

As part of the induction for new NEDs, Vivienne Toal covered, very briefly, the NED role under Maintaining High Professional Standards (MHPS) for doctor and dentist conduct and performance cases.

Following discussions with the Chair, Vivienne feels that a training session re MHPS should be provided to all NEDs. This will be carried out by June Turkington, DLS. The session should take no more than an hour and June is available to do this

on Thursday 22nd September 2016 at 2.30 pm (Patient and Client Experience Committee meeting is that morning and would be due to finish around 1.30 pm).

Could you please advise of your availability by return email.

Kind regards

Jennifer



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Training on MHPS Procedure

For Southern Trust HR Staff

22nd September 2016

Presented by June Turkington
Assistant Chief Legal Adviser, DLS

www.hscbusiness.hscni.net

Maintaining High Professional Standards Framework (MHPS)

- Introduced by DHSSPS Circular dated 30th November 2005
- Effective from 1st December 2005
- Formal departmental Directions require all Trusts to comply with MHPS
- MHPS procedure is incorporated into the contracts of employment of individual doctors – see case of Mark Ali v Belfast Trust (NI High Court 2008)
- Therefore any breach of the procedure is also a breach of contract – see case of Lamey v Belfast Trust (NI High Court 2013) re injunctions to prevent anticipated breach

Scope/application of MHPS

“A framework for the handling of concerns about doctors and dentists in the [HSC]”

Applies to

- Medical and dental employees

Concerns regarding

- Conduct
- Clinical performance
- Health



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Scope/application of MHPS

What issues fall outside of MHPS?

See case of *Ezsias v North Glamorgan NHS Trust 2011*

- Reason for dismissal was breakdown in relationships within the team – SOSR
- EAT held that this fell outside MHPS

See also case of *Lamey v Belfast Trust (NI High Court 2013)*

- (potentially) where confidence of patients, colleagues etc is damaged beyond repair – SOSR

Scope/application of MHPS

Definition of “performance” (Intro para 2)

Where the term “performance” is used in MHPS, it refers to

- All aspects of a doctor’s work, including
- Conduct, health and clinical performance
- The term “clinical performance” means those aspects of a doctor’s work which require exercise of clinical judgment or skill

Scope/application of MHPS

Introduction para 5 states that “*local conduct procedures will apply to all concerns about the conduct of a doctor*”.

Treat this statement with caution!

Subject to many limitations

No reference to Trust capability procedures



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Section VI – Formal Procedures – General Principles

- Training – managers and CIs must receive appropriate training on these procedures and on equal opps
- Where an employee is excluded or facing formal procedures, normal sickness absence procedures apply – see para 2

Section VI – Formal Procedures – General Principles contd

- Where employee leaves before formal procedures completed, investigation must be taken to a final conclusion in **all** cases
- Performance procedures must be completed wherever possible
- Employer must make a judgment based on the evidence available as to whether the allegations are upheld – then take appropriate action – para 9

Context of MHPS

MHPS must be seen within wider context – 4 key elements

- Appraisal & revalidation
- Advisory & assessment services of NCAS
- Tackling blame culture
- New arrangements for handling exclusions

Also importance of remedial action including retraining

- See NCAS '*Back on Track Framework*'

MHPS Required Response

Safety of patients must be at the heart

Whatever the source of information about concerns, the response must be the same

- See Intro para 10

The logo for the Directorate of Legal Services (DLS), consisting of the letters 'DLS' in white on a blue square background.

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Section I – Action when a concern first arises

All allegations must be properly investigated to establish the facts and substance of any allegations

See key actions outlined at para 4

- Central role of NCAS – see also paras 9 to 14 – should be considered at any stage of case.
- When considering restrictions or exclusion, must adopt the least restrictive option sufficient to protect patient safety – NCAS must also be notified

Section I – protecting the public

See para 6 –“ in the vast majority of cases when action other than immediate exclusion can ensure patient safety the doctor should always initially be dealt with using an informal approach. Only where a resolution cannot be reached informally should a formal investigation be instigated”.

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Section I – Informal approach

See flowchart

- Clinical manager
- Preliminary inquiries to verify or refute substance or accuracy of concerns
- Decide on informal approach or formal investigation
- In consultation with Medical and HR Directors - advice from NCAS and OH as required
- Consider local action plan which may include NCAS assessment

Section I – Immediate exclusion

Para 19 – grounds

- Protect interests of patients or other staff (but not the doctor); and/or
- Breakdown in relationships which may endanger patient care

Duration – max 4 weeks



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Section I – Immediate exclusion

During period →

- case conference – clinical manager, Med Dir and HR
- doctor given opportunity to state case & propose alternatives
- invited to a meeting within 4 weeks
- clinical manager must advise of rights of representation
- where Med Dir decides on exclusion (formal?) GMC must be notified

NB All discussions must be minuted and a copy given to the doctor.

Formal Approach

See flowchart

Where this needs to be followed, the Chief Exec must (after discussion between Medical and HR Dirs)

Appoint

- a Case Manager – role is to lead the formal investigation – normally Medical Dir but can be delegated
- a Case Investigator – role is to carry out the formal investigation – establishes facts and reports findings
the Case Manager – should be appropriately trained for this role

Right to be accompanied

Section I para 30

- applies at any stage of this process – or subsequent discip action – overrides Trust discip procedure – see case of Mark Ali v Belfast Trust – but article 6 right to fair hearing is not engaged
- to be accompanied to any interview or hearing by a companion
- companion must fall within one of the specified categories
- where they do, may be legally qualified, but must not act in a legal capacity

Formal investigation

Role of Case Investigator (CI) – see paras 31 to 33

- does not make a decision on what action should be taken
- must ascertain the facts in an unbiased manner

Role of Case Manager (CM) – see paras 34 to 36

- must write to the doctor to confirm an investigation is to take place, name of CI and the specific allegations
- doctor must be given an opportunity to see any correspondence re the case and a list of witnesses to be interviewed
- doctor must be given opportunity to put version of events to CI – can be accompanied

Timescale and decision

- Investigation – normally completed within 4 weeks
- Further 5 days to report
- Must give doctor opportunity to comment on factual accuracy
- Doctor can provide written comments re mitigation to CM within 10 days

Timescale and decision

- Report must give CM sufficient info to make a decision on way forward – see options in para 38
- Conduct cases – transfer to hearing stage of Trust Disciplinary Procedure

Section II Restriction of Practice & Exclusion

Exclusion

- Used only as interim measure whilst action is considered
- For min necessary period up to 4 weeks – normally max limit of 6 months (except for criminal investigations)
- Extensions must be reviewed every 4 weeks and brief report provided to C Ex and Board – see detailed table at para 28
- Detailed report must be provided to designated Board member on request
- Role of Dept in monitoring exclusions – para 30 & 31

Section II Exclusion contd

Reserved for “*only the most exceptional circumstances*”

The purpose of exclusion is

- To protect the interests of patients or other staff and/or
- To assist the investigative process – risk of impeding the gathering of evidence

Note that this differs from the purpose of immediate exclusion

NB Reference at para 1 to “article 6 right to fair hearing” is probably now out of step with the general law

Section II Exclusion contd

Key aspects - see para 8

- NB right to return to work if review not carried out
- May only take place in the setting of a formal investigation
- Gardening leave should never be used

Section II Exclusion contd

Procedure for exclusion includes:

- Case conf including clinical manager, Case Manager and Dir of HR
- Prelim report from CI to be available if possible
- Formal exclusion meeting para 14
- Confirmed in writing para 15
- Exclusion from work does not necessarily involve exclusion from the premises

Section II Exclusion contd

Keeping in contact and availability

- Full pay provided dr remains available for work
- Should not undertake other work during time for which being paid
- Does not apply to remainder of time
- CM may decide payment not justified eg if dr has gone abroad without agreement

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Section II Exclusion contd

Informing other organisations

- Where concern about danger to patients, Trust should inform other organisations
- Where an HSC employer has placed restrictions on practice, the dr should agree not to undertake any work in that area of practice with any other employer
- Where such undertaking is breached, CM should contact GMC and Dept re alert letter

Section II Exclusion contd

Return to work

Must be formal arrangements for return to work. Must be clear about any ongoing restrictions and monitoring to ensure patient safety

Section III Guidance on Conduct Hearings and Disciplinary Procedures

- Where the outcome of investigation is case of misconduct which should be put to a conduct panel
- Covers both personal and professional misconduct
- Must be resolved locally under normal procedures
- **If a case covers both misconduct and clinical performance issues it should usually be addressed through clinical performance procedure**

Section III Guidance on Conduct Hearings and Disciplinary Procedures

- Where a case involving issues of prof misconduct goes to hearing panel must include a medically qualified member who is not currently employed by the employer
- If dr considers a case is wrongly classified as misconduct, can use grievance procedure and/or make representations to the designated Board member

Section IV – Health concerns

Where outcome of investigation under section I shows health concerns

- Should be considered by OH and report to employer
- Wherever poss should be treated, rehabilitated or retrained
- OH consultant should agree course of action with the dr
- then meeting convened Dir of HR, Med Dir or CM, dr and OH to agree a timetable of action and rehabilitation
- Dr can be accompanied

Section IV – Health concerns

- Where impairment of clinical performance or conduct due solely to health, disciplinary proceedings should only be considered in most exceptional circumstances (para 6)
- Reference to DDA & duty to make reasonable adjustments

Section V – Clinical Performance Procedures

- Case must be referred to NCAS before performance hearing
- Where both conduct and clinical performance issues are involved - Usually addressed at clinical performance hearing



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Section V – Clinical Performance Procedures contd

Matters include

- Outmoded clinical performance
- Inappropriate practice – lack of knowledge or skills
- Incompetent practice
- Inappropriate delegation of clinical responsibility
- Inadequate supervision of delegated tasks
- Ineffective team working skills



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Section V – Clinical Performance Procedures contd

Duties of employer

- NCAS Action Plan
- Employer must facilitate agreed plan
- Performance hearing necessary where:- “*performance is so fundamentally flawed that no educational and/or organisational plan has a realistic chance of success*”

But see recent case *Chakrabarty v Ipswich Hospital NHS Trust 2014 EWHC*

Section V – Clinical Performance Procedures contd

- Pre – hearing procedure
- Hearing framework
- Appeals procedure

Very detailed and convoluted!

Keep copy of MHPS close by!

MHPS – Particular Situations

Trainees

- See Introduction para 11
- Post Grad Dean should be involved in the appropriate cases from the outset
- Employers responsible for the conduct of investigations and necessary action

MHPS – Particular Situations

Harassment/Working Well Together cases

- Need to comply – as far as possible - with both procedures at investigation stage
- Where case to answer → Trust Disciplinary Procedure

MHPS – Sources of Advice & Guidance

- NCAS
- GMC Employer Liaison Adviser
- CMO's Office
- Other Trusts
- DLS



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information, the need for clarity and amendments around meeting minutes, and so on would necessitate a longer protracted period of investigation.

- d. The Case Manager and Investigator continued throughout this to carry out their day-to-day clinical roles in a professional manner. On top of this they were charged to investigate the MHPS case within a given timescale. In my view, this seemed an unreasonable demand. To expedite the MHPS case their work plan should be amended significantly to allow for the case outcomes to be reached within acceptable timescales.
- e. If timescales were not going to be met then this should be clearly articulated to those involved in the case.
- f. Human Resources were placed in an unenviable position. They had an obligation to monitor progress of the case. They too had to be mindful of the health and wellbeing of the clinician under investigation. They needed to keep the Trust and Trust Board members informed without compromising the case. Additionally, they were most accessible to me as the designated NED as I sought direction to enable the expedition of the case. It seemed to me that HR could be seen to be facilitators and also respondents in the case. Perhaps another support could be appointed to act as an advisory.

20. Consider and outline the extent to which you feel the designated Board member can effectively discharge their role under MHPS and the Trust Guidelines in the extant systems within the Trust and what, if anything, could be done to strengthen or enhance that role.

94. Upon joining the Trust I had absolutely no knowledge of the Health and Social Care policies, procedures and governance. During the first year I received, along with 3 other colleagues, a general induction programme lasting approximately 1 year. This proved to be intense and demanding. Towards the end of this period I received MHPS training from DLS lasting approximately 1½ hours. The import of this training was that my role was to ensure that the momentum of the case was being maintained and to respond to queries from the clinician. The inter-relationships and expectations surrounding the Case Manager, Case Investigator, HR, Medical Director, Trust Board, and the Chief Executive were not explained sufficiently.



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95. To this end, role definition/role expectation/role accountability were not sufficiently defined within the MHPS process or expanded upon. To ensure that the NED is exercising the role appropriately, he/she could have a mentor or have 'supervision' from an experienced NED or competent other who has been involved in the process previously. Such a person could be outside the Trust. In the absence of such a person, I relied upon HR for advice and occasional enquiries made to DLS.
96. Whilst induction training was given by the Trust in MHPS it would be beneficial and indeed necessary to have 1:1 training either by the Trust and/or HR when the NED was designated to a case. At this meeting, a case briefing could be made with notes offered describing the case thus far. I recognise the need to ensure that everything needs to be done in a manner which ensure openness, transparency and does not compromise 'natural justice' for the clinician.
97. I found myself bewildered, if not compromised, from time to time. Because of the complexity of the case, I had to defer queries made by the clinician to me to HR or to the Case Manager. Indeed, I advised the clinician to correspond directly with the relevant person if he had queries and to contact me if he was facing an impasse. I felt that I was not in a position to answer the questions put by AOB and thought it would be more expedient to get the answers if he went to the person directly. On the other hand, if AOB found that he was not getting timely replies, then he should direct his concerns to me. Whether this was the right thing to do or not could be covered with additional training. I do believe that other designated NEDS who had experienced the Designated NED role before would be able to add value to the training.
98. In this respect the role of the NED needs to be defined so that all parties are clear on role expectation. Key areas of concern included the designated NED in relation to the clinician – as 'supporter'; as 'liaison person'; as 'inquisitor'; as 'mediator'; as 'investigator'; as 'compliance controller'; as 'initiator'; as 'evaluator of progress'. In deciding this, one needs to be mindful of 'what can reasonably be expected of a designated NED who is a lay person?'
99. Therefore, I do believe that presently the designated NED can have a limited impact in effectively discharging their role in MHPS. To be more effective



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from HSC Trusts on the MHPS framework, however it would appear that these comments were collated for the Office of the Chief Medical Officer, so therefore I am not entirely clear who is best placed to take responsibility to progress the review. In my view, it does need to be a joint review from both a professional medical governance perspective and a workforce policy perspective, however, I believe input from HR Directors and Medical Directors would be key to any such review going forward. I believe any review needs to significantly simplify the document, with a logical flow and structure, with greater clarity and definition on all key designated roles within the Framework to make it easier for me and other designated individuals to discharge their responsibilities. The role of the Medical Director is currently not defined, nor is the role of any HR support to any of the designated roles in the Framework.

- 27(v) The role of the Designated Board Member is particularly difficult in my view to comprehend, which in turn makes my advisory role, as HR Director, difficult to discharge. The role of the Designated Board Member as outlined in Section I para 8 refers to '*consider any representations from the practitioner about his or her exclusion or any representations about the investigation*'. Mr O'Brien made representations to John Wilkinson as the Designated Board Member in the early stages of the investigation in February and March 2017, however, given the detail of those representations, and following legal advice, we considered that the Case Manager, Dr Khan and Medical Director, Dr Wright, were best placed to respond to those representations. This leads me to question what exactly the role of the Designated Board Member can realistically be under the MHPS Framework, as I do not believe that John Wilkinson, as a Non Executive Director, would have had sufficient knowledge to determine or challenge if Mr O'Brien's representations were responded to appropriately. Any review of MHPS, in my view, needs to consider this, and provide greater clarity about what their role is and is not.
- 27(vi) The timescales contained within MHPS are not realistic, and do not reflect the reality of clinical commitments and day to day operational pressures in the HSC. I fully acknowledge, however, the importance of ensuring that concerns



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2. On 19th January 2017 I was appointed as the Designated Non-Executive Director ('NED') by the Chair of SHSCT, Mrs. R. Brownlee ('RB'). The primary purpose of my role was to liaise with Mr Aidan O'Brien ('AOB') and ensure the momentum of the Maintaining High Professional Standards ('MHPS') process in respect of AOB was maintained by ensuring timely responses to requests made by AOB. I met with Vivienne Toal ('VT'), Director of Human Resources and Organisational Development, to review the role of Designated NED.
3. On 24th January 2017 a meeting (see appendix located in Relevant to CX Chair's Office, Evidence Added or Renamed 19 01 2022, 20170206 - E - S Hynds to J Wilkinson.) was held with AOB, Mr Weir ('CW') and Mrs Siobhan Hynds ('SH'). CW was the Case Investigator and SH is the Head of Employee Relations who was assisting Mr Weir with the investigation.
4. On 25th January 2017 I sent a letter to AOB introducing myself as the Designated NED (see appendix) and I made him aware that I was informed about his immediate exclusion which became effective on 30th December 2016. At this time the Case Manager was Dr A Khan ('AK') and the Case Investigator was CW. The relevant documents can be located in Relevant to CX Chair's Office, Evidence after 4 Nov 21 CX Chair, ref no 77 for John Wilkinson NED, 20170125 - Doc - J Wilkinson to AOB re MHPS
5. On 25th January 2017 I received an email from VT outlining the next steps in the process I received another email from VT providing me with an update prior to the Trust Board meeting (see appendix located in Relevant to CX Chair's Office, Evidence Added or Renamed 19 01 2022, 20170125 E V Toal to J Wilkinson re Confidential Mr AOB and located in Relevant to CX Chair's Office, Evidence after 4 Nov 21 CX Chair, ref no 77 for John Wilkinson NED, 20170126 - E - V Toal to J Wilkinson re MHPS Case).
6. On 26th January 2017 I met with RB and we discussed the case. RB expressed her opinion about the case. She explained that she had known AOB for a number of years and that he had been her consultant; that he was an excellent surgeon and that he had helped many people; that he had built up the urology department

in SHSCT and had worked hard to meet patients' needs as they awaited surgery or a diagnosis. She asked me to make contact with AOB. I received an email (see appendix located in Relevant to CX Chair's Office, Evidence after 4 Nov 21 CX Chair, ref no 77 for John Wilkinson NED, 20170126 - E - V Toal to J Wilkinson re MHPS Case) from VT who advised that AOB's exclusion would be lifted subject to the implementation of controls and restrictions on his practice. I was also advised that a formal investigation would be undertaken. This would be reported to Trust Board at its monthly meeting.

7. On 2nd February 2017 I telephoned AOB and arranged a date to meet.
8. On 6th February 2017 SH shared notes (see appendix located in Relevant to CX Chair's Office, Evidence Added or Renamed 19 01 2022, 20170206 - E - S Hynds to J Wilkinson.) with me for my information which were from a meeting with AOB regarding his exclusion. Having considered these notes it was apparent that AOB and the Trust that a significant interaction between the Trust and AOB had been ongoing. A letter sent by email to AOB was also copied to me indicating that the panel had agreed that there was a formal case to answer and that a decision was taken to lift the immediate exclusion. A meeting between Dr Khan and AOB to discuss an action plan to enable him to return to work was planned for 9th February 2017. An Occupational Health appointment was also arranged for that day.
9. On 7th February 2017 I attended a meeting with AOB in his office at Craigavon Area Hospital, Craigavon. His son Personal information redacted by USI was also in attendance. AOB provided us with his view of the situation. He was annoyed at the way in which he had been 'treated'. He cited various concerns, including, appraisal, revalidation, workload, workload imbalance, why immediate exclusion had been exercised without him being given the opportunity to address the issues, SHSCT not following their own guidelines, and the lack of response to concerns he had expressed regarding process and timescales not being adhered to. AOB speculated that if he was to be found wanting in his practice then he would bring a degree of embarrassment to the SHSCT. I remember him citing a few names but I do not have a record of these. In my opinion this was a difficult meeting. There was reference made to a number of matters which I was unfamiliar with including positions and internal procedures within the Trust. I felt that I did not have a full understanding of the situation. I assured AOB that Trust was

Concerns Regarding the Investigation Process

7th February 2017

1. A letter dated 23rd March 2016 was provided to Mr O'Brien at a meeting on or around that date by Mr Mackle and Ms Corrigan. The letter raises a number of issues which are now the subject of a formal investigation. There are a number of concerns arising from this letter.

- It does not constitute a formal or informal process under MHPS or any other Trust Guidelines. It included no local action plan to resolve the problems or any suggestions regarding a plan.
- It was provided by Mr Mackle, an individual in respect of whom Mr O'Brien has extant though stayed formal grievance. Mr O'Brien had previously been provided an assurance by both Dr. Gillian Rankin and Mr Mackle that Mr Mackle would have no further meetings with him.
- At the meeting Mr O'Brien asked what he should do to resolve the matter. The only response received was a shrug and silence from Mr Mackle.

The letter of 23rd March 2016, gives rise to a number of questions:

- What was the nature of the complaint that led to this letter being issued?
- What investigation occurred prior to the letter being completed?
- Who completed this investigation?
- How have the suggested numbers of untriaged patients and the review backlogs been arrived at?
- Was there a decision taken by a Clinical Manager that the concerns should be approached by the issue of the letter of 23rd March 2016 or by any other individual? In any case, who took this decision?
- Was this decision taken with reference to MHPS?
- Was this decision taken in consultation with the Medical Director, the Director of Human Resources or any other individual?

2. The origin of this current investigation remains unclear. It has been suggested that this investigation arises out of an ongoing Serious Adverse Incident (SAI) investigation. The following concerns arise

- The issues of concern have been reported before the completion of the report of Serious Adverse Incident Investigation and before Mr O'Brien had even been afforded the opportunity to comment on the SAI. It is therefore concerning that it is premature to commence a formal investigation.
- Insofar as the SAI relates to Mr O'Brien's practice, it is only with reference to triaging referrals whilst urologist of the week. The other issues regarding administrative practices are entirely unrelated. It is therefore unclear how the other concerns became a part of the investigation.
- It is concerning that the initial correspondence regarding the investigation from Dr Wright refers to the letter of 23rd March 2016 as an informal attempt to resolve the issues under investigation when the letter of 23rd March 2016 did not constitute any such process. It seems likely that the erroneous presumption that an informal attempt had been made to resolve the issues and that this attempt had failed has had an effect on the decision to commence a formal investigation.

Therefore, the following questions arise out of the decision to commence a formal investigation.

- Who made the complaint to the Trust that gave rise to this investigation?
- To whom was the complaint made?
- When was the complaint made?
- In what form was the complaint made?
- What was the nature of the concerns brought to the attention of the Trust?

- What investigation had been completed prior to the 30th December 2016, which resulted in the data that was presented at that meeting relating to untriaged referrals and a backlog in dictation?
- Who completed the above investigation?
- What consideration was given to handling this matter through an informal approach?
- If consideration was given to proceeding with an informal approach, why was this deemed inappropriate?
- What effect, if any, did the letter of 23rd March 2016 have on the decision to proceed with a formal investigation?
- What was the rationale for the immediate exclusion? What alternatives were considered?
- As the SAI, insofar as it concerns Mr O'Brien, only relates to triage, why was the investigation launched into the entirety of the administrative practices?

3. The conduct of the investigation is also concerning.

- The Trust Guidelines mandate that an investigation must be completed within four weeks. We are now in the sixth week of this investigation. This is a breach of contract and this was acknowledged by the HR representative at the meeting of 24th January 2017.
- It has been stated that all of these investigations take longer than the four weeks required and therefore there has been no justification offered as to why this investigation must take longer than four weeks.
- At this point, there is no end date in sight for this investigation whatsoever.
- The Non-Executive Director was not appointed until at least two weeks had passed in the investigation, half of the permitted time for completion of the investigation.
- At the meeting of the 24th January 2017, Mr O'Brien was advised that there is a team of investigators attached to this investigation. It is

concerning that any chance of confidentiality being maintained within the investigation is now lost as an unknown number of unidentified people are involved.

- The investigation has now expanded beyond administrative practices and encompasses an alleged issue that private patients have been receiving preferential treatment in having their procedures completed more quickly than NHS patients. It is unclear how this issue can arise out of an investigation into administrative practices.

The following questions arise.

- How long is the investigation expected to take?
- What justification is there for the investigation continuing in breach of the contractual term contained in the guidelines that an investigation must be completed within 4 weeks?
- How many people are now involved in the investigation and what are the identities of the investigators?
- How does the Trust propose to ensure confidentiality and the rights to privacy given the number of professionals involved in this investigation?
- What has given rise to the addition of Mr O'Brien's private practice becoming the subject of investigation?



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13 February 2017

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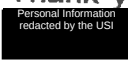
BY E-MAIL ONLY

Mr Aidan O'Brien

Personal Information redacted
by the USI

Dear Mr O'Brien

Re: Process under Maintaining High Professional Standards Framework (MHPS)

Thank you for meeting with me on Tuesday 7 February 2017 along with your son . I welcomed the opportunity to meet with you and I hope you felt our meeting was helpful.

I have shared the submission you provided to me with the Oversight Committee and I have also shared my notes of our meeting. I feel it is important that I take time to properly consider all of the representations you have made to me and to discuss fully with the relevant individuals involved in this process.

I am intending to undertake these discussions next week however some difficulties are presenting in that this coincides with planned annual leave of some key individuals and therefore I am writing to advise you that it will likely be the early part of week commencing 20 February 2017 when I am in a position to come back to you to respond to the points you have raised.

I understand you are already concerned about the timescales to date for this process however I trust you can appreciate the importance of ensuring the matters are fully considered in order to determine the appropriate way forward.

I thank you for your continued patience while we work through these matters.

Yours sincerely

Mr John Wilkinson
Non-Executive Director

Comac, Jennifer

From: Toal, Vivienne
Sent: 22 February 2017 17:45
To: Wilkinson, John; Wright, Richard
Subject: MHPS case

John / Richard

Following legal advice last week from June Turkington, we agreed that a response to AOB's letter would be issued from Dr Khan, Case Manager. This letter is currently in draft form to be issued this week to AOB.

Would it be possible for the 3 of us to meet for 15 minutes at 9am tomorrow morning so we can discuss?

Many thanks
Vivienne

Vivienne Toal (Mrs)
Director of Human Resources & Organisational Development
Trust Headquarters
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ

Tel: [Personal Information redacted by the USI]
Mob: [Personal Information redacted by the USI]

Comac, Jennifer

From: Toal, Vivienne
Sent: 23 February 2017 09:29
To: Wilkinson, John
Cc: Wright, Richard
Subject: MHPS case

John

Can we get an opportunity to discuss the AOB case this morning please, along with Richard?

Vivienne

Dear Mr O'Brien

Further to my letter to you on 13th February, I am keen to keep you informed with progress in terms of a response to your representations made regarding the MHPS process.

Dr Khan as Case Manager will be responding in writing to the issues you have raised and is finalising his response to you currently. I have asked to see a copy of the response before it is issued to you before close of business tomorrow.

Regards
Vivienne

Comac, Jennifer

From: Hynds, Siobhan
Sent: 24 February 2017 12:20
To: Wilkinson, John
Cc: Khan, Ahmed
Subject: Letter from Case Manager to Mr A O'B 24 February 2017
Attachments: Letter from Case Manager to Mr A O'B 24 February 2017.docx

John,

Please see attached letter which will be issued today to Mr A O'Brien from Dr Khan.

I intend to send this via e-mail this afternoon but wanted to ensure you had an opportunity to go through the detail before it is issued.

Please let me know if you have any queries.

Many thanks

Siobhan

Mrs Siobhan Hynds

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

Personal information redacted by the USI



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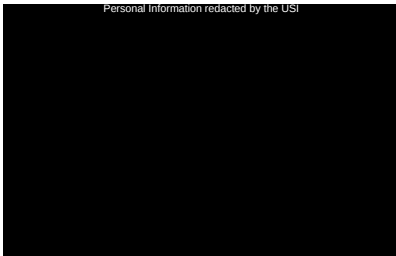
24 February 2017

STRICTLY PRIVATE & CONFIDENTIAL

BY E-MAIL ONLY

Mr Aidan O'Brien

Personal information redacted by the OSI



Dear Mr O'Brien

Re: Formal investigation under Maintaining High Professional Standards Framework (MHPS)

Mr John Wilkinson Non-Executive Director has shared with me details of representations you have recently made to him at a meeting on 7 February 2017 about the formal investigation under the Maintaining High Professional Standards (MHPS) Framework.

Following due consideration of the issues you have raised, I wish to respond to you on these matters.

1. The letter of 23 March 2016

I have considered the representations you have made in respect of the letter of 23 March 2016. It is important that I state at the outset, that I was not involved in the conversations or discussions that took place at that time. I understand that concerns were identified by managers within the Acute Services Directorate and the purpose of the March 23rd letter was to set out to you those concerns on an informal basis in order to enable you to put in place measures to rectify the concerns. The issues of concern did not result from a specific complaint.

The letter was not set out to you in the context of an informal process under the Maintaining High Professional Standards Framework but rather was an informal attempt at local resolution of the issues, sent to you through normal line management channels. It was expected that as an experienced and senior Consultant, this notification of concern to you was sufficient to ensure you took all necessary steps to address the concerns and to rectify the identified problems.

You state in your submission to Mr Wilkinson that an agreement was in place that formal contact or meetings would not take place between you and Mr Mackle due to a prior grievance process. I am not aware of this background or the agreement referred to. I understand the Medical Director, Dr Wright is also unaware of this matter. As you will be aware, Dr Gillian Rankin has retired from the Trust. I feel this is a matter best dealt with via the formal investigation process and I would ask that you raise this with the Case Investigator to fully explore the background and history of what preceded the management of the concerns under the MHPS Framework as is relevant to the current investigation.

2. Formal Investigation

You have raised the matter of the circumstances which led to the decision to manage the concerns under the formal process of the MHPS Framework. As you know, there were concerns raised with you in March 2016 about your administrative practices and the impact on patient management and care.

Management follow up is not clear to me at present. It is not my role to investigate the detail of this and I believe this is again a relevant matter for the formal investigation process. I am however aware that Mr Colin Weir was in post as Clinical Director in the period following March 2016 and given your representations to Mr Wilkinson, I feel it is likely Mr Weir may be required to provide information to the investigation on this issue. Therefore I have asked Mr Weir to step down from his role as Case Investigator and I have asked Dr Neta Chada, Associate Medical Director to undertake the role of Case Investigator. Dr Chada will be in contact with you in due course.

The SAI process you refer to in your submission, alerted the Trust to a very serious issue of concern which indicated harm had come to a patient who had not been properly triaged by you as was required. The issue was one of the same issues alerted to you informally in March 2016. You have noted that a decision was made to immediately exclude you from work prior to the finalised report on the SAI. The reason for this decision was due to the very serious nature of the concern. The Trust must ensure patient safety is properly safeguarded and when matters of serious concern arise, consideration is given to any necessary action to immediately ensure the safety of patients. It is for this reason, a decision was made to exclude you and to move to a formal investigation of the concerns.

You suggest the formal investigation has resulted because of an erroneous presumption that an informal attempt at resolution of the issues had failed. The Trust does not always manage issues of concern through an informal process, the seriousness of issues will always be considered. However an informal attempt to address concerns with you in March 2016 was made.

When a very serious issue of concern came to the attention of the Trust, i.e. the harm of a patient, it was necessary for the Trust to take action deemed necessary and proportionate to manage such a concern. This is the current formal investigation process.

A decision was initially taken to exclude you, this decision has since been reviewed taking into consideration the representations you made for alternatives to exclusion and you have returned to work with effect from 20 February pending conclusion of the formal investigation.

As discussed at our meeting on 9 February, you will be returning to work with a clear management plan for supervision and monitoring of key aspects of your work. An immediate priority is to ensure your job plan is reviewed and agreed to ensure a manageable and comparable workload with your other Consultant colleagues. I have asked for this to be completed as a matter of urgency.

3. Timescales of Investigation

The matter of the timescales for the investigation has also been raised by you with Mr Wilkinson and I understand this was also raised by you at a meeting with Colin Weir and Siobhan Hynds on 24 January.

The timescale for a formal investigation as set out in the MHPS Framework states: *'The Case Investigator should, other than in exceptional circumstances, complete the investigation within 4 weeks of appointment and submit their report to the Case Manager within a further 5 working days.'*

Given the vast scale of the concerns, the numbers of patients involved, the time period over which the concerns stretch, the records which need to be reviewed and the scale of facts to be gathered, a 4 week turnaround time is not practicable in these circumstances. These are exceptional circumstances.

I can assure you that the investigation process will be concluded as expeditiously as possible ensuring that it is fully and properly completed. I will ensure you are kept informed on an on-going basis as to the status of the investigation and the likely timescale for completion.

Your understanding that there is a team of case investigators looking at this case is not correct. The case investigator assigned to your case is Dr Chada, who will be assisted by Siobhan Hynds. However a review of the un-triaged patients must be completed to consider what, if any, impact there has been on patient care. A similar review must also be undertaken in respect of the undictated clinics. This can only be done from within the service directorate by individuals with the requisite expertise. This work will inform the case investigator's investigation.

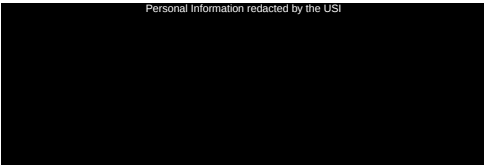
I wish to assure you that all matters pertaining to these concerns will be kept strictly confidential and any individuals involved are wholly bound by their obligations of confidentiality in line with Trust Policy and contract of employment.

I trust this address the issues you have raised and provides assurance to you of my commitment to ensuring the investigation process is concluded as quickly, thoroughly and robustly as possible.

I have shared a copy of this letter with Mr Wilkinson for his information.

Yours sincerely

Personal information redacted by the USI



Dr Ahmed Khan
Associate Medical Director &
Case Manager

Copy to: Mr John Wilkinson



Urology Services Inquiry

the availability of the people to answer the questions (a number of individuals were on holiday).

14. On 22nd February 2017 AOB forwarded an email and attached a letter (see appendix located in Relevant to CX Chair's Office, Evidence Added or Renamed 19 01 2022, 20170222 - E - AOB to J Wilkinson) he had sent to Dr. Wright who was the Medical Director at the time. He had requested that amendments be made to the notes from a meeting which had taken place on 30th December 2016. I was concerned that I would not be able to deal with this matter since I was not appointed at the time and my understanding of the issues would be limited. I took this matter up with VT who subsequently contacted June Turkington ('JT') at the Department of Legal Services ('DLS'). JT provided legal advice. (see appendix located in Relevant to CX Chair's Office, Evidence after 4 Nov 21 CX Chair, ref no 77 for John Wilkinson NED, 20170222 - E - V Toal to J Wilkinson and Dr Wright). SH sent me a copy of the letter to be issued to AOB from AK (see appendix located in Relevant to CX Chair's Office, Evidence Added or Renamed 19 01 2022, 20170224 - E -S Hynds to J Wilkinson).
15. I was aware that VT was to request/had requested a meeting with AOB and I was satisfied that the momentum of the case would be maintained, matters would be addressed and the reasons for the delays outlined.
16. On 23rd February 2017 I was made aware that a new Case Investigator had been appointed, namely, Dr Neta Chada ('NC'). I understand that there had been a conflict of interest with the previous Case Investigator, CW. AOB was content with this change.
17. On 23rd February 2017 I met with VT and Dr Wright to discuss the case. I did not take a note at this meeting.
18. On 24th February 2017 SH sent me a copy of the letter to be issued to AOB from AK (See appendix located in Relevant to CX Chair's Office, Evidence Added or Renamed 19 01 2022, 20170224 - E -S Hynds to J Wilkinson).
19. On 2nd March 2017 RB telephoned me and expressed her concerns about case progression and timescales. She stated that AOB was a highly skilled surgeon who had built up the urology department and was well respected by service



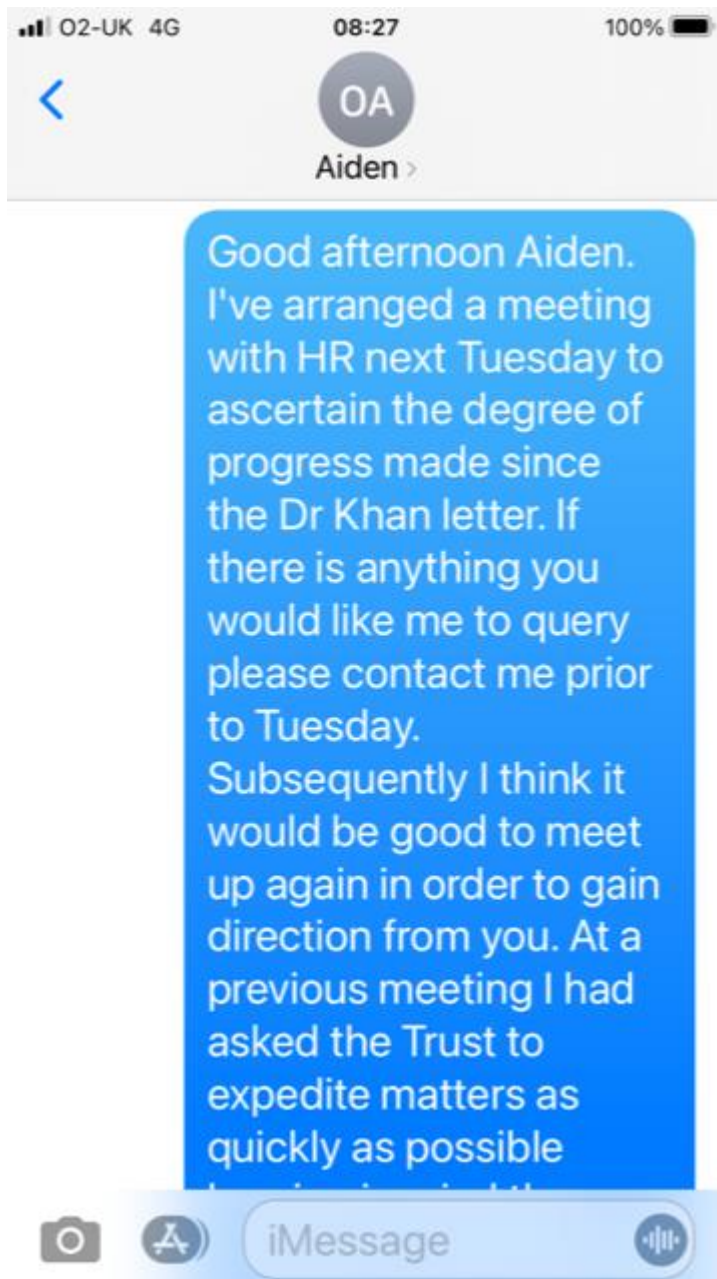
Urology Services Inquiry

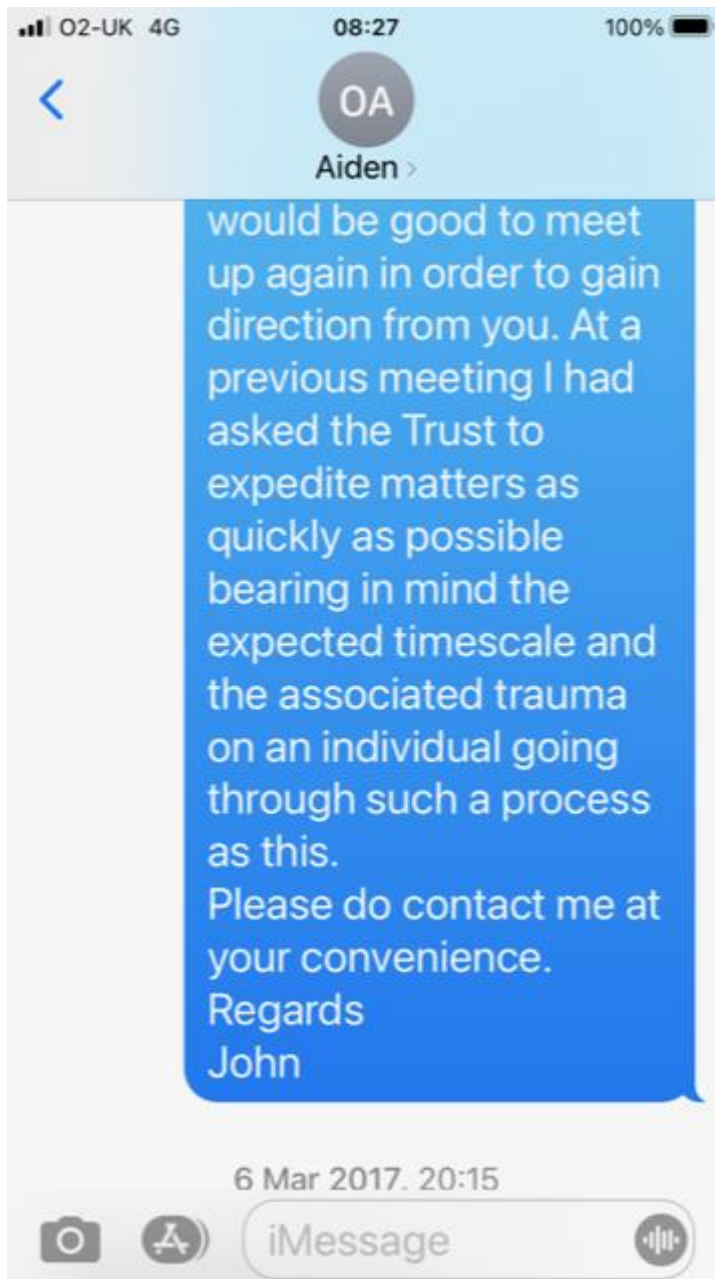
users. She further expressed concern about the handling of the case by Human Resources. RB pointed out that the case was having an adverse effect on AOB and his wife. She asked me to contact AOB.

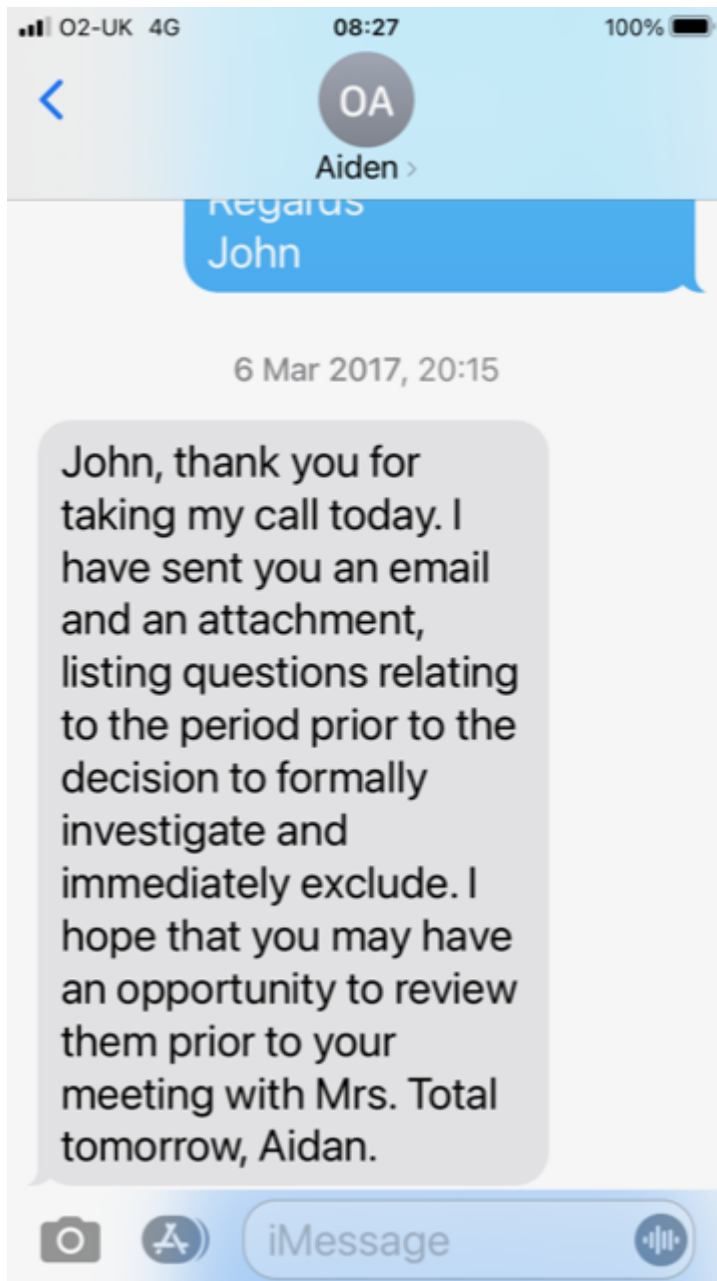
20. On 2nd March 2017 I telephoned and texted AOB seeking a meeting to discuss progress and any other concerns that he might have had. I received no response.
21. On 6th March 2017 AOB made contact with myself and raised the following concerns:-
 - a. He stated he was disappointed with AK's letter and that he felt that the reply should have come from myself or the Case Manager.
 - b. He further explained that he believed that the needs of the process was taking over rather than the needs of the case itself and in particular cited important points of clarity. AOB was concerned about the needs of his patients and he believed that he was taking every possible measure to expedite their needs even though it was causing him significant additional work.
 - c. He believed that the process had already come to an opinion.
 - d. He stated that the Trust Guidelines re the handling of MHPS were being overlooked and that the Serious Adverse Incident sequence had not been clarified.
 - e. He expressed concern that other measures had not been explored prior to him being excluded.
 - f. He also believed that the process that he was undergoing was being driven by Human Resources and not clinicians.

I explained to AOB that I was meeting VT from HR and that I would bring his concerns forward. AOB asked me to also:

- i. Enquire about case progress;
- ii. Request that the Terms of Reference for the Inquiry be shared if they were agreed and available;
- iii. Clarify whether the scoping exercise was complete and if the Inquiry had begun (and, if so, on which date it began). Appendix located in Relevant to CX Chair's Office, Evidence Added or Renamed 19 01 2022,



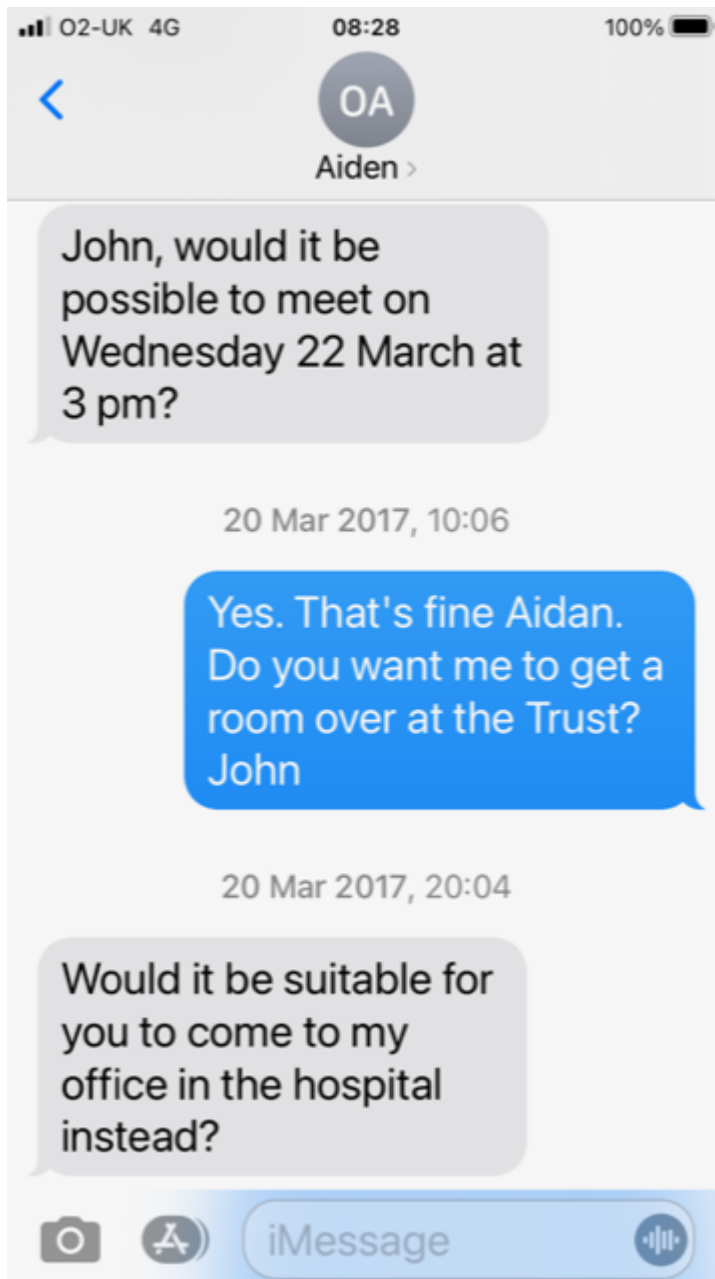


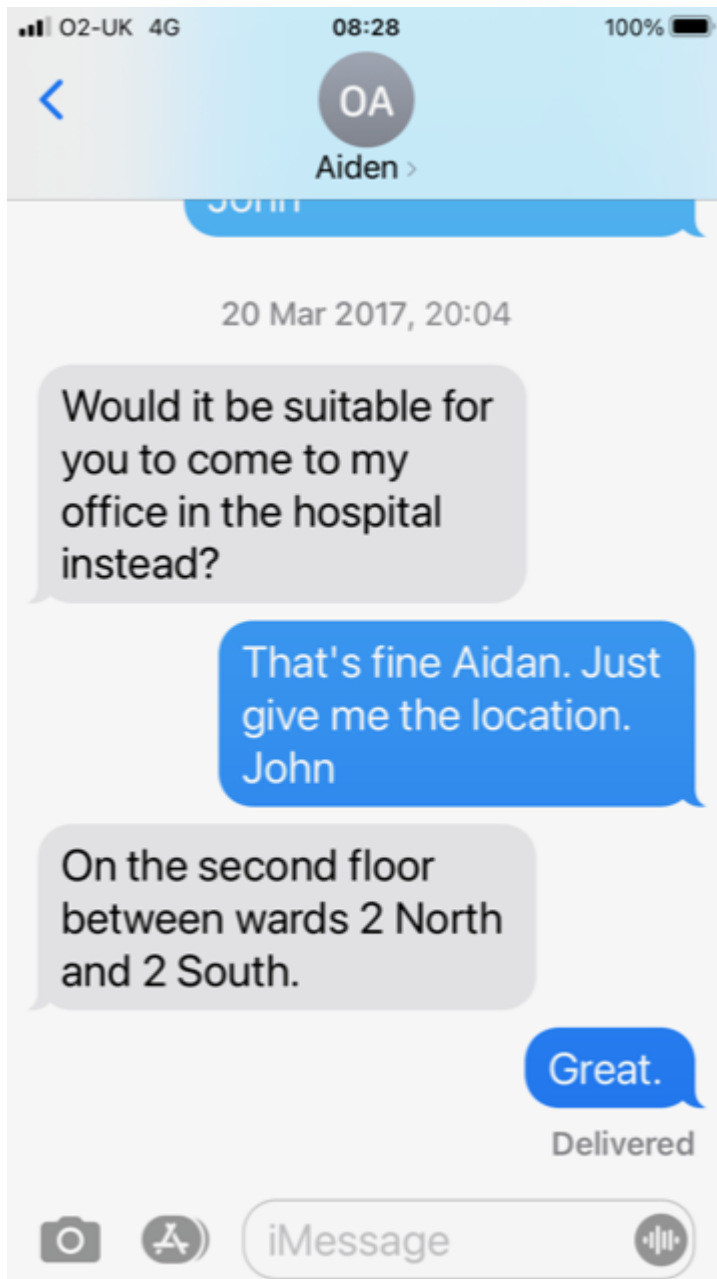












Comac, Jennifer

From: Aidan O'Brien Personal information redacted by the USI
Sent: 06 March 2017 20:08
To: Wilkinson, John
Subject: Questions to be asked
Attachments: Questions to be Asked 06 March 2017.docx

Dear John,

I thank you for taking my call earlier today and I regret disturbing you during your other work commitments.

I wish to emphasise to you how much I appreciate your efforts on my behalf.

However, I had expected or assumed that I would receive a communication from you informing me of answers which you had received to the questions which we had raised with you when we met on 07 February 2017.

I was entirely taken aback and disappointed that a response should come from the Case Manager.

That it did implied to me that your role on my behalf does not enjoy an autonomy.

Since speaking with you earlier today, I have reviewed the Trust Guidelines forensically.

I have attached a list of questions which I require to be answered concerning the conduct of the Trust in handling the concerns raised prior to the decision to formally investigate and immediately exclude.

As these questions pertain to the period prior to the appointment of the Case Manager, I will regard any reply from the Case Manager to be entirely inappropriate,

Many thanks,

Aidan.

Questions to be Asked

In Paragraph 1.5 of the Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance (23 September 2010), it states that, whatever the source of the concern, the response will be the same, i.e. to:

- a) Ascertain quickly what has happened and why.
- b) Determine whether there is a continuing risk.
- c) Decide whether immediate action is needed to remove the source of the risk.
- d) Establish actions to address any underlying problem.

Question 1:

How was it possible to ascertain what had happened and why it had happened without speaking with and enquiring of Mr. O'Brien?

Question 2:

Who made the decision not to speak to or enquire of Mr. O'Brien?

Question 3:

When was that decision made?

In Paragraph 2.2 of the Trust Guidelines, it states that concerns should be raised with the practitioner's Clinical Manager – this will normally be either the Clinical Director or Associate Medical Director.

Question 4:

Who was the Clinical Manager with whom concerns were raised?

Question 5:

When were concerns raised with that Clinical Manager?

Question 6:

Who raised the concerns with the Clinical Manager at that time?

In Paragraph 2.2 of the Trust Guidelines, it states that, if the initial report / concern is made directly to the Medical Director, then the Medical Director should accept and record the concern but not seek or receive any significant detail, rather refer the matter to the relevant Clinical Manager.

The Medical Director advised at the meeting of 30 December 2016 that the concerns had been brought to his attention during the course of an investigation into a Serious Adverse Incident.

Question 7: Who brought these concerns to his attention?

Question 8: When were these concerns brought to his attention?

Question 9: Did he refer the matter to the relevant Clinical Manager?

Question 10: If so, who was that Clinical Manager?

Question 11: When did he refer the matter to the Clinical Manager?

Question 12: If not, why not?

In Paragraph 2.4 of the Trust Guidelines, it states that the Clinical Manager will immediately undertake an initial verification of the issues raised.

Question 13: Did a Clinical Manager undertake an initial verification of the issues raised?

Question 14: If so, who was that Clinical Manager?

Question 15: If so, when did the Clinical Manager undertake the initial verification?

Question 16: If so, what methods or means was used to verify the issues?

Question 17: If so, did other persons assist in the verification process?

Question 18: If so, who were those persons?

Question 19: If so, why did the verification process not include a consultation with Mr. O'Brien?

Question 20: If an initial verification was not undertaken, why not?

Question 21: If an initial verification was not undertaken, who made the decision not to do so?

Question 22: If an initial verification was not undertaken, when was the decision made not to do so?

In Paragraph 2.6 of the Trust Guidelines, it states that the Clinical Manager and the nominated HR Case Manager will be responsible for investigating the concerns raised and assessing what action should be taken in response.

Question 23: Did a Clinical Manager and a nominated HR Case Manager investigate the concerns raised?

Question 24: If so, who was that Clinical Manager?

Question 25: If so, who was that nominated HR Case Manager?

Question 26: If so, when did the investigation begin?

Question 27: If so, when did the investigation end?

Question 28: If so, what methods or means were used to conduct the investigation?

Question 29: If so, did other persons assist in the investigation?

Question 30: If so, who were the other persons?

Question 31: If so, why did the investigation not include a consultation with Mr. O'Brien?

Question 32: If a Clinical Manager and nominated HR Case Manager did not conduct an investigation, why not?

Question 33: Who made the decision not to conduct an investigation?

Question 34: When was that decision made?

Question 35: Why was that decision made?

In Paragraph 2.6 of the Trust Guidelines, it states that the Clinical Manager and HR Case Manager should take advice from other key parties such as NCAS, Occupational Health Department, in determining their assessment of action to be taken in response to the concerns raised.

Question 36: Did the Clinical Manager or the HR Case Manager take advice from NCAS in determining their assessment of action to be taken in response to the concerns raised?

Question 37: If so, who sought the advice from NCAS?

Question 38: If so, what information was given to NCAS?

Question 39: If so, who provided that information?

Question 40: If so, what advice was given by NCAS?

Question 41: Why was advice not sought from the Occupational Health Department in determining the assessment of action to be taken in response to the concerns raised, particularly as Mr. O'Brien was on sick leave following surgery?

Question 42: Who made the decision not to seek advice from the Occupational Health Department?

Question 43: When was that decision made?

In Paragraph 2.7 of the Trust Guidelines, it states that where possible and appropriate, a local action plan should be agreed with the practitioner and resolution of the situation (with involvement of NCAS as appropriate) via monitoring of the practitioner by the Clinical Manager.

Question 44: Why was a local action plan not agreed with Mr. O'Brien?

Question 45: Why was Mr. O'Brien not consulted in determining whether a local action plan and resolution were possible and appropriate?

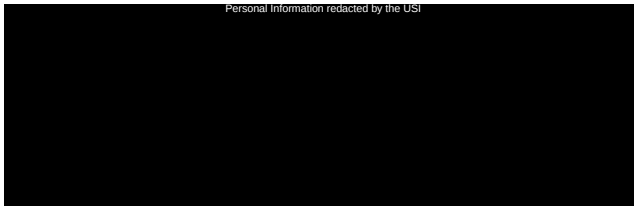
Question 46: Who made the decision not to consult with Mr. O'Brien or agree an action plan with Mr. O'Brien?

Question 47: When was that decision made?

In accordance with the Trust Guidelines, all of the above constituent parts of the process of Handling Concerns should have been conducted prior to the decision of formal investigation and immediate exclusion.

The constituent parts are screening, verification, investigation and an informal action plan with the objective of resolution, if possible and appropriate. It is my concern that some of these constituent parts have not been conducted properly and fully, if at all.

I have concerns regarding the accuracy of the evidence provided to date, and I would possibly have concerns regarding the sources of that evidence. Above all, I have found it remarkable and unjust that I was not consulted at any stage of the above process when I should have been.



Aidan O'Brien

06 March 2017.

Comac, Jennifer

From: Wilkinson, John
Sent: 07 March 2017 18:53
To: Aidan O'Brien
Cc: Wilkinson, John
Subject: RE: Update

Dear Aidan

Further to my meeting today, to receive an update as agreed, I can report the following:

1. I was given assurances that the case is progressing.
2. The terms of reference re the investigation will be issued to you imminently .
3. In addition you will be provided with a list of the people, at this stage, with whom the Case Investigator will interview.
4. I am assured that you will be given the opportunity to state your case as part of the process.
5. As the list of people being interviewed will take place over the next 3-4 weeks you could expect to be interviewed by mid to late April '17.
6. The questions you emailed to me last night I have passed on to HR for a response. The questions will be addressed by appropriate persons. I am assured these will be responded to as quickly as possible.

As per my role I will continue to ensure that the momentum is maintained.

If you have any further representations which you would like me to make on your behalf re the investigation, you should forward them to me using this email or using Personal Information redacted by the USI

I hope this is helpful.

Regards
John

From: Aidan O'Brien Personal Information redacted by the USI
Sent: 06 March 2017 20:08
To: Wilkinson, John
Subject: Questions to be asked

Dear John,

I thank you for taking my call earlier today and I regret disturbing you during your other work commitments.

I wish to emphasise to you how much I appreciate your efforts on my behalf.

However, I had expected or assumed that I would receive a communication from you informing me of answers which you had received to the questions which we had raised with you when we met on 07 February 2017.

I was entirely taken aback and disappointed that a response should come from the Case Manager.

That it did implied to me that your role on my behalf does not enjoy an autonomy.

Since speaking with you earlier today, I have reviewed the Trust Guidelines forensically.

I have attached a list of questions which I require to be answered concerning the conduct of the Trust in handling the concerns raised prior to the decision to formally investigate and immediately exclude.

As these questions pertain to the period prior to the appointment of the Case Manager, I will regard any reply from the Case Manager to be entirely inappropriate,

Many thanks,



Urology Services Inquiry

22. On 7th March 2017 I emailed AOB to update him that I had met with VT and put forward his queries and concerns. (Appendix- located in S21 No 38 of 2022, 201706307 Contemporaneous Notes)
23. Following my meeting with AOB, I had concerns that he misunderstood what my role of NED entailed. My role under the MHPS framework and Trust Guidelines of 2010 was to ensure that the momentum of the case was maintained, to consider representations made by AOB, and to report the MHPS findings to the Board in due course. I did not feel that I was equipped to carry out the level of inquiry requested by AOB. Further I did not perceive myself to be an advocate, a representative, supporter, mediator or inquirer I advised AOB that if he needed aspects of the Inquiry clarified that he should address his queries and concerns to the Case Investigator or Case Manager directly. I advised him that he should contact me if he felt that matters were moving slowly or if he felt that he was being obstructed in any way.
24. On 18th March 2017 I received a telephone call from AOB. I have no notes of this call. I suspect it was to set up a meeting on the 21st March 2017.
25. On 21st March 2017 a meeting took place in AOB's office. His son Personal information redacted by USI was in attendance. The Appendix summarises the main topics of discussion.
26. On 30th March 2017, with regards to correspondence sent to me from AOB on 6th March 2017, Dr Wright (Medical Director) responded to the concerns outlined in the paper forwarded to me from AOB. (see appendix located in Relevant to CX Chair's Office, Evidence Added or Renamed 19 01 2022, 20170331 - E - H Mallagh-Cassells to J Wilkinson).
27. From this point on, I have limited records of any direct contact made by AOB to myself regarding the case. (except through copied emails). I continued to track progress with SH and with VT. From time to time I received emails from AK which assured me that the case was progressing. (see appendix located in Relevant to CX Chair's Office, Evidence after 4 Nov 21 CX Chair, ref no 77 for John Wilkinson NED, 20170413 - E - J Wilkinson to A Khan and 20170515 - E - A Khan to J Wilkinson). I felt uneasy that AOB had not contacted me and I



Urology Services Inquiry

to non engagement of Mr O'Brien to meet with Case Investigator and I understood he spoke to Mr O'Brien.

- b. Dr Wright went off on Personal Information leave at the beginning of 2018. After a recruitment and selection process I was appointed as the Acting Medical Director in April 2018. I remained in this post until December 2018, when Dr Maria O'Kane was appointed as substantive Medical Director. I handed this case to her as part of my Medical Director's handover.

Medical Director Handover-2018- This can be located at Attachment folder S21 31 of 2022- Attachment 25.

7.6 Designated Board Member:

- a. I liaised with the Designated Board Member (Mr John Wilkinson) multiple times throughout the MHPS investigation, mainly to keep him updated regarding the progress of the investigations. Once I received the Case Investigator's Report I informed him. I also informed him when Mr O'Brien was referred to the GMC in April 2019. (Email correspondence attached). **This can be located at Attachment folder S21 31 of 2022- Attachment 7.**

7.7 The clinician:

- a. As per my role, I informed the Mr O'Brien in writing that the MHPS investigation was to be undertaken. I also informed him of the Case Manager's name and the Terms of Reference for the investigation. Mr O'Brien was provided with the opportunity to see correspondence and evidence related to this case. He was also given the opportunity to put forward his views and provide his statement.
- b. I liaised with him on multiple occasions either to inform him on the progress or reply to his queries. I shared the Case Investigator's Report with him and requested his comments in June 2018.
- c. I met with him on a number of occasions, especially at the beginning of the investigation and at the end of formal investigations with my Case Manager's Determination report in September 2018.
- d. I informed Mr O'Brien in October 2018, when the GMC Employer Liaison Adviser had requested a copy of my Case Manager's Determination report.
- e. I also informed him when the GMC referral was made in April 2020.

1 "Responsible for overseeing the case to ensure that
2 momentum is maintained and consider any representations
3 from the practitioner about his or her exclusion, or
4 any representations about the investigation".

14:16

5
6
7 In terms of your relationship or interaction with
8 Mr. wilkinson, one can see from a flurry of emails over
9 the period of the investigation that there's an effort
10 to update him by you or on your behalf, and sometimes 14:16
11 by Mrs. Hynds on behalf of Dr. Chada about the progress
12 of the investigation.

13
14 were you being challenged by Mr. wilkinson at any time
15 to move things along or to address particular issues or 14:17
16 any concerns?

17 A. Yes, I had a number of communications with
18 Mr. wilkinson. On the other hand, he also approached
19 me on various occasions inquiring about the current
20 progress of the investigations. I don't think that 14:17
21 there was an element of challenging but I believe there
22 was more about keeping up-to-date and also to
23 encourage, to move along and finish the investigations.
24 But I wouldn't consider that as a challenge to me or to
25 the Case Investigator. 14:18

26 99 Q. I don't mean that in any antagonistic way. Was he, if
27 you like, a friendly challenger to the process? If you
28 like, in answer to his job description as I've read it
29 out from the two documents, is that what he was, in

1 essence, doing?

2 A. In fairness to Mr. Wilkinson, he was asking about and
3 he was requesting the updates on regular intervals, and
4 I was providing the information to him as well. That
5 was the bulk, really, of what these communications 14:18
6 were. I had some sideline meetings with him - well,
7 not meetings, discussions or chat - when I became the
8 Interim Medical Director and attended the Trust Board
9 meetings and things. But apart from that, that was
10 really what our discussions were. 14:19

11 100 Q. Yes.

12
13 In terms of the role, perhaps more generally, of the
14 nonexecutive director within an MHPS process, are they
15 well-equipped? Do they have any, I suppose, weapons at 14:19
16 their disposal to ensure momentum in an investigation
17 that's perhaps going slowly, or is it simply, as you
18 have described, asking questions on a regular basis?

19 A. I think in my experience, in my view, the biggest
20 weapon they have is the Trust Board. They are expected 14:19
21 to update the Trust Board and the Trust Board can ask
22 the Trust to update in terms of the follow-up or the
23 update of the MHPS or any such investigation. So,
24 I believe the biggest tool they would have is going
25 through the Trust Board and the Trust Board is 14:20
26 requiring further information. But in my experience,
27 both as a Case Manager and with an addition to Interim
28 Managing Director when I was a Trust Board member,
29 I didn't see many ways of requesting other than that,

- 7.18 One of the themes that must be addressed is the extent to which, once made aware of the issue, (albeit belatedly, as I have suggested), the Board then discharged its responsibilities. The national framework for managing concerns about doctors, “Maintaining High Professional Standards in the Modern NHS” requires that once an internal investigation is launched, a Non-Executive member of the Board must be appointed to “oversee” the investigation. Ms East was appointed³⁷. On the face of it, this appears to be a mechanism whereby the Board, and more particularly, the Non-Executive members, have a link with and are kept apprised of developments in the investigation. As such, it looks like a sensible mechanism of assurance for the Board.
- 7.19 I was told, however, that there was no protocol, nor guidance for the designated Non-Executive to follow in carrying out this role. No-one, for example, briefed Ms East when she took on the role that there had been a previous investigation and Report from Mr Wake, which included a number of recommendations about the MDT and Mr Paterson’s surgical practice.
- 7.20 The Minutes of the Board, September 27, 2007, at para 5.8 record that, “Ms East stated that the Board should receive progress reports on a regular basis. This was agreed”. The Minute invites the clear conclusion that the purpose of appointing Ms East to “oversee” the investigation was to provide assurance to the Board. It was not, however, seen that way, it appears. Rather, it was seen as some form of window-dressing, on the basis that the Executive was there to carry on the investigation and should be left to get on with it.
- 7.21 The view was taken that, while the NHS might have thought it a good idea to establish a procedure involving a Non-Executive, in practice it was a waste of time. The Non-Executive added nothing and was superfluous. Certainly, the appointment of a Non-Executive provided no assurance to the Board about the conduct of an investigation.
- 7.22 Two comments may be in order concerning this view. First, this interpretation of the role assigned to the Non-Executive clearly leaves the Board entirely in the hands of what the Executive chooses to do and to tell the Board. The role of the Board in holding the Executive to account is rendered undoable. Secondly, given that the role exists, the opportunity exists for the Non-Executive to become active, rather than be merely the passive recipient of updates. And, being active might allow a Non-Executive to propose possible actions which, in the Non-Executive’s view, might better advance the interests of the Trust. This, after all, is ultimately the responsibility of the Board. It did not happen.
- 7.23 Whatever may have been recorded in the Board’s Minutes in September 2007, neither Ms East nor anyone else ever formally reported back to the Board on the progress of the investigation, according to the Minutes of the Board. This was a serious failure. There may have been informal exchanges, but only a couple of months earlier the Minutes record the Chairman of the Board as having “raised the issue of the high number of apologies for the Governance and Risk Committee and highlighted that attendance at this meeting should be a priority”, suggesting that it and, perhaps, the area of its responsibility, was not seen as a priority by some at the

³⁷ Ms East is a financial services lawyer who was appointed to the Board in 2005. The Trust had recently gained Foundation Trust status and Ms East’s appointment reflected a change whereby the Board sought to adopt a more commercial focus, rather than being focussed primarily on the community and patients. She ceased to be a member in 2013.

time. And, in any event, informal exchanges, important as they are, cannot serve as a substitute for formal reporting. Without such reporting, the organisation, as an organisation, has no knowledge or memory of events.

- 7.24 It is an elementary rule of good governance that matters of such importance that they are judged to warrant both formal internal and external investigations must not be left to the vagaries of recollections of individuals, which, of course, may differ over time. It was undoubtedly wrong and a failure on the part of the senior management that the Board was not kept informed, quite apart from Ms East's duty to do so. When I asked Dr Polson whether he was aware that a Non-Executive member of the Board had to be appointed to "oversee" the investigation and that Ms East was the appointed person, he told me that he was "not aware of any of that. ... I would ask the question why Miss East is not asking where is that Report at future Board meetings". When I asked him whether there was any "overseeing", he replied "No, no, there wasn't. No, no".
- 7.25 A further mechanism, the Governance and Risk Committee, a sub-committee of the Board, was also available to provide assurance for the Board. It had been established by the Trust at least by 2004. At the relevant time, it was chaired by Ms East. Perhaps surprisingly, given its apparent brief, there is no formal record of any engagement with the issues regarding breast surgery until August 10, 2009. The Minutes for that meeting record that the Governance and Risk Committee discussed the "On-going investigation regarding breast surgery" and agreed to convene a sub-committee. There is no further record of this sub-committee's reporting to the main Committee, or of the Governance and Risk Committee's reporting to the Board.
- 7.26 It might be thought that, even if Ms East did not report back to the Board, an alternative route for updates and reports for the Board would have been through the papers of the Governance Committee. Papers may well have gone to the Board, but nothing is recorded in the Board's Minutes about any investigation into Mr Paterson's surgical practice until a brief reference in 2009 and then nothing until late 2010. Nor was there any record in the Minutes of the Governance Committee.
- 7.27 Indeed, the Committee had never discussed concerns about a particular individual clinician, because such matters were regarded as confidential, affecting the clinician's professional life. Rather, the Committee focussed on organisational matters. It might be thought that this approach provides too limited a measure of security for the safe care and welfare of patients, given that the Committee, as its name indicates, was specifically created by the Board to concern itself with the safety of care. In terms of the formal management of the Trust there was a series of gaps in the Board's system (if it can be so described) of assurance. The Board was not kept informed. Its Sub-Committee defined itself out of competence. The Executive were not effectively held to account.
- 7.28 Having been advised that it had been launched, the Board effectively was in the hands of the Executive as to the conduct and outcome of the investigation. It is difficult to see how, in such circumstances, the Board could exercise its overarching responsibility to patients.
- 7.29 Non-Executive members of the Board might claim, of course, that they were not competent to hold the Executive to account. Of course, one solution is to have agreed standards and the means of measuring compliance with them. Such an approach can then serve to provide regular objective information for the Board. But, such an

1. CHAIR'S WELCOME

Mrs Brownlee welcomed everyone to the meeting, particularly Ms G Donaghy, Mrs P Leeson and Mr M McDonald, the newly appointed Non Executive Directors.

The Chair congratulated the following on their recent promotions: - Mr S McNally, Acting Chief Executive; Mrs A Magwood, Director of Performance and Reform; and Ms O'Neill, Acting Director of Finance and Procurement.

The Chair reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops/IPads are to be used for accessing Trust Board papers only during the meeting.

2. DECLARATION OF INTERESTS

Mrs Brownlee requested members to declare any potential conflicts of interest in relation to any matters on the agenda. None were declared.

3. MINUTES OF PREVIOUS MEETING

The Minutes of the meeting held on 24th November 2016 were agreed as an accurate record.

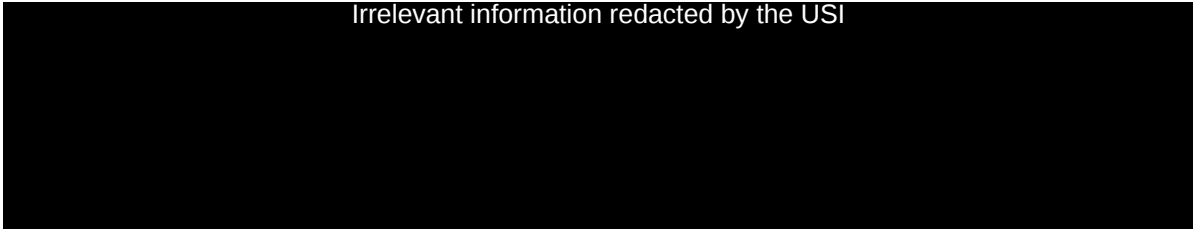
4. MATTERS ARISING FROM PREVIOUS MEETINGS

i) Judicial Reviews and Coroner's Inquests – Enhanced support for Trust staff

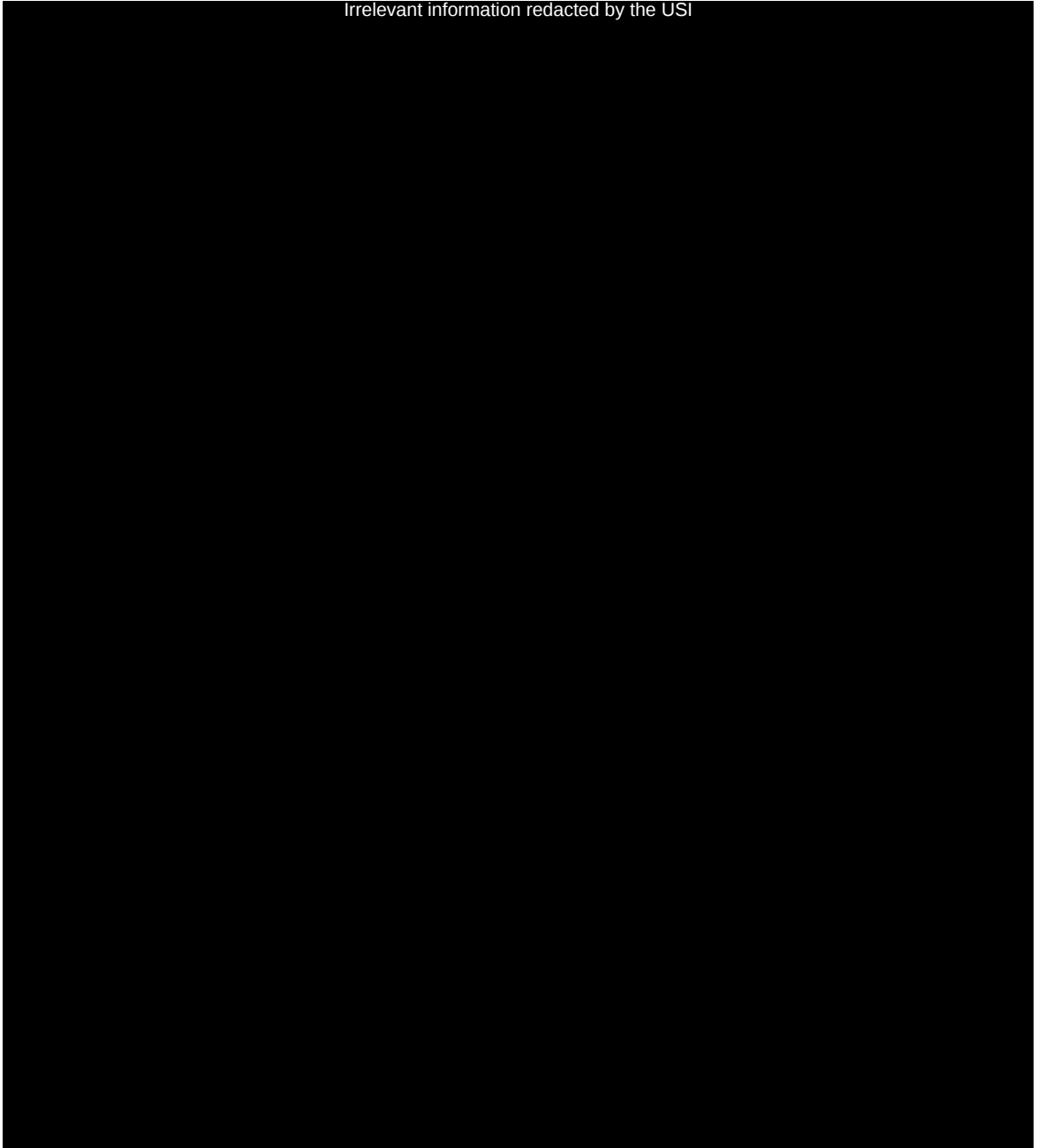
Members welcomed the establishment of an internal working group to take forward strands of work.

5. PROGRESS UPDATES

Irrelevant information redacted by the USI



Irrelevant information redacted by the USI



The Chair left the meeting for the next item.

6. **MAINTAINING HIGH PROFESSIONAL STANDARDS (MHPS)**
EXCLUSIONS

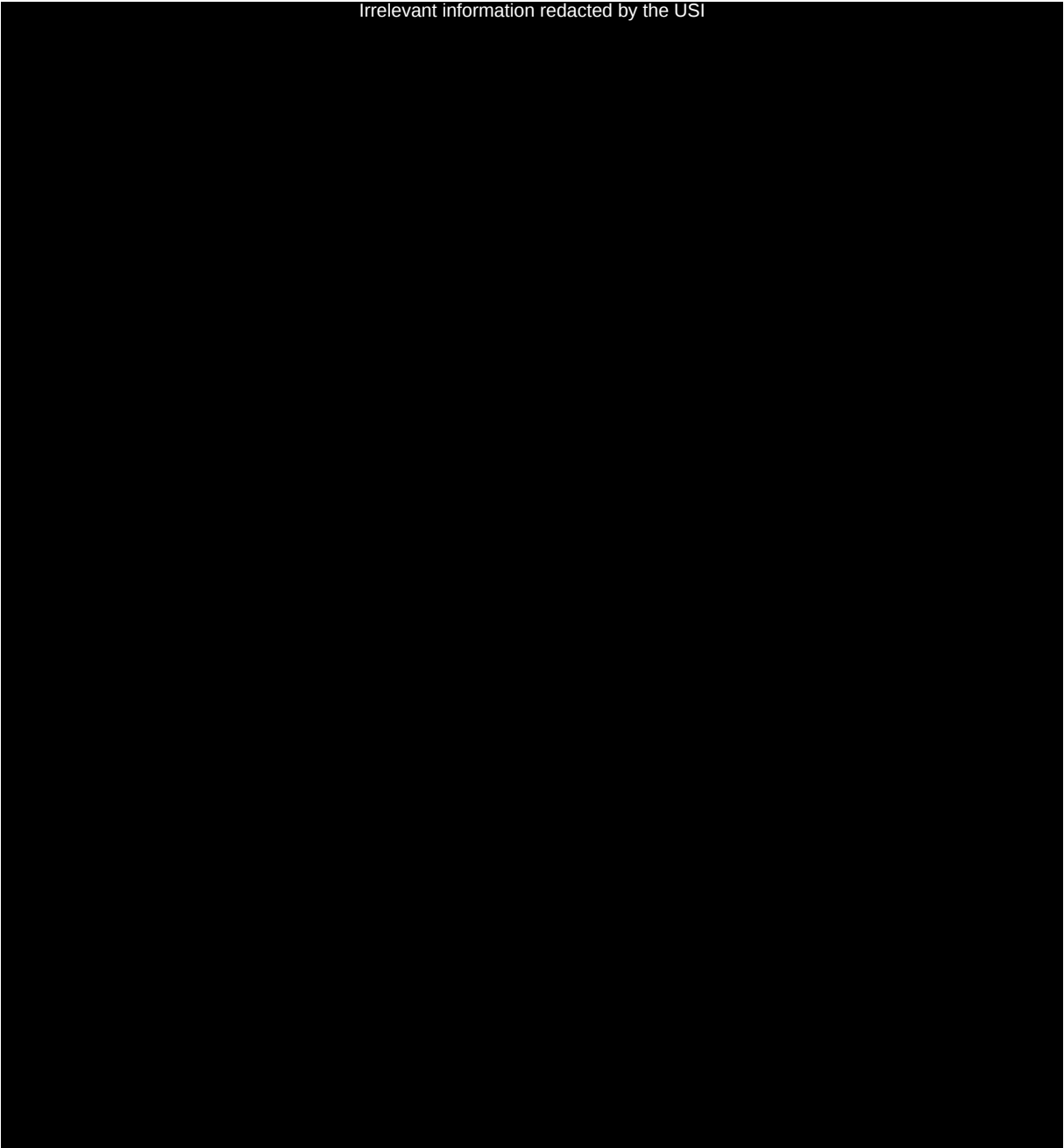
Mrs Toal advised that under the MHPS framework, there is a requirement to report to Trust Board any medical staff who have been excluded from practice. She reported that one Consultant Urologist was immediately excluded from practice from 30th December 2016 for

a four-week period. Mrs Toal reported that the immediate exclusion has now been lifted and the Consultant is now able to return to work with a number of controls in place.

Dr Wright explained the investigation process. He stated that Dr Khan has been appointed as the Case Manager and Mr C Weir, as Case Investigator. Mr J Wilkinson is the nominated Non Executive Director. Dr Wright confirmed that an Early Alert had been forwarded to the Department and the GMC and NCAS have also been advised.

7.

Irrelevant information redacted by the USI



NCAS

NHS Litigation Authority
2nd Floor, 151 Buckingham Palace Road
London
SW1W 9SZ

Website: www.ncas.nhs.uk

General Enquiries and Advice Line: 020 7811 2600

Direct Fax: 020 7931 7571

Email: casesupport@ncas.nhs.uk

29 December 2016

SENT VIA EMAIL ONLY

PRIVATE AND CONFIDENTIAL

Dr Richard Wright
Medical Director
Southern Health And Social Care Trust
68 Lurgan Road
Portadown
BT63 5QQ

NCAS ref: 18665 (Please quote in all correspondence)

Dear Dr Wright

Further to our telephone conversation on 28 December 2016, I am writing to summarise the issues which we discussed for both of our records. Please let me know if any of the information is incorrect.

In summary, this case which my colleague Dr Fitzpatrick had previously discussed with Mr Gibson, involves Dr 18665, a senior consultant urologist about whom there have been increasing performance concerns. The allegations are of poor record keeping, and slowness of triaging referrals and arranging reviews. Dr 18665 is also reported to have removed a very substantial numbers of charts from the Trust's premises without bringing them back; despite requests that these be returned many charts remain outstanding. Dr 18665's colleagues have, on occasions, seen patients for whom there have been no notes. Dr 18665 is currently on sick leave, but has indicated that he is returning to work in January 2017.

A recent Serious Adverse Incident (SAI) has caused concern that there is potential for patients to be harmed by the ongoing situation. You are awaiting the report of the SAI but on the information available to date, you feel the Trust will need to undertake a formal investigation of Dr 18665. The Trust is also considering exclusion.

As you are aware, the concerns about Dr 18665 should be managed in line with local policy and the guidance in Maintaining High Professional Standards in the Modern HPSS (MHPS). We discussed that as the information to date - no noted improvement despite the matter having been raised with Dr 18665 - suggests that an informal approach (as per paragraphs 15-17 of Section I of MHPS) is unlikely to resolve the situation, a more formal process is now warranted.

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Any formal investigation should be undertaken to robust and specific Terms of Reference (ToR) and in line with the guidance in paragraphs 28-40 of MHPS Section II. The Case Manager should write to Dr 18665 as per paragraph 35 informing him of the name of the Case Investigator and Designated Board Member; any objections by Dr 18665 to the appointment of nominated individuals should be given serious consideration. The investigation should not be an unfocused trawl of Dr 18665's work but we discussed that if there are concerns that patients may not have received appropriate treatment, or that there are patients with inadequate records, then this could be managed separately with an audit/ look back to ensure that patients have received the appropriate standard of care. We noted that further preliminary information (such as from the SAI and taking account of Dr 18665's comments) may be helpful in deciding the scope of the investigation and therefore the ToR.

As well as being outwith the Trust's Information Governance policies, the allegations, if upheld, may mean that the legislation (DPA) has been breached, and once more information is available you may wish to take further advice on this. Paragraphs 20 and 21 of the GMC's Good Medical Practice also set out standards for record keeping including a requirement that records are kept in line with data protection duties.

Dr 18665 is due to attend Occupational Health to ascertain whether he is fit for work; if he is not, we noted that there would be no need at this time to consider exclusion but you may then wish to ask the Occupational Physician whether/when Dr 18665 would be fit to participate in an investigative process.

If Dr 18665 is deemed fit for work, we discussed the criteria for formal exclusion, and the option of an interim immediate exclusion for a maximum of 4 weeks (as per paragraphs 18-27 of Section I MHPS). The latter would allow for further information to be collated and to take account of Dr 18665's comments about the allegations, before deciding whether there are reasonable and proper grounds for formal exclusion such as a concern that the presence of the practitioner in the workplace would be likely to hinder the investigation. I note that there had been a concern expressed previously about a record missing for 2 years inexplicably appearing on a secretary's desk. In line with paragraph 22 of Section II MHPS, there is an obligation to inform other organisations, including the private sector, of any restriction or exclusion of a practitioner and a summary of the reasons for it.

Dr 18665 should be encouraged to contact his defence organisation/ BMA for help and advice. He may also benefit from staff support such as counselling, at what is likely to be a stressful time for him. Dr 18665 should be told of the involvement of NCAS and you are welcome to share this letter with him if you think this would be helpful.

As discussed, and as Dr 18665 may be excluded, NCAS will keep this case open and I will review it with you in approximately 1 month. Please call in the interim if you have any queries.

Relevant regulations/guidance:

- Local procedures
- General Medical Council Guide to Good Medical Practice
- Maintaining High Professional Standards in the Modern HPSS (MHPS)

Review date:

27 January 2017

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From: [McLoughlin, Sandra E DoH](#)
To: [Early Alert](#)
Subject: SHSCT Early Alert
Date: 04 January 2017 09:53:43
Attachments: [Dr Richard Wright.pdf](#)

Please see attached Early Alert from Southern Health and Social Services Board for appropriate action.

Many thanks

Mrs Sandra McLoughlin

Corporate Governance Support Officer

Corporate Clinical & Social Care Governance Office

SHSCT Headquarters

68 Lurgan Road

Portadown

BT63 5QQ

Tel Personal Information redacted by the USI

Email Personal Information redacted by the USI

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Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

EA 01/17

RECEIVED 04/01/2017

ANNEX A

☒ Initial call made to Dr Michael McBride (DHSSPS) on 30th December 2016
(DATE) informed by letter

Follow-up Proforma for Early Alert Communication:**Details of Person making Notification:**

Name Dr Richard Wright Organisation SHSCT
Position Medical Director Telephone Personal Information redacted by the USI

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. **urgent regional action**
2. **contacting patients/clients about possible harm**
3. **press release about harm**
4. **regional media interest**
5. **police involvement in investigation**
6. **events involving children**
7. **suspension of staff or breach of statutory duty**

Brief summary of event being communicated: **If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - please confirm report has been forwarded to Chair of Regional CPC.*

Under the Terms of Maintaing High Professional Standards the Southern Health and Social Care Trust has excluded a Doctor to allow a four week period to scope out the scale of potential issues in relation to the Doctors administraitve practices, which may have had an impact on patients.

In the event of the identification any signifiant concerns resulting from the scoping process the Trust will provide a further update. Please do not hestiate to contact me if you require any further information.

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact

Dr Richard Wright

Contact details:

Telephone (work or home)

Personal Information redacted by the USI

Mobile (work or home)

Personal Information redacted by the USI

Email address (work or home)

Personal Information redacted by the USI

Forward proforma to the Department at:

Personal Information redacted by the USI

Personal Information redacted by the USI

and the HSC Board at:

FOR COMPLETION BY DHSSPS:

Early Alert Communication received by: Office:

.....

Forwarded for consideration and appropriate action to: Date:

.....

Detail of follow-up action (if applicable)

.....

From: [Woods, Paddy](#)
To: [McBride, Michael](#)
Cc: [Carson, Jane](#)
Subject: Email to Dr McBride - Ltr to Dr Michael McBride - re Aidan O'Brien
Date: 04 January 2017 17:30:00
Attachments: [image002.png](#)
[image003.png](#)
[image004.png](#)
[image005.jpg](#)

Michael

There is no requirement on the trust to notify you or the Department at this stage of investigation. The Department has received an early alert this morning.

p

From: White, Laura Personal Information redacted by the USI
Sent: 03 January 2017 08:37
To: McBride, Michael
Cc: Woods, Paddy; Carson, Jane
Subject: Ltr to Dr Michael McBride

Dear Dr McBride

Please find attached letter as discussed with Jane this morning.

Regards, Laura

Laura White

PA to Medical Director

Dr Richard Wright

Southern Health & Social Care Trust

Trust Headquarters

College of Nursing

68 Lurgan Road

BT63 5QQ



Direct Line:

Personal Information redacted by the USI



Personal Information redacted by the USI



Please consider the environment before printing this email

no back sig



From: Carson, Jane Personal Information redacted by the USI **Sent:**
03 January 2017 08:34

To: White, Laura

Subject: FW: Ltr to Dr Michael McBride

Morning Laura email as discussed.

Jane

Jane Carson

Personal Secretary to Dr Michael McBride (Chief Medical Officer)

Room C5.21

Castle Buildings

Stormont Estate

Belfast, BT4 3SQ

Tel:
Fax:

Personal information redacted by the USI



From: McBride, Michael
Sent: 31 December 2016 12:38
To: Carson, Jane; McBride, Michael; .
Subject: FW: Ltr to Dr Michael McBride
Jane,

I've had no acknowledgement from Marion, Out of Office from Angela.

Grateful if you could ensure Southern Trust is advised to appropriately redirect.

Michael

Sent from my Windows Phone

From: [McBride, Michael](#)
Sent: 31/12/2016 11:32
To: [Moffett, Marion](#)
Subject: FW: Ltr to Dr Michael McBride

Sent from my Windows Phone

From: [McBride, Michael](#)
Sent: 31/12/2016 11:31
To: [Muldoon, Angela](#)
Subject: FW: Ltr to Dr Michael McBride

Please ask Southern Trust to forward to my correct Departmental email address and to copy to Dr Paddy Woods.

The Southern Trust should also consider if there are grounds for an Early Alert.

Please confirm receipt and action.

Michael

Sent from my Windows Phone

From: [White, Laura](#)
Sent: 30/12/2016 12:40
To: [McBride, Michael](#)
Cc: [Wright, Richard](#); [Gibson, Simon](#); [Gishkori, Esther](#); [Toal, Vivienne](#); [Hainey, Lynne](#)
Subject: Ltr to Dr Michael McBride

Dear Mr McBride

Please find attached letter from Dr Wright in relation to Mr Aidan O'Brien, original in the post to you today.

Regards, Laura

Laura White
PA to Medical Director
Dr Richard Wright
Southern Health & Social Care Trust
Trust Headquarters
College of Nursing
68 Lurgan Road
BT63 5QQ

Direct Line: [Personal Information redacted by the USI]
[Personal Information redacted by the USI]

-----Original Message-----

From: laura.white [Personal Information redacted by the USI]

Sent: 30 December 2016 12:32

To: White, Laura

Subject: Scan from YSoft SafeQ

Scan for the user Laura White (laura.white) from the device CAH - Copy Room (General Office) - Trust HQ C454e

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Employer Liaison Service

FINAL (6.3.17) SHSCT RO/GMC ELA Meeting (8.2.17) Note

Organisation: Southern Health and Social Care Trust

Date and Time: 8 February 2017, 11:00

Meeting Location: Dr Wright's Office, Craigavon Area Hospital, 68 Lurgan Road, BT63 5QQ

Meeting type: In Person ☒ Telephone ☐

Attendees: Dr Robert Wright, Responsible Officer; Simon Gibson, Assistant Director - Medical Director's Office; Norma Thompson- Head of Revalidation Support Team; Joanne Donnelly, GMC ELA – Northern Ireland; Elizabeth Tysoe, GMC ELA -London.

Apologies: Malcolm Clegg, SHSCT Assistant Medical Staffing Manager

Any senior personnel changes – Exec Board / MD support team?	Any senior personnel changes – Exec Board / MD support team? RW advised: New interim acting Chief Executive, Mr Stephen McNally (former Director of Finance and Procurement); acting Chief Executive, Francis Rice, is Personal information redacted by the USI - is expected to be off for approximately 4/5 months.		
Any regulatory issues –RQIA	Any regulatory issues – RQIA Discussed: recent (Jan 17) publication of RQIA's Report following		

	their "Review of Governance Arrangements within HSC Organisations that Support Professional Regulation.": https://www.rqia.org.uk/RQIA/files/a8/a8547025-1073-4ef4-bb02-401bd088d99b.pdf  RQIA - Governance.pdf		
RQIA Unannounced Hospital Inspection	SG advised previously: The RQIA conducted an unannounced hospital inspection of the SHSCT just before Easter. RQIA has now sent the draft report to SHSCT for factual accuracy checking. Previously - verbal feedback was positive overall - some areas require improvement. RW advised: the final RQIA Report has not yet been published.		
Any difficult Deanery issues / QM visits? Is the DB in enhanced monitoring, if so what progress is being made?	Any difficult Deanery issues / QM visits? Is the DB in enhanced monitoring, if so what progress is being made? RW advised: SHSCT is not under enhanced monitoring. Forthcoming (21 March 17) regional GMC Education quality assurance visit.		
Any major service pressures currently?	Any major service pressures currently? RW advised:		

	• NI election/purdah- is having an impact on progress of dealing with waiting lists- despite Minister for Health (Michelle O'Neill's) announced today that 31m must be set aside to deal with waiting lists. • Emergency Department continues to be under pressure (predicted extra-pressure during forthcoming mid-tem next week and St Patrick's Day.) • OOH GP Services - this has improved. Angela McVeigh - SHSCT Director of planning and Services is leading on this. Shortage of GPs available for OOH on call; GPs are stretched during the day and are not prepared to work OOH as well. • SHSCT has just agreed, in principle, to take over Bannview Medical Centre (Portadown) (we already own the building). The plan is that the SHSCT will employ salaried GPs in the Trust. This is a one-off.		
Any strategic developments locally – including key service tendering issues / cross-Trust service developments / major service reviews?	Any strategic developments locally – including key service tendering issues / cross-Trust service developments / major service reviews? SG advised previously: Long term plans in terms of complete redevelopment of the Craigavon Hospital site ongoing. Part of the process is that the Department of Health will have questions for SHSCT around governance of process.		

Regional Developments	RW advised: Trusts are working on progressing a number of regional work streams flowing from the Health Minister's response to the Bengoa Report. There seems to be a political will/acceptance that there needs to be a re-profiling of services. Bengoa Report - <i>Systems not Structures: Changing Health and Social Care</i>  expert-panel-full-report.pdf  expert-panel-report-executive-summary.pdf Health Minister - <i>Health and Well Being 2026- Delivering Together</i> Oct 16  health and wellbeing 2026- delivering together.pdf		
Good news from the DB	Good news from the DB RW advised: SHSCT remains in a sound financial position - will break even this		

	year. Dept. of Health is content with SHSCT projections. When the Health and Social Care Board is gone will be interesting to see which of their responsibilities go to the Department of Health and which will go to the Trusts.		
2. Local concerns/ investigations (concerning doctors)	Notes	Actions	
a. Previously discussed			
Personal Information redacted by the USI	JD advised: This case was subsequently referred to GMC by RW - see "GMC Open Cases" below.		Category Refer doctor
b. New (including incidents/system regulator reports raising concerns about doctors)			
1. "Local issues"	Standing item in Meeting Note 1. "Local issues" means cases involving doctors undergoing local (i.e. not GMC) performance/health/conduct procedures – doctors about whom there are concerns. GMC expectation is that ROs may wish to discuss these cases with the ELA– to obtain advice/guidance, including advice/guidance on GMC thresholds for referral and thus assure themselves that local procedures alone continue to be the appropriate approach; mindful of course that (1) discussing a case with the ELA does not amount to a "referral" to the GMC and (2) discussions with the ELA may be on an anonymous basis- i.e. the doctor does not have to be identified. The GMC Employer Liaison Adviser is available to discuss any individual		

	situation outside of the scheduled ELA/RO Meetings. See also MHPS and DHSSPS revised "Guidance on the Role of Responsible Officers For Doctors and Employers".		
2. Timing of Referrals:	2. Timing of Referrals: It should not be assumed that referrals should only be made to GMC after the conclusion of local investigations. There are many situations where referral should be made at an earlier stage. Where a matter is referred to GMC, the local investigation should of course continue to its conclusion. An example of one situation where a referral should be made to the GMC before the completion of a local investigation is where the doctor could be working elsewhere without your knowledge; an early referral to the GMC will allow for consideration of interim orders to restrict/suspend the doctor's practice, wherever the doctor is working, thus protecting patient safety. Again, the GMC Employer Liaison Adviser is available to discuss any individual situation. See also MHPS and DHSSPS revised "Guidance on the Role of Responsible Officers For Doctors and Employers"		
Dr Urology Consultant	RW advised: SAI almost complete and MHPS investigation in progress involving concerns about a urology consultant competence re administration of his urology clinic in the SHSCT- including timeliness of recording of patient contact, referrals, follow up testing required. No actual patient harm, but potential patient harm - the event that triggered the SAI was a late diagnosis; it was initially decided that the doctor would be excluded from work (an alert letter was sent from the Dept. of Health), while the scope of the concerns was explored however exclusion was lifted and he is permitted to work with supervision of his admin responsibilities. However- during the period of the exclusion he was off on sick leave, and remains on sick leave- Personal information redacted by the USI He is to attend	ACTION: RW to send JD a copy of the SAI Report, re Dr Urology Consultant, as soon as he receives it. ACTION: RW to double-check (given ROs'	Category Monitor

	SHSCT occupational health. He does not do any other work outside the SHSCT except for seeing private urology patients in his home - first appointments only to advise the patient on whether they need referred for further testing/investigation; undertakes physical examination/takes history only - no testing/medical treatment. RW is currently satisfied that there are no patient safety issues- MHPS investigation is at an early stage. JD/RW agreed: that RW will send JD a copy of the SAI Report as soon as he receives it. RW will also double-check (given ROs' responsibility for whole-practice appraisal) that he is satisfied with the nature of the assurances he has about the doctor's private work - including verification/triangulation of any information provided by the doctor himself about his private work. He will also find out whether the doctor's private clinic is/should be registered with the RQIA.	responsibility for whole-practice appraisal) that he is satisfied with the nature of the assurances he has about the doctor's private work - including verification/triangulation of any information provided by the doctor himself about his private work. He will also find out whether the doctor's private clinic is/should be registered with the RQIA.	
	SG/NT/RW confirmed: there are no concerns about any other doctors		
3. GMC Cases	Notes	Actions	
a. Open			
Personal Information redacted by the USI	JD asked: does this doctor still work in the SHSCT RW confirmed: Dr [Personal Information redacted by the USI] has resigned from the SHSCT (with effect from 4 Aug 16) however keep on list for discussion at this		

		meeting for organisational learning. Dr Wright is no longer his RO. JD advised: Case opened 24/10/2014. IOT review – 22 Dec 17, Dr suspended, to be reviewed 13/03/2017. Dr [Personal Information redacted by the USI] is currently residing in [Personal Information redacted by the USI]; PSNI are arranging extradition. Await a PSNI/PPS update		
	Personal Information redacted by the USI	JD asked: does this doctor work in the SHSCT RW confirmed: No – had worked as a locum – his designated body is the NHSCT. Keep on list as learning for SHSCT. JD advised: Case opened 11/06/2015. IOT conditions in place. GMC IO had been liaising with the Northern Trust and Southern Trust re allegation that Dr [Personal Information redacted by the USI] worked in the Southern Trust contrary to the conditions of his exclusion by the Northern Trust. GMC investigation ongoing. RW confirmed: GMC legal have taken a witness statement from him.		
	Personal Information redacted by the USI	JD asked: does this doctor work in the SHSCT RW advised: Dr [Personal Information redacted by the USI] was dismissed following a Trust Investigation and was, therefore, removed from SHSCT list of connected doctors- RW is no longer his RO. JD advised: Case opened 26/02/2015. Dr [Personal Information redacted by the USI] has been charged with x3 offences:		

		i. Voyeurism installing equipment ii. Attempting voyeurism iii. Voyeurism recording Interim Order Tribunal on 1 August 2016 – Conditions converted to suspension. IOT review 7 Dec 16– Suspension maintained, to be reviewed 26 May 2017 JD advised: 16 Nov 16 - Dr [Personal Information redacted by the USI] pleaded guilty to x2 counts. Sentenced on 2 Feb 2017 - 9 months' probation - not placed on sexual offenders register. GMC will now obtain confirmation of sentence from the court and case will proceed then case examiners will take a decision on how to proceed. RW advised: Dr [Personal Information redacted by the USI] had appealed his dismissal by the Trust but had requested that the appeal be postponed until after the criminal hearing. Doctor has now asked that his appeal proceed.		
Personal Information redacted by the USI		JD asked: does this doctor work in the SHSCT RW advised: No - was referred to GMC by SHSCT when she worked in SHSCT as a trainee. She is now with Direct Medics. JD advised: It is alleged that Dr [Personal Information redacted by the USI] has worked a locum shift on the afternoon of 27/06/2016 at Craigavon Hospital whilst she was also scheduled, and paid, to complete a standard F2 shift on the same day, also at Craigavon Hospital. Employer disclosures: Direct Medics, NIMDTA. Witness statements being finalised.		
b. Closed				

Personal Information redacted by the USI		JD asked: did SHSCT receive GMC decision in this case - Case opened 6/04/2016 - case has now been closed with advice.		
		RW confirmed: he did receive decision. He has no issues with the decision.		
4. Appraisal and Revalidation		Notes	Actions	
a. Local Update				
System discussion		Annual Audits and Board oversight NT advised: Final Medical Appraisal and Revalid NT advised: SHSCT has 325 connected doctors. Dedicated revalidation website for SHSCT doctors - password protected though contains no confidential information. SHSCT has considered electronic appraisal system - though not proceeding with this currently. JD asked: for thoughts on Pearson Report: Discussion on:		

	1. Patient involvement- real time feedback page 45 2. "Re-licensing" - /- no difference (renewal of fee 3. Questions for Boards - page 4. Pg 40n - organisation's should work with patient groups to publicize revalidation 5. Weaknesses in Information sharing re doctors who move between designated bodies - page 62 6. Locums - 7. Doctors with no prescribed connection		
b. Deferrals/Non engagement recommendations			
Drs discussion	NT advised: • Deferral rate- 8 % • Individuals approaching or reaching non engagement - none • Update on licence withdrawal processes/appeals - none • Other recommendations requiring discussion, i.e. exceptions highlighted by GMC Revalidation Team. - none		Category Sub-Category
	NT confirmed: there are no issues re revalidation of any SHSCT doctors. One lady was currently being deferred for 12 months as she was about to return from maternity leave.		Category Sub-Category
5. GMC Update	Notes	Actions	
State of Medical Education	The GMC has published the sixth annual report about the state of medical		

and Practice report 2016	education and practice. In addition, there is an extensive online resource of our registration, education and fitness to practise data. This contains more than 400 tables, set out in a structure designed to make it easy to find key figures. The aim of the report is to promote discussion and debate about some of the practical steps the GMC and others could take in better supporting doctors and improving patient care.		
RO e-bulletin	The latest version of the GMC RO e-bulletin can be found at http://www.gmc-uk.org/publications/30237.asp . If you or your team would like to sign up to receive the bulletin by email, please contact gmcnews-ROs@gmc-uk.org .		
Independent Review of Revalidation	Sir Keith Pearson has produced a review of Revalidation entitled "Taking Revalidation Forward" which considers the operation and impact of revalidation during the 1st cycle. He has gathered feedback from a wide range of individuals and organisations involved in the process, and analysed the findings of recent research. The research can be viewed here, Read the report and the GMC response here Our response.		
Publication of new guidance "Confidentiality: good practice in handling patient information"	Publication of new version of GMC Confidentiality guidance On Wednesday 25 January the GMC published the new "revised, expanded and reorganised" version of our Confidentiality guidance for all doctors practising in the UK. The new guidance "Confidentiality: good practice in handling patient information" will come into effect on Tuesday 25 April 2017. the revised guidance now clarifies (this not an exhaustive list): • The public protection responsibilities of doctors, including when to make disclosures in the public interest.	ACTION: JD to liaise with Standards colleagues re previous SHSCT question on impact of new Confidentiality guidance on Trusts approach to seeking patient consent re complying with GMC s35A letter (see	

	• The importance of sharing information for direct care, recognising the multi-disciplinary and multi-agency context doctors work in. • The circumstances in which doctors can rely on implied consent to share patient information for direct care. • The significant role that those close to a patient can play in providing support and care, and the importance of acknowledging that role. JD advised: JD liaising with Standards colleagues re previous SHSCT question on impact of new Confidentiality guidance on Trusts approach to seeking patient consent re complying with GMC s35A letter (see page 20 of Confidentiality guidance).	page 20 of Confidentiality guidance). JD to update SHSCT.	
Medical Licensing Assessment Consultation (MLA)	On 2.2.17 we have launched a consultation to seek views on plans to establish a Medical Licensing Assessment (MLA). The MLA would create a single objective demonstration that doctors entering UK practice have met a common threshold for safe practice. It would give everyone, particularly patients and the public, confidence that doctors, wherever they've qualified, have met the same threshold of competence. We have shaped our proposals by working collaboratively with key partners from across the UK, including medical schools, the Medical Schools Council (MSC), Medical Schools Council Assessment Alliance (MSCAA), organisations responsible for medical education and training, and the four UK governments. The consultation is open until 30 April 2017. You can find more details on our MLA webpage. RW advised: There may very well be an adverse impact on workforce planning in NI if doctors from the Republic of Ireland	ACTION: JD to feed back SHSCT views on MLA to relevant GMC colleagues. ACTION COMPLETED 10.2.17	

	have to pass a MLA to obtain GMC registration; currently their qualifications are recognised automatically. Also - ultimately the additional cost will have to be met somehow - even if it is through the GMC annual retention fee (ARF). JD advised GMC would be grateful if RW responds to the MLA consultation through the consultation website.		
b. Thematic discussion			
	JD asked: for experiences and views about the atmosphere and morale among the doctors (esp juniors) and whether/how any discontent is manifesting itself locally? RW advised: It seems to him that there is a notable discontent among junior doctors - 40% reduction in applications to training programme. This has in part been fuelled by the junior doctor contract issues in England. The NI Health Minister issued a statement saying she was "not minded" to impose a settlement - but did not take the opportunity to rule it out completely. This has caused a degree of uncertainty that may well have impacted on recruitment. Just under half of the undergraduates completing medical degrees in Scotland are from NI. Morale here is poor. A lot of junior doctors are choosing to work as locums/work in Australia in order to pay of student loans/get mortgages - as banks are now treating student loans as a reason not to grant a mortgage. However the SHSCT appears to have no trouble attracting trainees - we get really good feedback from doctors in training who work here.	ACTION: JD to feed back to relevant GMC colleagues. ACTION COMPLETED 17.2.17	
6. Media interest	Notes	Actions	
a. Local			
	None		

b. GMC press cuttings			
	None		
7. AOB			
UMbRELLA	RW advised previously : he has not (since he left the BHSCT) (quite some time ago) had any involvement with the UMbRELLA research – contrary to the information still being given on the GMC and UMbRELLA websites. He has informed UMbRELLA that he no longer works in the BHSCT and is becoming increasingly concerned that this information gives the misleading impression that the Northern Ireland position on revalidation is being represented to UMbRELLA, through him. RW advised that to date, so far as he is aware, the NI position has not been taken account of by any the UMbRELLA research. RW advised: He would be content to discuss the possibility of him re-joining UMbRELLA in his capacity as RO for the SHSCT. JD advised: RW should write to UMbRELLA to reiterate his views. JD will feedback to relevant revalidation colleagues. JD advised: RW's position has been fed back to relevant GMC colleagues.		
Concerns about doctors – informing RO/MD of other organisations where doctor works	Concerns about doctors – informing RO/MD of other organisations where doctor works JD asked at last meeting: whether, following discussion at the NI RO Forum on 17.12.16, RW/the SHSCT has taken any steps to introduce a requirement, in their processes around dealing with a doctor when a serious concern, that the doctor is asked to advise if he/she is working anywhere else outside the Trust – whether or not he is an employee/locum – so that a decision can be taken as to whether to share the concern with any other person/organisation. RW/SG/NT/MC advised previously: this is still to be followed up –he will speak to the SHSCT Director of HR about including something in relevant policy so doctors are aware and a paragraph will also be added to the letter that goes to	Action from last meeting: RW to speak to SHSCT Director of HR re obtaining details from doctors about other places of work.	

	doctors about whom there is a concern. NB: Whilst not expressly written into the relevant policy, ROs/MDs of other organisations where a doctor works are informed by the Southern H&SC Trust of concerns that arise. NT advised: Malcom Clegg in HR deals with this - this will be followed up.		
New Graduate Medical School in NI	RW advised: He is aware of current plans to set up a graduate medical school in NI. JD advised: GMC is aware of this - Education colleagues.		
New 2 year PgDip/ MSc- physicians associates at the University of Ulster	RW advised: SHSCT will be facilitating placements for physician associate students from the University of Ulster - https://www.ulster.ac.uk/courses/course-finder/201718/physician-associate-studies-13788		
8. Next meeting date			
	To BE CONFIRMED		

Employer Liaison Service

FINAL GMC ELA/SHSCT RO Meeting (25.7.17)

Organisation: Southern Health and Social Care Trust

Date and Time: 25 July 2017, 12:00 – 13:30

Meeting Location: Dr Wright's Office, Craigavon Area Hospital, 68 Lurgan Road, BT63 5QQ

Meeting type: In Person ☒ Telephone ☐

Attendees: Dr Robert Wright, Responsible Officer; Simon Gibson, Assistant Director - Medical Director's Office; Norma Thompson-Head of Revalidation Support Team; Mrs Zoe Parks, Head of Medical Staffing; Joanne Donnelly, GMC ELA – Northern Ireland.

Apologies: Malcolm Clegg, SHSCT Assistant Medical Staffing Manager

Any senior personnel changes – Exec Board / MD support team?	Any senior personnel changes – Exec Board / MD support team? RW advised: Chief Executive, Francis Rice, is back in post. Mr Stephen McNally, who had been acting Chief Executive, is back in his post as Director of Finance and Procurement.		
Any strategic developments locally – including key	Any strategic developments locally – including key service tendering issues / cross-Trust service developments / major service reviews?		

service tendering issues / cross-Trust service developments / major service reviews?	SG advised previously: Long term plans in terms of complete redevelopment of the Craigavon Hospital site ongoing- Phase 1 works relating to Paediatrics at Craigavon Hospital site will be finished by October/November.		
Issues in Emergency Department - Daisy Hill	Issues in Emergency Department - Daisy Hill SG advised: There had been issues with ED in Daisy Hill. There was a regional summit meeting on 5/6 June 17. Pathfinder Project has been agreed - starts tomorrow. Other Trusts have agreed to provide senior medical cover out of hours if it becomes necessary. To be reviewed at end of 12 months. Annmarie Telford (previously Director of Public Health) is leading the Pathfinder Project.		
New initiative to improve Emergency Department flows	RW advised: New initiative to improve Emergency Department flows - has been running for 5/6 weeks - focus is on improving timeliness/efficiency of hospital discharge at ward level. Basic premise/concept is 100 % peer challenge/holding each-other to account/commitment where it seems that there may be delays to discharge. This is working really well in the SHSCT.		
2. Local concerns/ investigations (concerning doctors)	Notes	Actions	
a. Previously discussed			
1. "Local issues"	Standing item in Meeting Note 1. "Local issues" means cases involving doctors undergoing local (i.e. not GMC) performance/health/conduct procedures – doctors about whom		

	there are concerns. GMC expectation is that ROs may wish to discuss these cases with the ELA– to obtain advice/guidance, including advice/guidance on GMC thresholds for referral and thus assure themselves that local procedures alone continue to be the appropriate approach; mindful of course that (1) discussing a case with the ELA does not amount to a “referral” to the GMC and (2) discussions with the ELA may be on an anonymous basis- i.e. the doctor does not have to be identified. The GMC Employer Liaison Adviser is available to discuss any individual situation outside of the scheduled ELA/RO Meetings. See also MHPS and DHSSPS revised “Guidance on the Role of Responsible Officers For Doctors and Employers”.		
2. Timing of Referrals:	2. Timing of Referrals: It should not be assumed that referrals should only be made to GMC after the conclusion of local investigations. There are many situations where referral should be made at an earlier stage. Where a matter is referred to GMC, the local investigation should of course continue to its conclusion. An example of one situation where a referral should be made to the GMC before the completion of a local investigation is where the doctor could be working elsewhere without your knowledge; an early referral to the GMC will allow for consideration of interim orders to restrict/suspend the doctor’s practice, wherever the doctor is working, thus protecting patient safety. Again, the GMC Employer Liaison Adviser is available to discuss any individual situation. See also MHPS and DHSSPS revised “Guidance on the Role of Responsible Officers For Doctors and Employers”		
Dr Urology Consultant	RW advised previously (8.2.17): SAI almost complete and MHPS investigation in progress involving concerns about a urology consultant competence re administration of his urology clinic in the SHSCT- including timeliness of recording of patient contact, referrals, follow up testing required. No actual patient harm, but potential patient harm - the event that triggered the SAI was a late diagnosis; it was initially decided that the doctor would be excluded from work (an alert letter was sent from the Dept. of Health), while the scope of the concerns was explored however	ACTION: RW to send JD a copy of the SAI Report, re Dr Urology Consultant, as soon as it is completed	Category Monitor

	exclusion was lifted and he is permitted to work with supervision of his admin responsibilities. However- during the period of the exclusion he was off on sick leave, and remains on sick leave- Personal information redacted by the USI He is to attend SHSCT occupational health. He does not do any other work outside the SHSCT except for seeing private urology patients in his home - first appointments only to advise the patient on whether they need referred for further testing/investigation; undertakes physical examination/takes history only - no testing/medical treatment. RW is currently satisfied that there are no patient safety issues- MHPS investigation is at an early stage. JD/RW agreed previously (8.2.17): that RW will send JD a copy of the SAI Report as soon as he receives it. Agreed previously (8.2.17) - RW will also: double-check (given ROs' responsibility for whole-practice appraisal) that he is satisfied with the nature of the assurances he has about the doctor's private work - including verification/triangulation of any information provided by the doctor himself about his private work. He will also find out whether the doctor's private clinic is/should be registered with the RQIA. RW advised: SAI Investigation is not yet complete - there had been a delay at the start because of difficulties identifying a Chair. Julian Johnston is now acting as chair. JD asked: whether issues re private work have been resolved to his satisfaction - do the same restrictions apply to the doctor's private work as apply to his work in the SHSCT; RW, as RO, is responsible for the FTP of the doctor irrespective of where he/she works, arguable, an RO bears a greater risk in respect of a doctor's work outside the doctor's main designated body. JD asked whether RQIA regulates the private medical work that the doctor does from his home.	ACTION: RW to consider (given ROs' responsibility for FTP of connected doctors wherever they work) that he is satisfied with the nature of the assurances he has about the/restrictions on the doctor's private work - including verification/triangulation of any information provided by the doctor himself about his private work. ACTION: JD to seek confirmation from RQIA re their role re regulation of doctor's who work privately from home. And to update RW.	
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	RW advised: he is not aware as to whether RQIA has a role as regards this doctor's private work. RW is not sure how he would obtain objective assurances about the work the doctor does at home (first appointments only to advise the patient on whether they need referred for further testing/investigation; undertakes physical examination/takes history only - no testing/medical treatment). JD & RW agreed: as JD has a meeting with RQIA on Thursday 26.7.17 JD will seek confirmation from RQIA re their role re regulation of doctor's who work privately from home. JD to update RW.		
b. New (including incidents/system regulator reports raising concerns about doctors)			
Personal information redacted by the USI		ACTION: RW to send to JD the letter from the Clinical Director, Dr Hampton, to RW of 26.5.17 which sets out the concerns. ACTION COMPLETED 26.7.17	FtP Monitor

Personal Information redacted by the USI		 LET R WRIGHT RE Personal Information redacted by the USI .D ACTION: JD to advise further on Personal Information redacted by the USI necessary.	
	SG/NT/RW confirmed: there are no concerns about any other doctors		
3. GMC Cases	Notes	Connection to DB	Actions
a. Open			

Personal Information redacted by the USI	JD asked: does this doctor still work in the SHSCT RW confirmed: Dr [Personal Information redacted by the USI] has resigned from the SHSCT (with effect from 4 Aug 16) however keep on list for discussion at this meeting for organisational learning. Dr Wright is no longer his RO. JD advised: Case opened 24/10/2014. IOT - Dr suspended- High Court Extension granted -expiring 18 May 2018Dr [Personal Information redacted by the USI] is still residing in [Personal Information redacted by the USI] extradition still to be secured. Await a PSNI/PPS update		
	JD asked: does this doctor work in the SHSCT RW confirmed: No – had worked as a locum – his designated body is the NHSCT. Keep on list as learning for SHSCT. JD advised: Case: [Personal Information redacted by the USI] Allegation- Referral from Northern Health and Social Care Trust regarding an allegation of sexual assault against a patient in A&E in April 2015. There is an allegation about another incident in the same A&E Department around the same time has been made from a patient who alleges that inappropriate comments of a sexualised nature was made by Dr [Personal Information redacted by the USI] IOT Order (conditions) expires 25 Oct 17. Await Case Examiner decision. [Personal Information redacted by the USI]. Allegation - sexual assault on a patient in which the patient alleged Dr [Personal Information redacted by the USI] rubbed their foot against his (Dr [Personal Information redacted by the USI] groin. IOT order expires 25 Oct 2017. Informed on 11 July 2017 that PPS have decided not to prosecute. GMC to make a		

		s35a request to police for their evidence file and to request reasons for decision not to prosecute.		
Personal Information redacted by the USI		JD asked: does this doctor work in the SHSCT RW advised: Dr [Personal Information redacted by the USI] was dismissed following a Trust Investigation and was, therefore, removed from SHSCT list of connected doctors- RW is no longer his RO. However, Dr [Personal Information redacted by the USI] has appealed the dismissal- appeal had been put on hold pending completion of GMC investigation however Dr [Personal Information redacted by the USI] has now agreed that the appeal can go ahead. RW advised it would be useful to have information on how long it is likely to be before the GMC investigation is completed - the timeframe for the GMC investigation has a bearing on the timeframe for the SHSCT investigation. Background: Case opened 26/02/2015. Dr [Personal Information redacted by the USI] has been charged with x3 offences: i. Voyeurism installing equipment ii. Attempting voyeurism iii. Voyeurism recording 16 Nov 16 - Dr [Personal Information redacted by the USI] pleaded guilty to x2 counts. Sentenced on 2 Feb 2017 - 9 months' probation - not placed on sexual offenders register. JD advised: Await information from police - GMC investigation ongoing. Difficult to say how long it will be before GMC investigation completed. JD advised SHSCT to write to GMC IO - copying in JD - to request information on time-frame. At IOT Review: suspension converted to conditions on 26-05-2017. To be reviewed 17-08-2017.		

Personal Information redacted by the USI	JD asked: does this doctor work in the SHSCT RW advised: No - was referred to GMC by SHSCT when she worked in SHSCT as a trainee. She is now with Direct Medics. Keep on list as incident occurred when she worked in SHSCT. JD advised: It is alleged that Dr Personal Information redacted by the USI has worked a locum shift on the afternoon of 27/06/2016 at Craigavon Hospital whilst she was also scheduled, and paid, to complete a standard F2 shift on the same day, also at Craigavon Hospital. Rule 7 letter (i.e. letter setting out allegations and evidence and requesting doctor views) sent to Dr Personal Information redacted by the USI on 19/07/2017, response due: 16/08/2017.			
	RW advised: SHSCT has received a letter from the GMC requesting patient records of Personal Information redacted by the USI . This relates to the SAI/inquest involving Dr Personal Information redacted by the USI (was a locum at the time of the incident but now works full time in the SHSCT). RW advised: any further request for information will of course be complied with. He has no concerns about Dr Personal Information redacted by the USI competence - and she has reflected deeply on the events. JD asked: if RW could send a copy of the Coroner's verdict.		ACTION: RW to send JD a copy of the inquest verdict. ACTION COMPLETED 26.7.17	
b. Closed			Connection to DB	Actions
		None		
4. Appraisal and Revalidation		Notes	Actions	
a. Local Update				

System discussion	NT advised: 302 out 320 SHSCT doctors have now been revalidated. Now entering 2 nd cycle (for 2 nd cycle there are approximately 340 doctors).		
RW as RO (as original BHSCT RO has a conflict) for [Personal information redacted by the USI] [redacted] [redacted]	RW advised: He was asked to act as RO for [Personal information redacted by the USI] No. [redacted] as her original RO - Dr Cathy Jack has a conflict of interest. He was asked to take over responsibility, as case manager, for an investigation involving [Personal information redacted] (an external investigator was used). The investigation has concluded with no findings/actions [Personal information redacted] remains as her Responsible Officer.	Get copy of the investigation report	
RW as RO (as original NHSCT RO has a conflict) for [Personal information redacted by the USI] [redacted] [redacted]	RW advised: with effect from 3 months ago (end of April 17) he has been RO for [Personal information redacted by the USI] [redacted] so is the line manager for the RO/medical director of the NHSCT - so there could be an apparent conflict of interest if the NHSCT RO acting as RO for his line manager. JD advised: if not already done - GMC Connect should be updated to reflect this position (by original/conflicted RO "declining" the connection with [Personal information redacted by the USI] "conflict of interest" and the non-conflicted RO (RW) connecting [Personal information redacted by the USI] giving the same reason).	ACTION: RW to check/update GMC Connect to ensure that [Personal information redacted by the USI] position re correct non-conflicted RO being RW is reflected on GMC Connect. ACTION: JD to check with NHSCT that they are aware of the process for reflecting on GMC Connect where non-conflicted RO	

		is appointed for a doctor instead of their original RO. ACTION COMPLETED 4.8.17	
b. Deferrals/Non engagement recommendations			
Drs discussion	NT advised: no issues as regards deferral - none deferred because of involvement in local processes. No non-engagement.		Category Sub-Category
5. Themed Discussion	Notes	Actions	
1. Hooper suggested that revalidation carried a risk of being misused in cases involving whistleblowing doctors. Do you agree? What is your view of the nature and extent of this risk?	RW advised: There may be a "perception" of risk however I think that in practice statutory and GMC requirements around revalidation are such that revalidation decisions can only be made if certain criteria are complied with. However there is a remote possibility that while a valid reason is given for a revalidation decision - there an irregular factor has influenced the final decision. So even if there is just a perception of risk it may be necessary to have procedures/policies in place to demonstrate that that perception/remote possibility of risk is being managed. The choice of topic for this meeting's thematic review is quietly timely - as in Northern Ireland, the RQIA (systems regulator in Northern Ireland), has recently agreed a regional whistleblowing policy and following on from this regional policy, SHSCT has drafted a Trust whistleblowing policy. This is almost finalised. It creates a structure whereby the Trust Director responsible for staff who raise "whistleblowing" concerns will be the Medical Director rather than		

	the Director of Human Resources - so the Medical Director will be the "freedom to speak up guardian". The term "freedom to speak up" is preferred to "whistleblowing". There will also be freedom to speak up advocates. However this themed discussion has trigger the question - could there be perceived to be a conflict of interest in the medical director being the freedom to speak up guardian where the "whistle-blower" is a doctor given the medical director's responsibility as RO for the doctor? Perhaps in these cases consideration should be given to the Trust RO remaining as the "freedom to speak up guardian" for doctors - but where a doctor has raised a concern, in a situation where the RO had been minded to make a deferral/non-engagement recommendation - an alternative RO, outside the organisation, should be appointed. This is something we will give more thought to - and amend our "Whistleblowing Policy" as appropriate.		
2. Do you have experience of, or know about other ROs' experience of managing the revalidation process of a doctor who has raised concerns or blown the whistle? If yes then,	RW advised: Yes - I have personal experience where a doctor in another Trust had raised concerns about a matter, a certain aspect of which involved the RO of the Trust and the RO of that Trust decided that there may be a perception of conflict if they were to remain as the doctor's RO. RW agreed to act as the doctor's RO.		
2a. What factors did you/they take into account when making your recommendation	RW advised: I made sure that I was not made aware of the complaint made by the doctor - as that was not relevant to my role as the doctor's RO. I made my revalidation decisions solely based on the relevant information in compliance with all relevant guidance. I		

to the GMC?	was also the Case Manager for a concern about the doctor. This investigation was concluded with no findings/action against the doctor and I made a positive revalidation recommendation. Being involved as Case Manager meant that I was better placed to make a revalidation recommendation.		
2b. How did you/they manage the risks and challenges associated with making a recommendation in the context of a doctor who had raised concerns or blown the whistle?	RW advised: I did not know the details of the whistleblowing complaint and did not discuss the case with the original RO at any time. When updating the doctor's designated body I updated the designated body's HR Director rather than the Medical Director/RO.		
3. How can the GMC mitigate against the risk of accepting a 'punitive' recommendation? For example, in cases where revalidation recommendations are contested and public interest concerns have been raised, what further information might we need to consider so that our decision making is assured?	RW advised: If the whistleblowing concerns are managed separately by a "non-conflicted" RO then there should not be an issue. However, if a doctor is contesting a revalidation recommendation then the GMC should seek information from the relevant organisations on the whistle-blowing concern and more detailed information on the basis for the revalidation recommendation.		

6. GMC Update	Notes	Actions	
Appraisal QA pilot for doctors with no prescribed connection	Since the launch of revalidation, the GMC has received feedback from ROs raising questions about the quality of appraisals for doctors without a connection. There is currently no independent process to quality assure the appraisals for these doctors. The revalidation team has commissioned the Wessex Appraisal Service to undertake a pilot audit of appraisals for these doctors. The pilot will involve developing an audit framework rooted in our guidance and carrying out audits of a number of appraisals (c.100-150) to establish whether we need to establish a formal audit process in the long term for these doctors.		
Doctor support service	The GMC has commissioned BMA Doctors for Doctors to provide dedicated confidential emotional support to any doctor whose is under investigation by the GMC or in the licence withdrawal process following non-engagement. This service is available to all doctors regardless of whether they are a BMA member. Doctors can access the service by calling 020 7383 6707 or email doctorsupportservice@bma.org.uk		
Change to the length of publications of warnings	Work has now been completed on reviewing the length of time the GMC publishes a warning on the <i>List of Registered Medical Practitioners</i> . It has been agreed that the publications of warnings on will be amended from 5 years down to 1 year on the front page of the doctor's record and a further 1 year on their history page. These changes will be introduced at the same time as we implement wider changes to the publication and disclosure of FtP sanctions in 2018.		
Report from survey of ROs about their experience of the ELS	In Autumn 2016, we surveyed ROs and their teams to seek feedback on your experiences and perceptions of the Employer Liaison Service. We also asked for feedback on our approach to communications with ROs and how we could develop it further.		

	Thank you to those individuals who responded to the survey. The report has been published on the GMC website. It highlighted that the ELS is viewed positively by ROs but also some learning including establishing more robust cover arrangements and reviewing our contribution to RO networks.		
Updated GMC guidance on Insurance and Indemnity	The GMC has published some updated insurance and indemnity guidance including the following clarifications: • it is the <i>doctor's</i> responsibility for ensuring that they have appropriate indemnity/insurance arrangements in place and this has been a legal requirement since 2015. • doctors' responsibilities regarding insurance and indemnity when they retire or stop providing healthcare services. • that locum doctors should check their contracts to understand whether they need to make their own insurance or indemnity arrangements. • we are strongly advising ROs/SPs to obtain assurance about a doctor's insurance or indemnity arrangements and to support this we have developed a list of insurance/indemnity discussion points for ROs and SPs.		
Doctors with Approved Practice Setting restrictions	ROs are reminded to ensure any pre-employment checks include looking at the GMC register and noting any restrictions on the doctor. If a doctor has an APS restriction, designated bodies should ensure the doctor has an RO connection before adding them to a locum bank or issuing a zero hours contract unless in doing so they will create a new prescribed connection to the RO and their DB.		
New standards for postgraduate training	In May, the GMC has launched new standards and guidance for postgraduate medical curricula, assessment and approvals following on from the launch of our report - Adapting for the future: a plan for improving the flexibility of UK postgraduate medical training . We have		

	published a number of new documents including: • Excellence by design: standards for postgraduate curricula - the outcomes a doctor must achieve during their training, giving doctors more flexibility to adapt learning to their needs; and providing colleges and faculties with more support to design innovative curricula. • Generic professional capabilities (GPC) framework and explanatory guidance – how postgraduate curricula should include and embed training in broader skills which are crucial to safe and effective patient care, such as communication, leadership and patient safety. • Designing and maintaining postgraduate assessment programmes - advice for training organisations on what to consider when designing assessments • Making changes to your curricula: A guide and application form for those developing postgraduate curricula – advice on the approvals process for colleges and faculties; setting out our refined approach; providing templates and tools to navigate the changes.		
RO statements for MPTS tribunals	From June 2017, ROs will be contacted for a statement when one of their connected doctors is referred to an MPTS tribunal. The statement should be a factual account of the doctor's response to the concerns raised including: • details of professional courses the doctor has completed to address the concerns • confirmation of any reflection that the doctor has undertaken (perhaps through meetings with the RO or other colleagues) or reflective logs/statements		

	• details of any expressions of regret or apology made by the doctor • information about the doctor's involvement and co-operation with any Trust enquiry • an update in relation to the doctor's current practice The statement should also include a statement of truth signed by the RO. A factsheet is available with more information. The RO is not required to provide an opinion about whether the doctor has shown insight or whether the issues have been addressed. Those are matters for the MPT to consider based on the information presented to them.		
NTS survey results published	The GMC has published the results of the 2017 surveys of doctors in training and trainers. We have also published a short summary report highlighting a range of initial findings across the four countries of the UK. This year over 98% trainees and nearly 54% of trainers - more than 75,000 doctors - took part in both surveys. While satisfaction with the quality of teaching remains high, and there are small improvements in some areas – including fewer trainees reporting heavy or very heavy workloads – results also show continued signs of pressure on time for training. • More than half of trainees say they work beyond their rostered hours on a daily or weekly basis. • 70% of trainers report that their workload is heavy or very heavy. • About 20% of trainees and trainers told us that their working patterns leave them short of sleep. • Nearly a third of trainers said they were not always able to use the time allocated in their role for training, specifically for that purpose. • Around a third of trainees and a similar proportion of trainers believe that rota gaps impact on training opportunities.		

	We are now conducting detailed analysis of this year's results – including responses to our new test questions on rota design and career intentions. We will report on our findings later this year. You can access the results in our online reporting tool at http://www.gmc-uk.org/nts2017 - data can be viewed in a number of ways including by country, training organisation, employer, site, or specialty. For the survey of trainees, it is also possible to look at results for up to six years.		
Updated GMC thresholds guidance	An updated version of the GMC Thresholds guidance has now been published on the GMC website. The revised guidance includes new information about preliminary enquiries; who we contact when doctors do not have an RO; and updates relating to our management of health concerns and certain types of criminal and anti-social behaviour. The GMC has also published a new information leaflet outlining How we investigate concerns about a doctor.		
RO e-bulletin	The latest version of the GMC RO e-bulletin can be found at http://www.gmc-uk.org/publications/30927.asp If you or your team would like to sign up to receive the bulletin by email, please contact gmcnews-ROs@gmc-uk.org.		
7. Media interest	Notes	Actions	
a. Local			
	Nothing not already referred to above		
b. GMC press cuttings			
	None		
8. AOB			
GMC RO Reference Group	RW advised: he was not able to attend the most recent RO Reference Group Personal information redacted by the USI.		

New Chief Executive of the WHSCT - Dr Anne Kilgallen	RW advised: Dr Anne Kilgallen currently Deputy CMO, has been appointed as Chief Executive of the WHSCT.		
9. Next meeting date			
	4 October 2017, 11:00 – 12:30		

1 I've raised. I was also aware that he was a challenge
 2 to challenge, and I knew that from discussions that we
 3 would have had as a group. I also had an awareness of
 4 his personal connections, if you like, with members of
 5 his family within the legal profession, his personal 14:59
 6 connections with the Chair of the Board, and the rumour
 7 mill had told me that a previous AMD had been accused
 8 of bullying when trying to tackle Mr. O'Brien. I guess
 9 the answer to why didn't I personally tackle him when
 10 I knew the Clinical Director was, is because I had to 14:59
 11 work within a team with him, I didn't want to --
 12 essentially, it was a fear thing. I didn't want to
 13 find myself in a difficult small team working
 14 relationship as a result of the other bits that I was,
 15 if you like, aware of. I think, as I just said, 15:00
 16 grapevine, it's that sort of rumour mill, grapevine
 17 fear rather than anything documented, but that would
 18 have played a significant part in it.

19 61 Q. Just two points there before I move on. It was a small
 20 urological team of Consultants, I think six at that 15:00
 21 point. Is it not inevitable, as Associate Medical
 22 Director, that you are going to be dealing with
 23 a professional colleague and you will need to be
 24 dealing with a professional colleague on difficult
 25 issues, and the job simply can't function unless the 15:01
 26 post holder is prepared to rise above that and grasp
 27 the nettle, difficult though that might be in human
 28 terms?

29 A. I think so, but, as I said, when I came into post in

1
2 Just those first two. The two seemed to be more
3 focused on availability of staffing and resources to
4 meet the demands?

5 A. Yes. Those were certainly issues at the time, yes. 11:38

6 103 Q. Number 3:

7
8 "Insufficient progress was made on some of the actions
9 required to fully address the backlog. An example of
10 this was that both Mr. Young and Mr. Akhtar agreed to 11:38
11 amend their clinic templates but Mr. O'Brien refused to
12 amend his clinic templates in October 2010. The clinic
13 templates for all three consultants were amended to
14 reflect the BAUS guidance with effect from mid-November
15 2010. However, Mr. O'Brien's clinics started to 11:39
16 overrun by two hours for each clinic and this was not
17 a sustainable position for the associated nursing and
18 support staff needed at each clinic. The result was
19 that the number of new patients per clinic for
20 Mr. O'Brien was then reduced by two new patients. This 11:39
21 meant that Mr. O'Brien saw five pure new patients each
22 week than if he had adopted the BAUS guidelines for
23 clinic templates, and the number of reviews required
24 would have reduced if he had agreed to move from his
25 ratio of one-to-two from four, and to adopt the BAUS 11:39
26 guidelines of a new-to-review ratio of one-to-two."

27
28 So, the crux of that paragraph is that Mr. O'Brien's
29 own individual way of working or inability or refusal

1 to engage with the suggested approach of BAUS that was
 2 adopted by the Trust actually resulted in an increase
 3 -- or decrease in capacity to deal with patients?

4 A. It did, yes. The BAUS guidance was required of us from
 5 the Commissioning Board; it wasn't that the Trust had 11:40
 6 decided to do this. This was part of the regional
 7 implementation, that across the three teams within
 8 Northern Ireland we would all follow the same guidance
 9 so that patients had all the same access to services no
 10 matter where they lived in Northern Ireland. 11:40

11 104 Q. Was the guidance time-limited in there was -- was it
 12 a 10-minute or 15-minute slot for patients?

13 A. I think the first clinic appointment for a patient was
 14 20 minutes, and review, it may have been 10. I mean, I
 15 am not sure on those details but that sort of order. 11:40
 16 20 minutes for a first patient and 10 for a review.
 17 The day four cancer patients required a longer slot.

18 105 Q. For the follow-up review for someone who may have
 19 a tumour or some form of cancer, a 10-minute slot,
 20 would there be an argument from a clinician's 11:41
 21 perspective that that is perhaps inadequate?

22 A. I think when you are talking to a cancer patient at the
 23 point of diagnosis and talking about the preferred
 24 treatment plan, that's the day four cancer patient who
 25 needed a longer slot, which was agreed. I think that 11:41
 26 was in the minutes of the meeting that Heather Trouton
 27 had chaired that we looked at just a few minutes ago.
 28 But those, the 20 minutes and the 10 minutes, those are
 29 prescribed nationally. Those are what all the

1 specialties would be doing. It means you need to be
2 very organised in terms of the approach you are taking
3 to the patient, and keeping notes throughout that.

4 106 Q. And were the other clinicians able to adhere to those
5 time slots? 11:41

6 A. They were.

7 107 Q. You have mentioned in that paragraph that the clinics
8 overran by two hours. This obviously had a knock-on
9 effect to other support staff as well if they were
10 running late? 11:42

11 A. Mm-hmm.

12 108 Q. Did you see those clinics running late or how did you
13 come to have that information about the lateness of the
14 clinics?

15 A. Oh, that was brought to me by Martina Corrigan. 11:42
16 I think this was an afternoon clinic, possibly in
17 Banbridge. Instead of having a finish at 5:00, it was
18 finishing at 7:00. The nursing staff had not been
19 rostered to be there at 7:00 and may have had other
20 commitments to go to. The support staff, the reception 11:42
21 staff and administrative staff that are always present
22 at a clinic, they were not rostered beyond that. So
23 certainly all the staff would have stayed on on an ad
24 hoc basis, very willingly, there was a great culture of
25 wanting to do the right thing, but it was not possible 11:42
26 to do that on a sustainable basis. So, it came to me
27 through Martina at that stage.

28 109 Q. Just in relation to timeframes and staffing in order to
29 meet the capacity envisaged by the implementation plan

1 have gone through them. She would have - I'll be
 2 honest - my secretary but some other secretaries as
 3 well likewise, if they had spotted anything obvious,
 4 they would have highlighted to you in advance. But it
 5 wasn't expected to be the secretary's job to highlight 15:10
 6 issues on it. That rested with the clinician.

7 MR. WOLFE KC: TRU-276804. Next page up. Thank you.
 8 Just the bottom of the page.
 9

10 Mr. Mackle, you are picking up on Mr. O'Brien's list of 15:11
 11 questions which, I suppose, are by way of protest to
 12 what he is being asked to do. You say to Dr. Rankin:
 13

14 "I have been forwarded this email by Martina". Martina
 15 Corrigan. "I think it raises a governance issue as to 15:11
 16 what happens to the results of tests performed on
 17 Aidan's patient. It appears that at present he does
 18 not review the results until the patient appears back
 19 in the Outpatient's Department."
 20

21 Is that suggesting that he reads them when the patient
 22 is next in for review?

23 A. Yes.

24 MR. WOLFE KC: For the reasons you outlined, you don't
 25 find that acceptable? 15:12

26 A. No.

27 MR. WOLFE KC: So you are calling it a governance
 28 issue. Just go further up, please. Dr. Rankin is
 29 writing back just over a week later. "Dear all",

further and we're not aware of any further issues in this respect.

This IV antibiotic issue, the advice to the Trust from Mr. Fordham and others was that there was no peer review or scientific support - or clinical support is maybe the appropriate word - for this method of treatment. The Trust came in through the Medical Director and said this isn't to be done, or if it is to be done, it has to go through this protocol. You found breaches of that or suspected breaches of that happening in 2010, '11 and possibly into 2012. Does that tell you anything about the difficulties in managing Mr. O'Brien, and what does it tell us?

A. That he didn't always follow up what was requested. He did his -- he did ultimately comply but very, very, very, very reluctantly before he would comply.

MR. WOLFE KC: He had a view that this treatment was appropriate and that it was safe, and the Trust disagreed. In the face of his disagreement and, as is suggested here, his non-compliance from a managerial perspective, what was done?

A. Not that I recall anything specific. The Medical Director was informed of, you know -- breaches like that, in a one-on-one meeting with him, he would have been informed "we've had another one". I suppose we've got it sorted, for the moment anyway. But nothing specifically managerial was done, No.

MR. WOLFE KC: Is this issue typical of a significant

Corrigan, Martina

From: Haynes, Mark [Personal Information redacted by the USI]
Sent: 21 June 2016 09:09
To: Weir, Colin
Subject: FW: Memo from Dr Wright re DUTY OF CARE

FYI as he's one of yours!

From: Wright, Richard
Sent: 20 June 2016 17:22
To: O'Brien, Aidan
Cc: Haynes, Mark
Subject: Re: Memo from Dr Wright re DUTY OF CARE

Hi Aidan

We live in a new world. what has been suggested is in line with GMC best practice and I would expect that like everyone else you should comply.

I suspect if you don't you may find more of your patients will be disadvantaged.

regards Richard

Sent from my iPad

On 2 Jun 2016, at 22:41, O'Brien, Aidan [Personal Information redacted by the USI] wrote:

Dear Richard,

Thank you for your memo concerning Duty of Care.

I do entirely agree that no one should expect another to assume responsibility for the result of a test without explicit agreement.

This could, and probably should, be extended to the discharge of patients from review in secondary care with stated advice for or expectation of ongoing review in primary care without the prior agreement of the primary care physician.

We are currently discussing this very issue with Macmillan and with primary care in relation to the ongoing review of patients with prostate cancer.

Such issues have significant implications for both secondary and primary care.

However, neither of these issues should be confused with another scenario which occurs just as frequently and which impacts upon the efficient management of patients.

This is where we write to a GP requesting that a PSA be performed by the practice nurse one week prior to the patient's stated review on a specific date so that the result will be available on the date of review, rendering that review all the more meaningful.

That is something we urologists have done frequently for years.

Or to request that urinary culture is performed one week prior to a procedure, such as urodynamic studies, to ensure that it is safe to do so, or to prescribe appropriate antibiotic therapy beforehand, or to choose to defer, and replace with another patient instead.

Even when there has been absolutely no doubt whatsoever that there is no expectation placed upon primary care for the interpretation of results, we are now having primary care practices refusing to facilitate these tests as a consequence of this Agreement concerning Duty of Care.

Recently, a patient of mine was refused a PSA, requested of GP and of the patient, by me in writing prior to review, by a Practice Manager, because of the 'new regulations'.

I believe that such a lack of cooperation between primary and secondary care equally unacceptable.

I find it a new low in collaboration between primary and secondary care for the good of the patient.

It should be stressed that it has only been a minority of practices who have done so to date.
 Some believe that the agreement concerning Duty of Care is being cynically and opportunistically exploited by some in Primary Care.
 I believe this issues needs addressing.

Meanwhile, I personally have no intention of sending out to patients a completed biochemistry request form and labels when there was no need before,

Aidan.

From: White, Laura

Sent: 02 June 2016 15:56

To: Acheson, Janet; Adams, Dr Beverley; Adrian East; Ahmad, Munir; [ahsanalam](#) Personal Information redacted by the USI; Aljarad, Bassam; Anderson, Tracy; Arava, Shiva; Armstrong, Matt; Bennett, Tim; Best, Stephen; Boggs, Edgar; Boyd, Kathryn; Bradley, Una; Brazil, Dr R; Brown, Jeffrey; Brown, Martin; Browne, Gail; Bunn, Jonathon; Bunting, Helen; Campbell, Clarke; Campbell, John; Carson, Anne; Cassidy, Lisheen; Chada, Neta; Clarke, Chris; Clarke, Rosemary; Coghlin, Caroline; Conlan, Enda; Convery, Rory; Corkey, Chris; Cotter, Paul; Coulter, Paul, G; Craig, David; Cullen, Aidan; Cunningham, Marietta; Currie, Aoife; Daly, Cathy; Damani, Nizam; DeCourcyWheeler, Richard; Dedic, Karel; Donnelly, Brian; Doyle, Timothy; Duffin, Donal; Eedy, David J; Epanomeritakis, Manos; Ervine, Aaron; Eswedi, Hakim; Farnan, Turlough; Ferguson, Andrew; Flannery, Daniel; Forbes, Raeburn; Ford, Ruth; [gavinmbriggs](#) Personal Information redacted by the USI; Gibbons, Michael; Gilpin, David; Glackin, Anthony; Gormley, Damian; Gracey, David; Graham, David; Grier, David; Gudyma, Jaroslaw; Gupta, Nidhi; Hall, Sam; Hamilton, Beverley; Hampton, Gareth; Hanna, Heather; Harty, John; Hayes, Elaine; Haynes, Mark; Hewitt, Gareth; Hillemand, Christophe; Khwaja, Salman; Lewis, JulieZ; McConville, Conal; Moore, Michael; [nizdaman](#) Personal Information redacted by the USI; [smcosgrove](#) Personal Information redacted by the USI; Ahmed, Gamal; Chinnadurai, Anitha; [docgasmara](#) Personal Information redacted by the USI; Hogan, Martina; Holmes, Erskine; Hughes, James; Hull, Don; Iqbal, Nauman; James, Barry; John, Alexander; Johnston, Dr Linda; Jones, Claire; Kamath, Meeta; Kearney, Angela; Kerr, Paul P; Khan, Ahmed; Knox, Andrew; Korda, Marian; Kumar, Devendra; Lewis, Alastair; Leyden, Peter; Lichnovsky, Erik; Liggett, Nathaniel; Loane, Katharine; Lowry, Darrell; Macauley, Mark; Mackle, Eamon; Magee, Glynis; Maguire, Peter; Maiden, Nicola; Mangan, Brian; Martin, Laure; Mathers, Helen; Mathers, Rachel; McAllister, Charlie; McArdle, Gerarde; McCaffrey, Patricia; McCaul, David; McClean, Gareth; McClelland, Anthony; McConaghy, Paul; McConnell, Mae; McConville, Richard; McCormick, Michael; McCormick, Tim; McCracken, Geoff; McEneaney, David; McGalie, Clare; McGarry, Paul; McGivern, Sarah; McGleenon, Bronagh; McGovern, Anna; McGucken, Paul; McGuinness, Dr Joan; McKay, Damian; McKee, Raymond; McKeown, Ronan; McKeveney, Paul; McKinney, Karen; McKnight, Karen; McLoughlin, Caroline; McMahon, Dr; McMurray, David; McNaboe, Ted; McNeilly, Thomas; McVeigh, Gerry; Menown, Ian; Merjavy, Peter; Millar, Gerry; Millar, Sarinda; Milligan, Aaron; Mills, Heather; Minay, Joanne; Moan, Shane; Monaghan, Clare; Morgan, Neal; Morrow, Michael; Osmonde Morris; Patton, David; Ahmed, Suliman; [artohagar](#) Personal Information redacted by the USI; Bhat, Shivaram; [claireshevlir](#) Personal Information redacted by the USI; Funston, Lesley Ann; Henderson, Nicola-Ann; Kadhim, Hasan; Khan, Muhammad; Marks, John; McCambridge, Orlagh; McFadden, Matthew; McGarry, Philip; McKeown, Gillian; McParland, Michael; McSherry, Pauleen; Mulroe, Teresa; Murdock, Andrew; Murnaghan, Mark; Murphy, Philip; Murphy, Seamus; Neill, Adrian; Nelson, Elaine; Nicholl, Hilda; Nicholson, Michael; Noble, Edward; O'Brien, Aidan; O'Connor, Kieran; O'Donoghue, JohnP; O'Neill, Judith; O'Reilly, Seamus; Orr, Des; O'Toole, Conor; Parks, Lorraine; Patel, Dimple; Pathiraja, Melanie; Patton, Sean; Polley, Liam; Porter, Simon; Quinn, Ciara S; Quinn, Phil; Rafferty, Claire; Rajkumar, Shan; Rea, Margaret; Reddy, Ekambar; Rice, Paul; Roberts, Mark; Rutherford-Jones, Neville; Savage, Eimear; Scullion, Damian; Shah, Rajeev; Shah, Shilpa; Shahid, Sara; Sharpe, Peter; Sidhu, Harmini; Sim, David; Smith, Mike; Sobocinski, Dr Jacek; Spedding, Ruth; Stewart, Adriel; Subramanian, Arun; Suresh, Ram; Tariq, S; Thompson, Sam; Thorpe, Robbie; Walker, Stephanie; Watson, Bruce; Weir, Colin; Williams, Marc; Williams, Marian; Wilson, Lynn; Winter, Colin; Wright, Richard; Yarr, Julie; Young, Michael; Young, Thomas; Yousaf, Muhammad

Subject: Memo from Dr Wright re DUTY OF CARE

Dear Colleagues

Please find attached memo from Dr Wright in relation to Duty of Care for your attention.

Regards, Laura

*Laura White
PA to Medical Director
Dr Richard Wright
Southern Health & Social Care Trust
Trust Headquarters
College of Nursing
68 Lurgan Road
BT63 5QQ*

Personal information redacted by the USI



Please consider the environment before printing this email

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<20160601_Memo_DutyOfCare_RWpblw.doc>



Urology Services Inquiry

respond and I will admit I was quite taken aback as this was my first time meeting the urologists; I should add that both Mr Young and Mr Akhtar were very pleasant and welcomed me to the team.

30.6 After this unsure start with Mr O'Brien, I did manage to build a reasonable working relationship with him. But early on in my tenure I learnt that he was very opinionated and, in my personal view, arrogant, and it was always to be his way or no way. As mentioned above, I learnt early on not to ask for assistance with seeing extra patients or asking him to see if there were any patients suitable to be discharged sooner from the ward as, once I asked, I would always have got a lecture as to how this would be detrimental to other patients and that I, as a non-clinical person in the team, would not understand.

30.7 However, as part of my role it was my responsibility to hold him to account for issues that he was not adhering to, for example, non-triage, scheduling patients out of chronological order, and categorising his own patients using his own clinical priority rather than the recognised way, so that when I asked about chronological management I would get the lecture on how the Trust should not have done away with the 1-4 category and moved to Routine, Urgent and Red Flag, and that he would continue to do it his way as his belief was that he was correct and the system was wrong.

30.8 Behind all of this I knew that he believed that this was what was right for his patients and I also learnt, early on, that there was no backing down by him when he believed that he was correct and it was the system that was wrong, even when there was evidence as to why it was being done that way.

Documents attached namely:

284. 20190206 - patients awaiting results aob

285. 20190207 - patients awaiting results MH KR

These documents are located at WIT-27883 to WIT-27887 annotated by the Urology Services Inquiry.

and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

30.9 I can confirm that the above observations were also applicable to Mr O'Brien's interactions with other medical and professional managers who would have challenged his work methods, in particular, the Directors of Acute, Medical



Urology Services Inquiry

Directors and Associate Medical Directors. They were not unique to me. During the Review of (Adult) Urology services I can confirm that the weekly Monday evening meetings could become quite fractious as the Department of Health were trying to get the Trust to agree to clinic activity. Mr O'Brien would not agree to the BAUS guidelines of 20 minutes for a new patient and 10 minutes for a review patient (this had been accepted in the other two Urology 'Teams' in Northern Ireland) and, whilst agreement was eventually reached, Mr O'Brien was in the minority as he wouldn't sign up to this activity and would quote this back to me over the years.

30.10 Mr O'Brien was very aggrieved with the Review of Urology Services (2009), particularly the removal of radical pelvic surgery from Craigavon Hospital and it was his view, and he said it on a few occasions, that patients had died as a result of this decision. Mr O'Brien would have openly said that Mark Fordham (external author of the paper) should never have been allowed to be involved in suggesting this recommendation.

30.11 Mr O'Brien didn't hide the fact that he didn't work well with Dr Rankin and Mr Mackle. Both of these managers tried to manage him through the IV fluids and antibiotic review, through radical pelvic surgery moving to Belfast, and through his continuous non-compliance to triaging the new outpatients. Dr Rankin and Mr Mackle would have persevered in holding Mr O'Brien to account which, in my opinion, Mr O'Brien didn't like as he was used to 'doing it his own way'.

30.12 Mr O'Brien would often mention his legal connections through his brother and his son both being barristers and, in my opinion, made some of the medical and professional managers nervous and I would suggest was a reason for not challenging some of his practices.

30.13 I have an awareness of at least two occasions where managers had been asked to step back from managing Mr O'Brien. In approximately 2011/2012 Mr Mackle had been advised that he was being accused of bullying

Corrigan, Martina

From: O'Brien, Aidan [Personal Information redacted by USI]
Sent: 06 February 2019 23:33
To: McCaul, Collette
Cc: Young, Michael; Glackin, Anthony; Haynes, Mark; ODonoghue, JohnP; 'derek.hennessey' [Personal Information redacted by the USI] Corrigan, Martina
Subject: FW: Patients awaiting results
Importance: High

Dear Ms. McCaul,

I have been greatly concerned, indeed alarmed, to have learned of this directive which has been shared with me, out of similar concern.

The purpose of, the reason for, the decision to review a patient is indeed to review the patient.

The patient may indeed have had an investigation requested, to be carried out in the interim, and to be available at the time of review of the patient.

The investigation may be of varied significance to the review of the patient, but it is still the clinician's decision to review the patient.

One would almost think from the content of the process that you have sought to clarify, that normality of the investigation would negate the need to review the patient, or the clinician's desire or need to do so.

One could also conclude that if no investigation is requested, then perhaps only those patients are to be placed on a waiting list for review as requested, or are those patients not to be reviewed at all?

Secondly, if all patients who have had an investigation requested are not to be placed on a waiting list for review, as requested, until the requesting clinician has viewed the results and reports of all of these investigations, when do you anticipate that they will have the time to do so?

Have you quantified the time required and ensured that measures have been taken to have it provided?

Thirdly, you relate that it is by ensuring that the results are 'seen' by the consultant that patients will not be missed. I would counter that it is by ensuring that the patient is provided with a review appointment at the time requested by the clinician that the patient will not be missed.

Perhaps, one example will suffice.

The last patient on whom I operated today is a [Personal Information redacted by USI] lady who has been known for some years to have partial duplication of both upper urinary tracts.

She has significantly reduced function provided by her left kidney.

She also has left ureteric reflux.

However, she also has had an enlarging stone located in a diverticulum arising by way of a narrow infundibulum from the upper moiety of her right kidney.

She has been suffering from intermittent right loin and flank pain, as well as left flank pain when she has a urinary infection.

Today, I have managed to virtually completely clear stone from the diverticulum after the second session of laser infundibulotomy and lithotripsy.

She is scheduled for discharge [Personal Information redacted by USI]

I planned to have a CT scan repeated in May and to review her in June.

The purpose of reviewing her is to determine whether her surgical intervention has relieved her of her pain, reduced the incidence of infection, and as a consequence, reduced the frequency and severity of her left flank pain.

Review of the CT images at the time of the patient's review will inform her review.

It will evidently not replace it.

Lastly, I find it remarkable that your process be clarified with secretarial staff without consultation with or agreement with consultants who, by definition, should be consulted!

I would request that you consider withdrawing your directive as it has profound implications for the management of patients, and certainly until it has been discussed with clinicians.

I would also be grateful if you would advise by earliest return who authorised this process,

Aidan O'Brien.

From: Elliott, Noleen
Sent: 01 February 2019 13:17
To: O'Brien, Aidan
Subject: FW: Patients awaiting results
Importance: High

From: McCaul, Collette
Sent: 30 January 2019 12:33
To: Burke, Catherine; Cooke, Elaine; Cowan, Anne; Daly, Laura; Hall, Pamela; Kennedy, June; McCaffrey, Joe; Mulligan, Sharon; Nugent, Carol; Wortley, Heather; Wright, Brenda; Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; Loughran, Teresa; Neilly, Claire; Robinson, NicolaJ; Troughton, Elizabeth
Cc: Robinson, Katherine
Subject: Patients awaiting results
Importance: High

Hi all

I just need to clarify this process.

If a consultant states in letter " I am requesting CT/bloods etc etc and will review with the result. These patients ALL need to be DARO first pending the result **not** put on waiting list for an appointment at this stage. There is no way of ensuring that the result is seen by the consultant if we do not DARO, this is our fail safe so patients are not missed. Not always does a hard copy of the result reach us from Radiology etc so we cannot rely on a paper copy of the result to come to us.

Only once the Consultant has seen the result should the patient be then put on the waiting list for an appointment if required and at this stage the consultant can decide if they are red flag appointment, urgent or routine and they can be put on the waiting lists accordingly.

Can we make sure we are all following this process going forward

Collette McCaul
Acting Service Administrator (SEC) and EDT Project Officer
Ground Floor
Ramone Building
CAH
Ext 

Corrigan, Martina

From: Robinson, Katherine [Personal Information redacted by USI]
Sent: 07 February 2019 10:00
To: Haynes, Mark; O'Brien, Aidan; McCaul, Collette
Cc: Young, Michael; Glackin, Anthony; ODonoghue, JohnP; 'derek.hennessey' [Personal Information redacted by the USI]; Corrigan, Martina
Subject: RE: Patients awaiting results

Folks

Can I just back this up by saying that Dr Rankin introduced this process trust wide many years ago due as a result of safety issues with patients. It actually increases secretarial work load due to extra checks but this is in the best interest of patients. I am aware Mr O'Brien that your secretary in particular does not use DARO in all cases and will put patients directly on the review waiting list as per your instruction. I have expressed my concern with her not implementing the DARO process fully.

Collette McCaul is the Line Manager to Urology, ENT, Ophthalmology and Oral Surgery, it is her responsibility to follow directives and remind staff of processes that are in place. Collette was merely doing her job.

Regards

Katherine

*Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre
Ramone Building
Craigavon Area Hospital*

t: [Personal Information redacted by USI]
e: [Personal Information redacted by USI]

From: Haynes, Mark
Sent: 07 February 2019 06:24
To: O'Brien, Aidan; McCaul, Collette; Robinson, Katherine
Cc: Young, Michael; Glackin, Anthony; ODonoghue, JohnP; 'derek.hennessey' [Personal Information redacted by the USI]; Corrigan, Martina
Subject: RE: Patients awaiting results

Morning

The process below is not a urology process but a trust wide process. It is intended, in light of the reality that patients in many specialities do not get a review OP at the time intended (and can in many cases take place years after the intent), to ensure that scans are reviewed and in particular unanticipated findings actioned. Without this process there is a risk that patients may await review without a result being looked at. There have been cases (not urology) of patients imaging not being actioned and resultant delay in management of significant pathologies. As stated this is a trust wide governance process that is intended to ensure there are no unactioned significant findings. There is no risk in the process described.

If the patient described has their scan in May, the report will be available to you and can be signed off and the patient planned for review in June, there is no delay to the patients care. The DARO list is reviewed regularly by the

secretarial team and would pick up if the scan has been done but you hadn't received the report, if the scan hasn't been done etc.

It may be ideal that such a patient described would be placed on both the DARO list and a review OP WL but PAS does not allow for this.

I have no issue (as a clinician or as AMD) with the process described as it does not risk a patient not being seen and acts as a safety net for their test results being seen.

Mark

From: O'Brien, Aidan

Sent: 06 February 2019 23:33

To: McCaul, Collette

Cc: Young, Michael; Glackin, Anthony; Haynes, Mark; ODonoghue, JohnP; 'derek.hennessey' Personal Information redacted by the USI; Corrigan, Martina

Subject: FW: Patients awaiting results

Importance: High

Dear Ms. McCaul,

I have been greatly concerned, indeed alarmed, to have learned of this directive which has been shared with me, out of similar concern.

The purpose of, the reason for, the decision to review a patient is indeed to review the patient.

The patient may indeed have had an investigation requested, to be carried out in the interim, and to be available at the time of review of the patient.

The investigation may be of varied significance to the review of the patient, but it is still the clinician's decision to review the patient.

One would almost think from the content of the process that you have sought to clarify, that normality of the investigation would negate the need to review the patient, or the clinician's desire or need to do so.

One could also conclude that if no investigation is requested, then perhaps only those patients are to be placed on a waiting list for review as requested, or are those patients not to be reviewed at all?

Secondly, if all patients who have had an investigation requested are not to be placed on a waiting list for review, as requested, until the requesting clinician has viewed the results and reports of all of these investigations, when do you anticipate that they will have the time to do so?

Have you quantified the time required and ensured that measures have been taken to have it provided?

Thirdly, you relate that it is by ensuring that the results are 'seen' by the consultant that patients will not be missed. I would counter that it is by ensuring that the patient is provided with a review appointment at the time requested by the clinician that the patient will not be missed.

Perhaps, one example will suffice.

The last patient on whom I operated today is a Personal Information redacted by the USI old lady who has been known for some years to have partial duplication of both upper urinary tracts.

She has significantly reduced function provided by her left kidney.

She also has left ureteric reflux.

However, she also has had an enlarging stone located in a diverticulum arising by way of a narrow infundibulum from the upper moiety of her right kidney.

She has been suffering from intermittent right loin and flank pain, as well as left flank pain when she has a urinary infection.

Today, I have managed to virtually completely clear stone from the diverticulum after the second session of laser infundibulotomy and lithotripsy.

She is scheduled for discharge Personal information redacted by USI

I planned to have a CT scan repeated in May and to review her in June.

The purpose of reviewing her is to determine whether her surgical intervention has relieved her of her pain, reduced the incidence of infection, and as a consequence, reduced the frequency and severity of her left flank pain.

Review of the CT images at the time of the patient's review will inform her review.

It will evidently not replace it.

Lastly, I find it remarkable that your process be clarified with secretarial staff without consultation with or agreement with consultants who, by definition, should be consulted!

I would request that you consider withdrawing your directive as it has profound implications for the management of patients, and certainly until it has been discussed with clinicians.

I would also be grateful if you would advise by earliest return who authorised this process,

Aidan O'Brien.

From: Elliott, Noleen
Sent: 01 February 2019 13:17
To: O'Brien, Aidan
Subject: FW: Patients awaiting results
Importance: High

From: McCaul, Collette
Sent: 30 January 2019 12:33
To: Burke, Catherine; Cooke, Elaine; Cowan, Anne; Daly, Laura; Hall, Pamela; Kennedy, June; McCaffrey, Joe; Mulligan, Sharon; Nugent, Carol; Wortley, Heather; Wright, Brenda; Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; Loughran, Teresa; Neilly, Claire; Robinson, Nicola; Troughton, Elizabeth
Cc: Robinson, Katherine
Subject: Patients awaiting results
Importance: High

Hi all

I just need to clarify this process.

If a consultant states in letter " I am requesting CT/bloods etc etc and will review with the result. These patients ALL need to be DARO first pending the result **not** put on waiting list for an appointment at this stage. There is no way of ensuring that the result is seen by the consultant if we do not DARO, this is our fail safe so patients are not missed. Not always does a hard copy of the result reach us from Radiology etc so we cannot rely on a paper copy of the result to come to us.

Only once the Consultant has seen the result should the patient be then put on the waiting list for an appointment if required and at this stage the consultant can decide if they are red flag appointment, urgent or routine and they can be put on the waiting lists accordingly.

Can we make sure we are all following this process going forward

Collette McCaul
Acting Service Administrator (SEC) and EDT Project Officer
Ground Floor
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CAH



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(d) what was the outcome of raising the issue?

63.4 Mr O'Brien would conform for a short period and then slip back to his old ways of not complying.

If you did not raise any concerns about the conduct/performance of Mr O'Brien, why did you not?

63.5 Whilst I did raise some concerns about Mr O'Brien, on reflection, I believe that I should have continued to raise these every time that there was an issue. Looking back, I believe the reason why I didn't always raise them was because 'it was just Aidan' and he had 'gotten away with' bad behaviour from before my time, everyone in a senior position past and present knew what he was like, and the sad thing for me is that he got away with it. It is my belief that, whenever a manager nearly got to address his issues, he seemed to suddenly get away with what he had done, for example, Mr Mackle appeared to be managing issues such as the triage and IV fluids practice and then he was advised to take a 'step back' as it was deemed that Mr Mackle was bullying and harassing Mr O'Brien. I believe that I felt in part that, if Medical Directors, Chief Executives, Directors of Acute Services, Assistant Directors, Associate Medical Directors, and so on were unable to manage him or get him to conform, then there was little or no chance for me as his Head of Service. Mr O'Brien could be quite intimidating in that he was so strong in personality that he did things his way and I never could win the debate with him; he wore me down and, for that, I am sorry as it appears that patients have come to harm as a result. I am also aggrieved, on reflection, regarding the amount of time I spent chasing and trying to get Mr O'Brien to do what he needed to do, which meant that I never got to spend the time with my other consultants (who never gave me any bother) in further developing the services.

64. What support was provided by you and the Trust specifically to Mr. O'Brien given the concerns identified by him and others? Did you

1 of the working relationship with Mr. O'Brien."

2
3 You also say: "My impression is that the remaining
4 staff had the greatest respect for each other
5 regardless of discipline and were very professional in 12:18
6 their interactions and their patients and each other.
7 They appeared to work well together outside the
8 challenges of having to manage and work with
9 Mr. O'Brien.

10 12:18
11 My impression based on reading MHPS papers, including
12 witness statements and SAI documents, was that over the
13 years Mr. O'Brien's colleagues had developed ways of
14 not confronting him for fear of having to deal with
15 unpleasantness, but had found ways of constantly 12:18
16 working around him to avoid antagonising him and get
17 the work of treating patients done."

18
19 when we spoke about this earlier you said you got these
20 views from other people telling you that their 12:19
21 impression rather than anything you experienced. Did
22 you ever have anyone directly indicate that you should
23 not engage with Mr. O'Brien in any managerial way? was
24 that ever intimated to you or said to you directly?

25 A. The only time was, and it's mentioned there in 30.4, in 12:19
26 terms of my interaction with Mrs. Brownlee, when I took
27 up post, basically, and, you know, apropos of nothing,
28 she said this to me. Certainly, in terms of, you know,
29 not pursuing him, she believed he had been badly

14. The first time I became aware of the default process was in 2016 via the SAI process. I can understand why the default process was put in place but I don't agree with it.
15. The issue with patient Patient 10 came to light via Mr Haynes who had raised a Datix because of the delay with the referral. The case was discussed at MDT and I was asked to Chair the SAI by the governance team. I believe this was sometime in summer 2016, however the SAI didn't happen until autumn 2016. There were 3 key issues in this case. The SAI looked at problems with radiology reporting, the second issue was a failure of clinicians to understand findings from the radiology reports and finally the triage issue which in my view was the least of the 3 issues.
16. The patient was referred to Urology as a routine referral via her GP for a renal cyst and associated right renal angle pain. The Referral and Booking Centre did not receive the completed triage from the Urology Consultant of the week, Mr O'Brien. Therefore, the referral and booking centre managed this referral as routine. It is my view that a Consultant Urologist would have picked up on the more serious issue and therefore triaged it with greater priority than the default process allowed.
17. I was asked if I felt there was a delay with the treatment plan as a result of the non-triage. I advised it would have been triaged differently by a Consultant Urologist and as we had agreed as a team that we would arrange investigations before attendance at clinics I feel this would have picked up issues with this patient. The case could have been discussed at a variety of forums within the Trust. I feel there was enough information in the GP referral letter to have led a Consultant Urologist to do advanced triage. The routine referral by the GP was a reasonable referral on the part of the GP but the GP didn't have all the required information. This patient had a lesion on her kidney which was not mentioned on the MRI report. Mr Haynes immediately spotted the problem when he reviewed the referral.
18. I was asked if I had spoken with Mr O'Brien about the SAI. I advised I had not as during the period of the SAI Mr O'Brien was Personal information redacted by the USI leave. I advised that I provided a draft report which was sent to Mr O'Brien for comment by the Governance team. The report contained some factual errors which were amended upon receipt of Mr O'Brien's reply. The current MHPS investigation process had also commenced by this point. Mr O'Brien's written response was very lengthy and written in an adversarial and legal manner so I felt a conversation was not appropriate.
19. In December 2016 and early January 2017 the atmosphere in the Department had been difficult.. In November / December 2016 it became clear that the SAI was uncovering more issues. At a meeting called in early January 2017 we learnt to our dismay that Mr O'Brien had been excluded from work, the extent of the issues under investigation and we were advised by the Assistant Director, Ronan Carroll, not to discuss the matters.
20. We were shocked as a team. We have been given limited information but we have been made aware of the nature of the concerns. It has left us all feeling awkward and difficult because we

1 I've raised. I was also aware that he was a challenge
 2 to challenge, and I knew that from discussions that we
 3 would have had as a group. I also had an awareness of
 4 his personal connections, if you like, with members of
 5 his family within the legal profession, his personal 14:59
 6 connections with the Chair of the Board, and the rumour
 7 mill had told me that a previous AMD had been accused
 8 of bullying when trying to tackle Mr. O'Brien. I guess
 9 the answer to why didn't I personally tackle him when
 10 I knew the Clinical Director was, is because I had to 14:59
 11 work within a team with him, I didn't want to --
 12 essentially, it was a fear thing. I didn't want to
 13 find myself in a difficult small team working
 14 relationship as a result of the other bits that I was,
 15 if you like, aware of. I think, as I just said, 15:00
 16 grapevine, it's that sort of rumour mill, grapevine
 17 fear rather than anything documented, but that would
 18 have played a significant part in it.

19 61 Q. Just two points there before I move on. It was a small
 20 urological team of Consultants, I think six at that 15:00
 21 point. Is it not inevitable, as Associate Medical
 22 Director, that you are going to be dealing with
 23 a professional colleague and you will need to be
 24 dealing with a professional colleague on difficult
 25 issues, and the job simply can't function unless the 15:01
 26 post holder is prepared to rise above that and grasp
 27 the nettle, difficult though that might be in human
 28 terms?

29 A. I think so, but, as I said, when I came into post in

1 2014, and then as I came through and recognised issues,
2 these weren't new issues; these were issues that had
3 been attempted to be tackled with him before and had
4 become part of almost -- I hesitate to say, it's almost
5 accepted practice, he practised in this way and 15:01
6 everyone else practised in another way. You know, we
7 have talked about the notes at home. I'm not aware of
8 anyone else who would be taking notes at home and
9 storing them at home regularly, but that was accepted
10 practice and almost everyone knew. Of course I should 15:02
11 have tackled him personally, but I was coming in, if
12 you like, late to this, with a many year history of
13 other people attempting to tackle it to no success, and
14 it becoming part of normal working arrangements for
15 him. 15:02

16 62 Q. You do accept it essentially fell within your job
17 description, notwithstanding this history, to have
18 a fresh go at trying to tackle the issues?

19 A. Yes, and where other issues have arisen with other
20 individuals, not necessarily within Urology, I have 15:02
21 taken an active role in that, so it's specifically with
22 Mr. O'Brien I didn't.

23 63 Q. The second issue you raised just a short time ago,
24 which I intended to deal with later but I will deal
25 with it now. You've suggested through the rumour mill 15:03
26 I think was how you described it, a certain chill
27 factor in terms of being able to deal with him,
28 associated with what was known to be his family
29 connections to the legal profession and his social

1 contact, or whatever it might be, with what now is the
 2 former Chair of the Board, Mrs. Brownlee. Was this
 3 tearoom gossip, or at what level was this being
 4 communicated to you and affecting your actions?

5 A. It was an awareness. It wasn't something that I recall 15:03
 6 being formally communicated to me, but it was an
 7 awareness that I had and others would have had.

8 64 Q. Are you able to say how it came to your notice or
 9 attention?

10 A. I genuinely don't know how. I just know I was aware 15:04
 11 of.

12 65 Q. In terms of the support that you receive from the
 13 organisation, whether from the operational side or
 14 otherwise, to fulfil this challenging role, was it
 15 there? Was the support there to enable you to do as 15:04
 16 good a job as you can or, looking back, can you
 17 pinpoint anything that might have been done differently
 18 to assist you in your responsibilities?

19 A. Within my statement I have commented, the Clinical
 20 Managers do not, as a standard, have any administrative 15:05
 21 support to assist us in terms of as we are undertaking
 22 our role, and so, as daft as it sounds but in addition
 23 to trying to do the bits that I've got to do, I'm also
 24 managing my own diary and managing my own follow-up of
 25 things I need to chase and follow-up which, as you've 15:05
 26 outlined, when you are trying to do a job that needs 12
 27 hours in a considerably shorter period of time,
 28 inevitably, if someone is not reminding me to follow up
 29 on something, things will slip off the radar. So



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long hand. When digital dictation was introduced for clinics, results, and discharge summaries he was slow to utilise it.

38. At various stages he was given support from his colleagues with triage. He was offered help by the Trust after his Job plan went to facilitation but didn't engage. He had twice as much secretarial support as his colleagues. Debbie Burns in 2014 asked him to say what support he needed to help his practice. That summer, he was given a month with no clinics to catch up on his administration. I don't know if it was arrogance or fear of losing face that stopped him from requesting more help / the help he needed to change his style of practice.
39. The failure to investigate the false accusation of bullying and harassment against me was, I believe, done for the best of reasons. I was aware at that time that Roberta Brownlee was very friendly with Aidan O'Brien and was a director of his charitable company 'CURE' from, I believe, 1997. Unfortunately, by not being investigated and exonerated I was told to be very careful in my dealings with Aidan O'Brien and as a result it reduced my ability to challenge him or his practice sufficiently.
40. The prevailing culture at the inception of the Trust was to maximise performance and to maintain financial stability. These main foci were also expected by HSCB. This drive for performance, while maintaining financial stability, may have distracted the Trust from quality issues. There was neither the time in the working day nor the support staff to undertake regular audits of outcomes and the patient pathway either solely within urology or when there was engagement with other departments like the cancer directorate, laboratories, radiology, theatres and outpatients.
41. The organisational structure for Medical Management of urology was Medical Director, Associate Medical Director, Clinical Director and then Lead Clinician. My role as AMD was extensive and demanding but at the same time, I was a full time General Surgeon with a special interest in Oesophagogastric as well as Colorectal Surgery. The nature of my general surgical post and the number of colleagues on the team meant that, if I was to free up extra time for the



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his dealings with others; so much so that I believe that others (including myself) didn't challenge him enough because, when we did, he always challenged back and he wore people down to the extent that, in my opinion, he was able to continue to do his own thing (whether that was the correct way to do things or not). Mr O'Brien's response to me on numerous of occasions was, 'are you, as a non-clinical person, questioning my decisions?'. Examples of when he would have said this would have been when he was admitting patients straight from home a few days before they were going to theatre for work-up and the hospital system was struggling with bed pressures and trying to get the emergency department freed up to see other patients. When I took advice from other clinicians on this issue (as I always did first), they would have told me there was no need for them to be admitted so early in advance of their surgery and they would have detailed what needed to be done and what could be done in the community or via a visit to hospital outpatients in advance of being admitted. I always would have advised Mr O'Brien of this but he would then get cross, as he considered that I was going 'behind his back', and maintain that what the others were saying was incorrect.

67.3 From other consultants, I have heard some of them saying that Mr O'Brien was their mentor, either during training or when they came to work in Craigavon Area Hospital, and therefore I believe this made it more difficult for his colleagues to challenge his practice as they respected him too much.

67.4 Urology are a close-knit team with the majority of the team having been together for a long number of years and I think Mr O'Brien's practice became accepted, that there was a view that, when issues have been raised, nothing was done to him, and that people (including myself) became complacent. People would have said, 'it is just Aidan and, sure, that is the way he has done things for years'.

67.5 It is my opinion, on reflection, that outside influence from the Trust Chair (Mrs Brownlee) in dealing with Mr O'Brien's practices and Mr O'Brien



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using his connection to the Chair to his advantage, were other features or causes of what went wrong within Urology services. On occasions, Mr O'Brien in conversations with me and other members of the team would advise that he had spoken with the Chair directly to advise her of the capacity issues within Urology Services and he would have told us that she had assured him that she would sort this out, for example, that she would work on getting the urologists more theatre time. He would have advised of the times that he had met and spoken with Mrs Brownlee at social functions and that he had made her fully aware of what was happening in Urology. He also mentioned on a number of occasions that she was involved and supported the work of CURE (Craigavon Urological Research and Education), which is a limited company set up by a number of urological staff to provide funding (raised through fundraising) to allow for urology staff to do research and training and attend courses, and of which Mrs Brownlee had been a Director and she had also been actively involved in fund raising. As previously mentioned, I believe she was involved in asking at least two members of Trust staff who were actively trying to manage and address concerns regarding Mr O'Brien to step back (Mr Mackle and Mrs Gishkori). Although I am not aware of any other incidents, this outside influence always concerned me because, like the mentioning of his legal connections, Mr O'Brien also referenced this connection in his conversations and, in my opinion, the purpose may have been to make others feel intimidated by the knowledge that he was influential with someone who held a senior position in the Trust's senior management.

68. What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and the unit, and regarding the concerns involving Mr. O'Brien in particular?

68.1 In my opinion, there has been a lot of learning from a governance perspective and in this paragraph of my answer I confirm that I would agree

29. Please set out the details of any weekly, monthly or daily scheduled meetings with any urology unit/services staff and how long those meetings typically lasted. Please provide any minutes of such meetings.

29.1 I refer to my answer for question 28.

30. During your tenure did medical and professional managers in urology work well together? Whether your answer is yes or no, please explain by way of examples regarding urology.

30.1 From my limited interactions with them, my sense is that they did and do work well together, with the exception of the working relationship with Mr O'Brien.

30.2 My impression is that the remaining staff had the greatest respect for each other, regardless of discipline, and were very professional in their interactions with their patients and each other. They appeared to work well together outside the challenges of having to manage and work with Mr O'Brien.

30.3 My impression (based upon reading the MHPS papers – including witness statements – and SAI documents) was that, over the years, Mr O'Brien's colleagues had developed ways of not confronting him for fear of having to deal with unpleasantness but had found ways of constantly working around him to avoid antagonising him and to get the work of treating patients done.

30.4 I was also aware that Mr O'Brien had the support of the Chair of the Trust, Mrs Roberta Brownlee. At my first meeting with her after taking up post as Medical Director, on the 11th January 2019, she advised me against pursuing him in the way that she believed my predecessors had done and she intimated that she believed that he was an excellent surgeon and that he had saved her life.

1 properly and quickly".

2
3 Then, at 1.3, it's essentially telling the Trust what
4 could be taken into account as part of screening, what
5 should form part of screening.

12:52

6
7 "This could include clinical or administrative records;
8 serious untoward incident reports or complaints;
9 earlier statements are introduced for people with
10 first-hand knowledge of the concern; clinical audit and
11 clinical governance data; the views of professional
12 advisers; earlier occupations health reports."

12:53

13
14 That's not an exhaustive list. It appears to be
15 suggesting that relevant decision-makers should
16 carefully think through what it is that should come
17 within the terms of reference of an investigation.

12:53

18
19 would you agree with me that if there are
20 administrative-type shortcomings in one area of
21 a clinician's practice, it would be within the
22 obligations of a Trust and its decision-makers to set
23 the terms of reference wide enough to enable you, as
24 the investigator, to explore whether those
25 administrative shortcomings exist elsewhere?

12:53

12:54

26 A. I suppose it's the balance between earlier things in
27 NCAS, which is about not making this so wide that,
28 number 1, the investigation is unmanageable, and number
29 2, that you are just saying I am going to look at all

1 practice and see if I can find something. I think it's
2 about -- my view is that, yes, of course screening
3 needs to be properly carried out, of course it does.
4 But I think if there are specific areas of concern that
5 have been raised by managers or by SAI reviews or by 12:54
6 complaints or by patients, well then, those are the
7 areas, and issues around those areas certainly. I
8 don't think it's a well, let's look at everything.

9
10 I suppose, Mr. Wolfe, and I have said earlier, you 12:55
11 know, Mr. O'Brien's colleagues and managers, certainly
12 who gave evidence to -- who I was involved in
13 interviewing, were certainly very clearly saying that
14 they had no concerns about his clinical practice, you
15 know, other than, you know, the potential for patient 12:55
16 negative outcomes because he wasn't doing things like
17 triage which he didn't agree with. You know, as I say,
18 people seem to think that other areas he was spending
19 lots of time on and those seemed to be clinical areas.

20 111 Q. They were answering questions within a particular 12:55
21 framework, the framework being your terms of reference.

22
23 Let me test you with this example. We know that in
24 2020, Patient 5 and Patient 8 were the subject of
25 Serious Adverse Incident Reviews because, at least in 12:56
26 part with regard to Patient 5, it was alleged that
27 Mr. O'Brien had failed to action a CT scan, the results
28 of a CT scan. With Patient 8, he had failed to action
29 the results of a pathology report. Now, I know this

1 else, given that others had told me he was excellent,
2 I'm thinking right, well, since he is excellent, let
3 him do his dictations on all his patients, let him do
4 his triage, let him do the backlog in terms of
5 Outpatients and let this man work as part of the team. 15:46

6
7 I am not saying because he was a good practical
8 surgeon, let him away with it. No, not at all, not in
9 the slightest. I suppose the bonus was when he got
10 into theatre, he did a good job; far worse if he had 15:47
11 been incompetent there, you know. It wasn't a cop out.
12 He needed to deal with it. I just still felt that he
13 was best placed to do it. I honestly believed he if he
14 knew the gravity of the situation, as told to Charlie
15 by me, he would -- anybody wise would start toeing the 15:47
16 line and getting it right, I would have thought.

17 496 Q. When you think about MHPS and the investigation that
18 was conducted, and knowing what we know now about what
19 the Trust says was discovered in 2020 - after you had
20 left, of course - but the Trust say that there were 15:48
21 significant concerns of a clinical and a governance
22 nature, do you think the Trust, indeed any of the
23 people including yourself associated with these
24 issues --

25 A. Yes. 15:48

26 497 Q. -- in 2016, 2017, is there anything that could have
27 been done before 2020 to try to discover, uncover,
28 these other shortcomings which were to be discovered in
29 2020?

1 A. I think the minute anybody noticed that he wasn't
2 following -- you see, there is this thing about
3 systems, Mr. Wolfe. It is that - and I was always
4 taught and I think I have said this before - let the
5 system take the pressure, not you. You follow the 15:49
6 system because if something goes wrong and you are
7 following a system, nothing happens. If you just
8 decide to be a maverick and go off on a tangent, you're
9 on your own when something goes wrong. I cannot
10 believe that this individual didn't understand that. 15:49
11 For me, way back when Dr. Gillian Rankin or whoever was
12 before her decided to deal with it, he decided for his
13 own reasons not to follow it. To me, this is a
14 one-off. I can't understand the man's thinking.

15 498 Q. Yes, but what about the Trust's thinking? 15:49
16 A. The Trust's thinking?

17 499 Q. Could the Trust and people like you who were in a
18 position of influence have done any more to bring
19 forward the discovery of what was to be discovered in
20 2020? Can I put it in these terms? 15:49
21 A. Yes.

22 500 Q. You talk about the importance of systems, and you talk
23 about - and these are your words - maverick behaviour.
24 If there is evidence of that, and it's obviously a
25 matter for the Panel -- 15:50
26 A. Sure. Sure.

27 501 Q. -- who weigh your evidence and see if your description
28 is apt, but if it is apt, is there anything that the
29 Trust and people like you could have been doing by way

1 of inquiry, investigation, to get to the bottom of what
2 was to be discovered two years, three years later?

3 A. Yes, I think there is always more we could have done
4 and there were lots of missed opportunities. There is
5 absolutely no doubt about that. But when you're in the 15:50
6 moment, when there is so many other things. I told you
7 about firefighting, missing lots of meetings, having to
8 cancel things, having to have a report ready for
9 tomorrow lunchtime, this becomes just one other thing,
10 that's just the truth. It shows the level of risk that 15:50
11 people who work in the Health Service have to have; it
12 shows the level of risk. It is so high because you
13 cannot -- nobody will ever eliminate risk but it is
14 really hard to minimise it given the volume of work
15 that everybody has. Of course there were missed 15:51
16 opportunities.

17
18 Of course we could sit down now and write a gold
19 standard plan of what we could have done, of course.
20 But 20/20 vision is -- hindsight is 20/20. I look at 15:51
21 it too thinking, gosh, where did I -- whenever I have
22 been reading these pages, thinking what did I do about
23 that or that. Your mind just goes mad. This past year
24 that's been.

25 502 Q. Do you think it's only with hindsight that you are able 15:51
26 to realise what should have been done, or was it
27 perhaps more a complacency on the part of those who
28 were charged with dealing with this that led to a
29 failure to dig below the surface?

1 A. Well, I can only speak for myself, Mr. Wolfe, and I was
2 anything but complacent. I feel as though, as I said,
3 put my neck on the line to try and sort it out quickly.
4 I can't speak for everyone else, nor would I try to
5 judge them because I don't believe that's fair. I can 15:52
6 just say for myself I was anything but complacent,
7 really. It may not come across like that, but there
8 you go.

9 503 Q. Chair, I probably have an hour and a half or so going
10 into the governance aspect. There are a range of 15:52
11 questions and things that arise out of that. I am not
12 going to get finished today, adding in your questions.
13 CHAIR: Mrs. Gishkori, I am really sorry about this, I
14 am going to have to ask you to come back tomorrow
15 morning. 15:53
16 MR. WOLFE: Sorry to cut across you. We started early
17 and therefore I would be reluctant to push it on to
18 4:45 and still not be finished. Is this a convenient
19 time?

20 CHAIR: We'll rise today and start again tomorrow 15:53
21 morning.

22 MR. WOLFE: I was speaking to Mrs. Gishkori's
23 solicitor and 10:30 would be suitable in the morning?

24 A. Yes. I'm supposed to be looking after the grandchildren
25 tomorrow, so I will have to take one of them to school, 15:53
26 try and get the other to my mother's or something, and
27 then come.

28 CHAIR: Well, okay. Can I just confirm with Mr. Wolfe,
29 you intend we will finish by lunchtime tomorrow,

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

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

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

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

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

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

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

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

Casenote	Consultant Name	Date on Waiting List	Date Operation	Days between Added to WL to Operation Date	Is there a clinical reason why they should have waited such a short time
Patient 114	O'Brien A Mr	22/02/2016	22/03/2016	29	No
Patient 115	O'Brien A Mr	25/04/2016	04/05/2016	9	Reasonable – Red Flag
Patient 116	O'Brien A Mr	11/04/2016	15/04/2016	4	No
Patient 117	O'Brien A Mr	01/04/2016	27/04/2016	26	No
Patient 118	O'Brien A Mr	08/07/2016	09/08/2016	32	No
Patient 119	O'Brien A Mr	29/07/2016	21/09/2016	54	No
Patient 120	O'Brien A Mr	04/12/2015	24/02/2016	82	Reasonable
Patient 121	O'Brien A Mr	11/07/2016	17/08/2016	37	No
Patient 122	O'Brien A Mr	08/10/16	02/11/16	25	No
Patient 123	O'Brien A Mr	31/10/16	04/11/16	5	No
Patient 124	O'Brien A Mr	16/02/2016	24/02/2016	8	No

1
2 So, what did you take from that e-mail? Did you
3 understand, firstly, that Mr. Young had been asked to
4 conduct an evaluation of eleven patients against
5 a particular standard, which seems to be a time 15:55
6 standard; which doesn't have any other particular
7 definition? But this was all being done without
8 reference to you?

9 A. Yes.

10 193 Q. You didn't know that it was Mr. Young, the witness, who 15:55
11 spoke to you earlier in the year about his knowledge of
12 Mr. O'Brien?

13 A. I didn't know at the time that this was undertaken that
14 it was Mr. Young that was undertaking this, no. But
15 obviously I knew subsequently. 15:56

16 194 Q. There were no instructions or directions given by you
17 in respect of this private patients issue?

18 A. No. The private patient issue was term of reference 4,
19 which was provided to me.

20 195 Q. Mm-hmm. 15:56

21 A. And it was a wide -- you know, it was private patients
22 whose wait times appear to have been shorter than they
23 might otherwise have been. I think it was quite vague
24 in those terms. I don't recall mentioning it being
25 specifically TURP patients. But I mean, I had no input 15:56
26 into developing term of reference 4 or how it was
27 worded. It was just one of the terms of reference I
28 was provided with.

29 196 Q. Did you give any thought as to whether a practitioner

1 colleague of Mr. O'Brien within the Service, within
 2 Urology Service, was an appropriate person to be
 3 giving, I suppose, expert evidence to you or evidence
 4 involving an expertise around these matters in these
 5 circumstances?

15:57

6 A. I considered that Mr. O'Brien was a very senior
 7 colleague along with -- sorry, Mr. Young was a very
 8 senior colleague of Mr. O'Brien's. I thought,
 9 therefore, that he would have a good knowledge of
 10 waiting lists. I knew that his practice in terms of
 11 waiting times and waiting lists and the length of time
 12 he had been in the Trust was lengthy; not as long as
 13 Mr. O'Brien but certainly longer than some of the newer
 14 consultants. And I feel there's an obligation on all
 15 of us to act as independent practitioners in this
 16 situation so I expected that he would do a fair
 17 analysis. So, I didn't feel that it was inappropriate
 18 for Mr. O'Brien -- or, sorry, for Mr. Young to do that.
 19 I felt he would give a fair and balanced account. I
 20 believed that he would give a fair and balanced
 21 account. I felt because his practice and his length of
 22 time and so on was similar, that that would be helpful.

15:58

15:58

15:58

23 197 Q. Is it fair to say that at no point did you speak to him
 24 about his analysis on the private patients issue?

25 A. Yes, that's a fair comment.

15:59

26 198 Q. We will look at his product in a moment but he produced
 27 a table. Or he produced, first of all, notes; then he
 28 spoke to Mrs. Corrigan about what his notes meant; she
 29 sent the product across to you?

1 A. Yes.

2 199 Q. Mr. O'Brien, as we will see in due course, challenged
3 the conclusions which were reached by Mr. Young across
4 nine of the cases, that there were eleven cases in
5 total but Mr. Young felt two of them were appropriately 15:59
6 dealt with -- two of the patients were appropriately
7 treated at the time they were treated, but there was
8 conflict or dispute around the nine.
9

10 You accepted Mr. Young's view on that and didn't put to 16:00
11 Mr. Young -- didn't ask questions of Mr. Young in
12 respect of what Mr. O'Brien was saying. Have I got
13 that right?

14 A. Yes, that's correct. So, Mr. Young -- I was produced
15 a list of patients. Mr. Young had made comments on it 16:00
16 and whether he was felt it was appropriate or not for
17 them to be placed on a waiting list when they were.
18 I put that to Mr. O'Brien and asked Mr. O'Brien, once
19 he had a chance to see these, to look at them and to
20 see if he had an explanation for that. I included both 16:00
21 Mr. Young's opinion and Mr. O'Brien's opinion in the
22 investigation report.

23 200 Q. In terms of Mr. Young's product on this, could we just
24 bring up on the screen, please, TRU-01069. That's
25 a table showing eleven patients who had been seen by 16:01
26 Mr. O'Brien privately, who were then treated on the
27 NHS, or received diagnostics on the NHS. Those are the
28 days since they were added to the waiting list in the
29 view of Mr. Young. Isn't that right?

1 A. Yes, that's correct, yes.

2 201 Q. As I have said, he found that two of the cases were
3 reasonable. Or in the case perhaps of the second one
4 down, perhaps "mandatory" is the word that Mr. O'Brien
5 uses, mandatory, treats that patient having regard to 16:02
6 cancer access times.

7
8 If we just scroll down, please. The main document,
9 just to orientate the Inquiry, is a letter in the hand
10 of Mr. O'Brien to a general practitioner. Then what 16:02
11 Mr. Young appears to have done, although we have no
12 direct evidence on this, it's not contained in any
13 statement from him, is his Post-it note setting out
14 what he thinks of the case. It would require
15 translation from him, perhaps. It sets out a series of 16:03
16 dates and then it ends with a query "urgent", and he
17 repeats that exercise across eleven cases?

18 A. Yes.

19 202 Q. That's what you were getting through the Trust from
20 Mr. Young? 16:03

21 A. Yes.

22 203 Q. Not a report, not a statement, a series of Post-it
23 notes produced into a table summarising his views.

24
25 Did you think that was an entirely satisfactory way to 16:04
26 deal with this issue in circumstances where you didn't
27 have access or you didn't seek to achieve access to
28 Mr. Young to further discuss these issues?

29 A. I think it was -- I felt that it was a very senior

1 clinician considering this, with a lot of experience
2 behind him to know what the waiting times were. It was
3 perfectly clear from every witness that we spoke to
4 that waiting times for Urology were -- well, I mean,
5 they were just, I suppose, unacceptable but of course 16:04
6 they were unacceptable but they were very lengthy. And
7 waiting times for Outpatients appointments were
8 lengthy, waiting times for surgery were lengthy, and
9 therefore it was clear to me that waiting times which
10 appeared short, therefore, were outside what one would 16:05
11 have expected, but I didn't interrogate this any
12 further. It was put to Mr. O'Brien and Mr. O'Brien
13 gave a full response to each one of these.

14 204 Q. One of the things that Mr. O'Brien said to you was
15 where is the comparative analysis? In other words, if 16:05
16 you looked at patients who had not been treated
17 privately, would you see cases treated by him with
18 similar conditions treated in a similarly short
19 timeframe? Do you recall he made that point to you?

20 A. Yes -- 16:06

21 205 Q. He also made the point that if you look at his private
22 patients in total, or patients that had been treated by
23 him privately before going on to the NHS list, you will
24 see lots of private patients sitting on the list for
25 a lengthy period of time. The question becomes, in 16:06
26 trying to assess this issue and where the proper
27 conclusions could be drawn, could you have done more by
28 way of investigation to effectively bottom this out?

29 A. I think we could have done more and I think that

1 applies to most things when you are investigating. It
2 was difficult because interrogating waiting lists, I
3 was told, was difficult because if patients were
4 formerly private and then went on to the NHS waiting
5 list, at times it was difficult to identify that they 16:07
6 had been formerly private. I think that was one of the
7 questions I asked Mr. O'Brien. I said would I, if
8 I went along and looked at a waiting list, know that
9 easily? So, I think there were a lot of matters that
10 complicated the situation. 16:07

11
12 The comparator for this -- the comparator that was used
13 was an average NHS patient. Not an average Mr. O'Brien
14 patient but an average NHS patient. Was Mr. O'Brien
15 putting private patients -- were private patients 16:07
16 waiting a shorter period of time for surgery than one
17 might expect for an average NHS patient. I understand
18 that was the term of reference and that's the
19 comparator that was used. Rightly or wrongly, that's
20 the comparator that was used. I do accept that 16:07
21 Mr. O'Brien felt that that isn't the comparator that
22 should have been used. But, as I say, the issue of
23 trying to establish who was a private patient who then
24 becomes an NHS patient and at what point that happens
25 and so on became very complex. So these were put to 16:08
26 Mr. O'Brien. As I said, he provided a full response to
27 this and, you know, that's what we took and we
28 progressed with that.

29 206 Q. I may want to come back to this issue just to tidy some

1 threads of it up, but I suppose I'm asking you about
2 the role of Mr. Young primarily. He was a consultant
3 and a manager; he was the Clinical Lead; he was
4 a witness to your investigation who may - certainly it
5 was open for to you determine whether any criticism 16:09
6 should be visited him upon, particularly around ToR 5
7 and what management knew about these issues and what
8 they did or didn't do.

9
10 I introduced this morning the NHS Framework and drew 16:09
11 your attention to whether there was any need in this
12 case to involve someone with clinical expertise. It
13 appears from Mr. Young's work in this particular issue
14 that he was being asked to apply his clinical expertise
15 in respect of whether patients should have been seen at 16:09
16 the time they were seen.

17 A. Mm-hmm.

18 207 Q. He was giving that information to you in a circuitous
19 route. He wasn't putting it into his statement, he was
20 putting it in through Mrs. Corrigan, and you didn't 16:10
21 have access to him or didn't seek to have access to
22 him, and you didn't instruct him in the alternative as
23 an expert. This was a case where expertise independent
24 of the Service should have been brought in; is that
25 fair? 16:10

26 A. At the time I felt that Mr. Young was an appropriate
27 person to do this. I felt he understood how the
28 waiting lists in the Trust -- how long waiting lists
29 were; what the process was for adding people; what the

1 processes that the Trust adopted were. At the time
2 I felt that he was an appropriate person. On
3 reflection, I think if I was doing it again, I would do
4 it differently.

5 208 Q. As we know, you met with Mr. O'Brien again on 6th 16:11
6 November and, by that time, he had been provided with
7 this information that Mr. Young had developed and he
8 was able to comment on the ToR 4 issue. As I say,
9 there's some threads in association with that that
10 I want to come back to you with. We can see that 16:11
11 there's a transcript again of that meeting. For the
12 Inquiry's note, it's to be found at AOB-56285.

13
14 At that meeting, at the very outset Mr. O'Brien advised
15 that his priority after the meeting would be to deal 16:12
16 with his appraisal in the remaining weeks and months of
17 the year. Is it fair to say that you agreed with him,
18 that he was entitled to focus on that, notwithstanding
19 that there were other elements of the
20 investigation-related work that he needed to fulfil and 16:12
21 complete?

22 A. Yes. He was saying it had been a very difficult year
23 for him and that he felt that he needed to focus on his
24 appraisal as a matter of priority. I had raised with
25 him at the meeting in August that, in my view, issues 16:12
26 that needed to be carried out at certain times needed
27 to be carried out. You know, the GMC just didn't allow
28 you not to do your appraisal or not to do CPD or
29 whatever. He felt that this was weighing heavily on

1 please. It does appear to be an identical letter.
2 when did that come into your hands?

3 A. I think that came into our hands - I can't recall - as
4 part of information that we had requested in late 2018
5 or '19 after the investigation had been concluded. 12:56

6 142 Q. So, perhaps as part of the grievance?

7 A. Subsequent to that. That's my understanding. Because,
8 in fact, I think we have -- there's documentary
9 evidence where I have repeatedly requested that letter
10 and did not receive it. 12:56

11 143 Q. It appears that you were able to make, with a confident
12 tone, your comments in relation to the transcript of
13 the 30th December meeting because you had recorded the
14 meeting.

15 A. Well, I hadn't recorded it but my wife had recorded it. 12:56
16 I didn't know that it was being recorded. And my wife
17 recorded it because she does have impaired hearing,
18 which probably wasn't as bad then as it was now. Now,
19 it's to an extent that she is more confident in
20 declaring it, which has been an issue for her here in 12:57
21 this chamber. But back then --

22 144 Q. Sorry, to cut across you. She attended with you at the
23 meeting of 30th December?

24 A. Yes. That's right. She did.

25 145 Q. She probably could see that Dr. Wright was accompanied 12:57
26 by Ms. Hainey?

27 A. Hainey, that's right.

28 146 Q. And she was making a note of the meeting?

29 A. Yes.

1 147 Q. Your wife, Mrs. O'Brien, had decided to record it?
2 A. Yes.
3 148 Q. That wasn't brought to the attention of Dr. Wright, is
4 that fair?
5 A. That's right. 12:58
6 149 Q. Had it been brought to your attention --
7 A. No.
8 150 Q. -- in advance of the meeting, 'I've a hearing problem,
9 Aidan, I'm going to need to record it'?
10 A. No. I didn't even know it is possible. I'm not an IT 12:58
11 geek. So, I didn't know it was possible on
12 a smartphone to do so.
13 151 Q. When was it revealed to you that it had been recorded?
14 A. Maybe two hours after we got home that day.
15 152 Q. And you sat and listened to it? 12:58
16 A. Not for several days after. I was -- I wasn't in
17 a state to listen to anything, really.
18 153 Q. And we know that you have provided the Inquiry with,
19 I think, 26 such recordings, and transcripts have been
20 made. Is that all of the recordings that you have? 12:59
21 A. Yes.
22 154 Q. The second recording that we're aware of your wife
23 wasn't in attendance on 9th January when you met with
24 Martina Corrigan, I think in her car?
25 A. In my car. 12:59
26 155 Q. You don't have a hearing impediment?
27 A. No.
28 156 Q. So, you didn't need it recorded but it was recorded?
29 A. It was.

1 157 Q. And, again, recorded without Mrs. Corrigan's knowledge
2 or permission?
3 A. That's right.
4 158 Q. Is there any good reason for recording a private
5 conversation? 13:00
6 A. The only reason I had was that my wife had simply
7 asked, you know, 'could you record it so I know what
8 you've said or what questions you've asked or what has
9 been said in return?' I don't know how many of the
10 adult males in this room will identify with this, but, 13:00
11 you know, I don't always remember the detail of
12 conversations. So, like what did he say and -- it
13 wasn't done with any malign intent, it wasn't done with
14 any intent other than to be able to let her know what
15 the conversation was. 13:00
16 159 Q. So you do appreciate, however, that people like
17 Mrs. Corrigan, Mr. Weir, have regarded this recording
18 as a gross violation --
19 A. Yes, I do appreciate that.
20 160 Q. -- having found themselves upset by it? 13:01
21 A. Yes.
22 161 Q. Thereafter, what was the reason for recording
23 conversations and meetings? Because, for example, you
24 had Mr. Michael O'Brien in attendance with you at many
25 of these meetings. So, in terms of an ability to 13:01
26 report back to Mrs. O'Brien what was going on,
27 you didn't need to covertly record conversations for
28 that reason?
29 A. That's true. So what was the reason? So we got on,

1 I think on 18th January, the note of the meeting of
2 30th December with Ms. Hainey and Dr. Wright. And, you
3 know, even though Dr. Wright described her as
4 a professional notetaker, we saw that there were
5 inaccuracies and on first hearing me say that anyone 13:02
6 might consider is it not just a little bit of
7 nitpicking, but the one thing that really offended us
8 both was this note that on 30th December my wife had
9 said, in quotes, that "at the end of a long career,
10 that this is how you are repaid". And that was not 13:02
11 said. So, I came to appreciate that no matter who's
12 there, it is the convenor who produces the note. And
13 the note cannot be depended upon.

14
15 Now, I do appreciate the sense of intrusion and 13:03
16 violation that can be felt by anybody at the receiving
17 end and I wish it proved not to be necessary to do so.
18 However, when it comes to my meeting with
19 Martina Corrigan, I have read the transcript of that
20 meeting many times where I have gone over again and 13:03
21 again and again how it is recorded that the majority of
22 the 668 have been processed, the outcomes have been
23 done. In fact, very often not only has the outcome
24 been registered, but the operation that was the outcome
25 may already have been done. All of that. So, I found, 13:04
26 actually, that I had very, very good reason,
27 ultimately, to have a reliable record. In fact, when
28 I look back I very, very much wish that I had a record
29 or a recording of the meeting of March '16.

1 162 Q. At no stage did you seek permission from --

2 A. No.

3 163 Q. -- anyone, whether that's a formal meeting such as the

4 meetings you had with Dr. Wright, Dr. Khan or Mr. Weir

5 or the more informal, private conversations such as you 13:04

6 had with Mr. Weir.

7

8 The conversation with Mr. Weir, for example,

9 in October 2018, and that was recorded and from it

10 we looked at the point this morning about who was it 13:05

11 who asked him to step aside?

12 A. Yes. Yes.

13 CHAIR: Was that with Mr. Wilkinson?

14 MR. WOLFE KC: It was a meeting with Mr. Weir.

15 THE WITNESS: Mr. Weir. 13:05

16 164 Q. MR. WOLFE KC: That meeting was then reported into your

17 grievance, isn't that right?

18 A. Yes.

19 165 Q. Was that, plain and simply, an information-gathering

20 exercise for your grievance? 13:05

21 A. Well, the meeting, actually, was to find out whether or

22 not he had been spoken to by someone not to engage with

23 me back in September '16. That was the purpose of the

24 meeting. I think, actually, I was gathering two bits

25 of information. That's one of them. And whether I had 13:05

26 been allocated more administrative time than my

27 colleagues, which had been repeatedly reported. So,

28 it's just a recording of the information that was

29 gathered.

1 166 Q. Could I ask you to take a look at the following
2 document, AOB-56500. This is a meeting attended along
3 with Michael O'Brien on July 20th. If we go into the
4 first page, please, towards the bottom. Down to the
5 bottom of the next page. Thanks.

13:06

6
7 At the bottom of the page the speaker, Ms. Young, is
8 saying:

9
10 "The other things that we have checked, our phones are
11 off. Obviously, this is not the end of the world if
12 your phone is not off, but it might distract you from
13 what we are doing. So long as we don't distract you,
14 that would be the main thing. Okay?"

13:07

15
16 Ms. Young then says:

13:07

17
18 "We are taking our own notes and I want to make sure,
19 to let you know, we are not recording and I am asking
20 that you are not recording it either."

13:07

21
22 And Michael O'Brien answers "no". She then says:

23
24 "Because if you were, as long as you let us know,
25 that's fine."

13:07

26
27 Over the page:

28
29 "So we are here today in relation to this stage..."

1 etcetera.

2

3 Did Michael O'Brien know that you were recording?

4 A. No.

5 167 Q. He had, by this stage, attended some seven meetings 13:08

6 that had been recorded. This was the eighth, at least

7 by my count. Was he completely in the dark as to the

8 fact that you'd previously recorded meetings?

9 A. I can't recall -- I cannot answer that question

10 definitively. But, he was entirely unaware that I was 13:08

11 going to record this one. And, I should add, if he had

12 been aware previously that I had covertly recorded, he

13 was disapproving of it, he was uncomfortable about it,

14 for which reason -- it was another reason why I didn't

15 tell him I was going to record this. 13:08

16 168 Q. I didn't fully follow the sense of that, what you've

17 just said. Was he aware and was he disapproving of it?

18 A. Yes.

19 169 Q. So, he was aware of prior recordings?

20 A. Yes. 13:09

21 170 Q. He wasn't aware of this one?

22 A. No, let's be clear. I can't recall when Michael became

23 aware that we had recorded any meetings. I cannot

24 recall. What I certainly can recall is that when he

25 became aware he was uncomfortable and disapproving of 13:09

26 it. He would have preferred it hadn't happened.

27 I didn't advise him that I was recording this meeting.

28 Whether I didn't advise him of that because of his

29 previous awareness, if he was aware previously,

1 I cannot recall.

2 171 Q. why did you not intervene - you're sitting beside him -
3 and tell Mrs. Young, 'my son has answered no but in
4 fact the answer is yes, I am recording'?

5 A. well, I felt it wasn't an issue for her because she 13:10
6 said it was fine. So, I didn't think it was an issue.
7 And I didn't ever, ever anticipate that any of these
8 recordings would enter into an arena or forum like
9 this. They weren't even kept for any litigious or
10 other reason, I can assure you. So, it happened. 13:10
11 I was so thankful, on a number of occasions, that it
12 did happen because we were able to make significant
13 corrections, such as, like, Mr. Carroll stated that he
14 had never met me, whereas in fact we had a meeting.
15 Important things. And I know that it has been said 13:10
16 that it was the fact that it was being recorded that
17 had me steer the discussions that took place in some
18 meetings, but that's not the case at all. I was just
19 recording them. We had found it very, very useful to
20 be able to listen to them, to hear what people did 13:11
21 actually say. It enabled us, actually, to offer
22 corrections, and we became disappointed and despondent
23 at the fact that the corrections that we were able to
24 offer were not always amended.

25 172 Q. Could I ask you to reflect upon the integrity of the 13:11
26 first part of the answer you've just given me?

27 A. Mmm.

28 173 Q. The questioner says to you: Are you recording?
29 A. Mm-hmm.

1 174 Q. It's not something I will disagree with. But I need to
2 be told. And you have explained that your thought
3 process was, 'well, I didn't tell her but she doesn't
4 appear to mind and that justifies me not telling her,'
5 notwithstanding the clear question she placed in front 13:12
6 of you and your son?

7 A. What is the first part of the sentence at the bottom?

8 175 Q. Roll back up, please. She says:
9
10 "We're taking our own notes. I want to make sure, to 13:12
11 let you know, we are not recording and I am asking that
12 you are not recording it either because, if you were,
13 so long as you let us know, that's fine."
14

15 A. Well, I had intended to record it for the reasons that 13:12
16 I have given. I remember this exchange but I don't
17 remember in my mind the exact words, but we can read
18 them because of the recording. I was aware that
19 Michael wasn't aware of it. I felt uncomfortable him
20 saying no and I was going to record anyhow. And I felt 13:13
21 that they weren't particularly concerned about there
22 being a recording, that it wasn't going to impact upon
23 the content of our discussions. And we thought that
24 these were going to be very, very long meetings and
25 these were important, it was part of the grievance 13:13
26 hearing. And I only could be accompanied by one person
27 and my wife, in particular, who has been very, very
28 affected by all of this experience, it has been going
29 on for years, you know, just wanted to listen to what

1 was said. So, I'm not so sure that in any of the
2 previous meetings I would have necessarily been able to
3 advise people that I would like to record it, I want to
4 record it, I insist upon its recording, and that they
5 would have agreed. I don't think that that would have 13:14
6 happened. So, I've hopefully answered as fully as
7 I can.

8 MR. WOLFE KC: We have your evidence on that. Thank
9 you, Mr. O'Brien. I have slightly overshot.

10 CHAIR: It's quarter past one now. 13:14

11 MR. WOLFE KC: Quarter past two?

12 CHAIR: Quarter past two.

13
14 THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

15
16 CHAIR: Good afternoon, everyone. Mr. wolfe. 13:14

17 MR. WOLFE KC: Good afternoon, Chair.

18
19 MR. AIDAN O'BRIEN CONTINUED TO BE EXAMINED BY MR. WOLFE
20 KC AS FOLLOWS: 14:14

21
22 176 Q. MR. WOLFE KC: Good afternoon, Mr. O'Brien.
23 Just a few of the developments that happened after 30th
24 December when you met with Dr. Wright. You met with
25 Mrs. Corrigan to bring back the charts. You directed 14:15
26 her to the referrals that were kept in a cabinet in
27 your office. Outcome sheets, they weren't returned
28 with the patient charts?

29 A. That's correct. Just to correct you. I didn't meet

A

30 July 2020

B

FILE REFERENCE: 23

MR O'BRIEN

Accompanied by MICHAEL O'BRIEN

SHIRLEY YOUNG

AISLING DIAMOND

(FIRST GRIEVANCE HEARING – PART 1)

C

D

Audio Transcription Prepared by:

Personal Information redacted by the USI

E

F

G

H

DR DIAMOND: Good afternoon.

MR O'BRIEN: Hello.

DR DIAMOND: Hello, how are you? I am Aisling Diamond.

MR O'BRIEN: Hello, Aisling.

SHIRLEY YOUNG: I'm Shirley Young and I will do a bit more detail on the introductions on how I come to be here. So we will let you get settled and then make a start. There are some housekeeping things to start with so we will make our way through that first of all.

MICHAEL O'BRIEN: It's spread.

SHIRLEY YOUNG: That's okay. I was making the remark to Aisling that I admire her laptop and all her stuff. I am a dyed in the wool person.

MICHAEL O'BRIEN: Sometimes I keep things on the computer and sometimes I like to have (inaudible).

SHIRLEY YOUNG: As I say, when I work home I can work off that but when I am here and there are documents my overwhelming urge to make a mark on them knows no bounds.

So you're very welcome. So a few housekeeping things to start with. As you know we are still in the middle of the Covid-19 pandemic. So we have arranged ourselves unusually very far apart. Obviously, if you travelled together, you can sit where you need obviously. So there is wipes there. I can assure you that all the surfaces here have been wiped. And there is hand sanitisers. If you would prefer to use a mask they are there as well.

That also means that because some of the stuff that has coming through my professional organisation about these face to face or in person meetings, that we have been told about duration. So I am hoping that we will see what we can do in the two-hour slot today. If it needs to go over and it is a few minutes with your permission but if you are concerned at all about the duration just say. I have opened the window and I have carefully looked outside. It does not look like there will be passers-by but if you get cold we will close it but I have it opened just for the reason to keep the circulation going.

The other things that we have checked our phones are off. Obviously it is not the end of the world if your phone is not off but it might distract you from what we are doing. So as long as we don't distract you, that will be the main thing.

MICHAEL O'BRIEN: Okay.

SHIRLEY YOUNG: We are here. We are taking our own notes and I want to make sure, to let you know, we are not recording and I am asking that you are not recording it either.

MICHAEL O'BRIEN: No.

SHIRLEY YOUNG: Because if you were, as long as you let us know, that's fine. So we are

here today in relation to this stage 1 grievance. As I said at the outset, my name is Shirley Young and I am not employee of the Trust. I am a HR associate from the HSC leadership centre at The ~~Beaches~~ Beeches. You may have heard of them. It is a large, linked organisation. I have been working for them on specific HR inputs for the last four years. Prior to that, I have worked for the Western Health and Social Care Trust as assistant director and I have worked for them for 30 years. So I am here as that type of representative, someone with a HR background. And Aisling your proper title alludes.

DR DIAMOND: So I am Aisling Diamond. I am a consultant in emergency medicine by trade. I have been a doctor for almost 30 years. So I have worked in the Northern Trust, then Belfast, now I have come down into the Southern Trust. I work as deputy medical director as of 7 April. I think. – well somebody has to do it. ~~(Inaudible)~~

SHIRLEY YOUNG: So we are today and your companion, your selected companion is yourself and you are father and son.

MICHAEL O'BRIEN: Yes.

SHIRLEY YOUNG: To avoid any confusion on my part, I am happy very you call me Shirley. But if we have to make a distinguish distinction, if you are happy to be the Michael and if you want to be the Mr O'Brien. We can do it the other way round. It will help me if I am making any notes that Mr AOB won't help.

MICHAEL O'BRIEN: That's not a problem.

SHIRLEY YOUNG: I didn't want to be rude. So first of all, Michael, just in respect of your email that you had sent to Zoe Parks about some of the preliminary matters and I had gone back to Zoe and says to tell them that we will deal with all of that stuff when we meet. This is a stage 1 grievance hearing under the formal grievance procedure that the Trust has for all of its staff. So this is stage 1. Okay.

The matters that we will consider are everything that you sent in and your -- that had been here from your November 18 submission. We have received that in full and have read it. Then you sent a further submission in on 23 July, last Thursday. That was given to us. Usually we would not deal with new matters. However, given the length of time that it took, and we looked since November nothing had happened, we believe that we should see all of those matters and ~~(inaudible)~~ see them in that context rather than having somebody different looking at the delay when that is all before us. So we, to try and make sure this is as streamlined as possible and the people who are beginning to get the knowledge, we will deal with both submissions. Okay. Here at this stage. So you can be assured of that. Okay.

We want to be clear with you we will consider everything. There may well emerge

1 following set of e-mails: TRU-251540, starting at the
2 bottom of the page, please. Again, we are recalling
3 that MHPS has just reported, Mr. O'Brien is appraised
4 of the outcome, and what comes next in terms of
5 a conduct hearing. Mr. Carroll is writing to Esther
6 Gishkori, who is the Director of Acute, Colin Weir and
7 Michael Young. Ronan has been speaking to Mr. Young,
8 who has advised him that morning that he received phone
9 calls from Mrs. O'Brien on the Saturday evening, and
10 Michael O'Brien, who I understand is the son of
11 Mr. O'Brien, on the Monday evening, and both of those
12 phone calls centre on Mr. O'Brien's investigation.

13
14 "Give me a ring if you require anything further."

15
16 It's just signed off.

17
18 Mr. Weir then records that he met with Mr. O'Brien in
19 Mr. Weir's office. Mr. O'Brien requested the meeting,
20 and the conversation centred around the investigation.
21 I am conscious a moment or two ago I asked you whether
22 Mr. Weir had met with him to discuss the shortfall on
23 dictation, but that isn't this meeting. Mr. O'Brien
24 requests this meeting. Mr. O'Brien has recorded the
25 meeting, which is of some benefit to the Inquiry,
26 I suppose, although I understand that you and others
27 are somewhat upset by the fact that recordings of
28 conversations have taken place.

29 A. I think what you have got here is, Mr. O'Brien

1 initiated a meeting with an agenda, and a tape-recorder
2 effectively in his pocket. It also documented below
3 that, you've got family members putting pressure on
4 individuals within the service. I think there was
5 a lot -- why hadn't someone asked, do you mind if
6 I record this conversation? that would be reasonable,
7 I wouldn't have an issue with it. The fact that you've
8 had meetings where the agenda has perhaps been led by
9 someone who knows they are recording it, with their own
10 agenda and own intended outcome, it's a bit underhand.
11 It's a bit frustrating.

12 14 Q. The surreptitious nature of the recording that you
13 allude to, just to be clear, there are at least two
14 other meetings involving you which were recorded, your
15 consent wasn't sought?

16 A. Two meetings and a phone call, and never at any point
17 were we made aware that a recording was being taken.

18 15 Q. Yes. Mr. Weir seems upset about the nature of
19 Mr. O'Brien's approach in this meeting. He feels that
20 he should not have made this approach, that "his
21 questioning and responses could undermine the
22 investigation and action plan."

23
24 I assume that's a reference to the MHPS investigation
25 and subsequent plans that were never brought into
26 fruition for an action plan.

27
28 "He put me in a difficult and awkward position and
29 having met Mr. Young and knowing his experiences, he

1 protecting myself by sharing it with these people.

2 218 Q. Your final sentence there:

3

4 "Can we please be protected from this, as I suspect

5 evidence is being gathered from us and make the Medical 12:48

6 Director is aware."

7

8 Now, before your attendance before this Inquiry Panel

9 today, you're aware that Mr. O'Brien was in fact

10 recording that conversation? 12:48

11 A. Yes, I've seen those transcripts.

12 219 Q. And had, in fact, recorded a number of interactions

13 with yourself.

14 A. Six.

15 220 Q. Just, perhaps, on reflection, how do you feel as 12:48

16 a professional colleague of Mr. O'Brien?

17 A. It's totally -- well, like, breaking bad news it's like

18 anger and denial. The immediate response is sheer

19 anger about a breach of trust and then can't quite

20 believe that somebody has done this. I never heard of 12:49

21 such a thing. Then I thought -- then obviously it made

22 me think that any conversation I had around any issues,

23 that conversation was obviously or potentially being

24 steered for the purposes of this recording. So it just

25 sort of questioned then in retrospect the engagement 12:49

26 and honesty and support that I tried to provide to

27 Mr. O'Brien.

28 221 Q. Finally, you ask to be protected by The Trust.

29 Dr. Khan subsequently wrote to Mr. O'Brien. Was there

1 AOB-56221.
2
3 So you're making reference to the fact that Mr. O'Brien
4 recorded this?
5 A. That's correct, yes. 12:46
6 268 Q. Did you know it was being recorded?
7 A. I didn't. No.
8 269 Q. Do you know if Mr. Weir or Mr. Carroll were aware of
9 it?
10 A. No, none of us were aware. 12:46
11 270 Q. Now you became aware of it as a result of the Inquiry?
12 A. Yes.
13 271 Q. What was your view or your feeling, knowing that had
14 been recorded without you being aware?
15 A. Well, there was actually four recordings. Three of 12:47
16 them, I was with other colleagues. Initial reaction
17 was quite angry, but I suppose the one that annoys me
18 the most is....
19 272 Q. If you need to take a moment. If you need to stop for
20 a moment, we can do that, just to give you a short 12:47
21 break. There's no problem. Do you want to take
22 five minutes.
23 A. Yes, thank you.
24
25 THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS: 12:47
26
27 CHAIR: Ms. McMahon?
28 273 Q. MS. McMAHON BL: Are you ready to continue?
29 A. Yes.

1 274 Q. As a general point, you mentioned that there were
2 several meetings with Mr. O'Brien that had been
3 recorded without your knowledge.
4 A. That's correct.

5 275 Q. I just asked you what your views were on that? 12:54
6 A. That's right. Yes. Sorry about that. I suppose the
7 three with the colleagues, I was angry about, but there
8 was other people in the room with me. The one that
9 annoyed me was on the 9th January when I agreed to meet
10 Mr. O'Brien outside of the hospital. I facilitated 12:54
11 a meeting in his car when he was handing over the
12 outcome sheets and advised me of the letters in his
13 drawer. So I actually feel quite violated about that,
14 that a colleague would, on a one-to-one basis record me
15 because I don't know what he expected me to say or do. 12:54
16 The other three meetings, it's very obvious from
17 listening to them that there was an agenda of
18 Mr. O'Brien's because the meeting is steered to the
19 areas that he wanted to talk to us about.

20 276 Q. Okay. The Panel have those transcribed and they can 12:55
21 take a view on that.
22 A. Okay.

23 277 Q. But that's your view on what you consider to have
24 happened.
25 A. It is, yes. 12:55

26 278 Q. I just want to give a list of e-mail references to
27 either potentially what could be construed as breaches
28 of the action plan or compliance with the action plan
29 so the Panel have a note of that and the core

1 A. I don't know what I recall a specific reaction.
2 I don't think I was asking Mrs. Toal to do anything.
3 I probably have had that conversation in passing with
4 her to say this is what has happened. But no, I don't
5 recall any specific -- any specific comment or 12:35
6 conversation.

7 158 Q. Now, the 24th January meeting, the first meeting with
8 Mr. O'Brien. I think as a result of information
9 provided from the Inquiry, you have discovered that
10 that was recorded? 12:35

11 A. I have, yes.

12 159 Q. I think that was one of six meetings involving you that
13 were recorded. Can I just ask, you weren't aware then
14 in advance; there was no advice or --

15 A. No, there wasn't. 12:35

16 160 Q. -- consent sought from you around that?

17 A. No.

18 161 Q. Would it be unusual for people to record meetings, in
19 your experience, being an Employee Relations manager?

20 A. It is not unknown; it's not unheard of and I've had 12:36
21 colleagues who have had that experience. It's not
22 frequent but it's not -- it's not something we haven't
23 come across, I suppose, is what I would say to you.

24 162 Q. How did you feel when you discovered that these
25 meetings had been recorded? 12:36

26 A. I suppose it's a difficult one for me. I have to say
27 I was absolutely appalled, I suppose to the extent that
28 I returned them to the legal team unopened for quite
29 a substantial period of time. I didn't wish to read

1 them, I didn't wish to look at them. I actually felt
2 very -- it's a really odd one now again on reflection
3 for me, but where my thought process went immediately
4 on becoming aware of that, and I think I made it known
5 to the legal teams, I felt particularly vulnerable 12:37
6 around the 24th January meeting. I was a lone female
7 in a meeting with three male colleagues, three male
8 individuals. Bizarrely, I suppose, my thought process
9 went to was this a video recording, what is this
10 recording, who has this recording, where has it been 12:37
11 kept, who has been watching it. I didn't know. So,
12 those were all questions I had posed back through the
13 legal team at that time. I suppose that was the impact
14 that that had on me as a very immediate reaction. So,
15 I suppose it just describes just how appalled I was at 12:37
16 finding that out.

17
18 I suppose on reflection and over what has been quite
19 a period of time, and I ultimately did then go through
20 the transcript obviously in preparation for coming, 12:38
21 I think I was particularly taken aback probably given
22 who was in the room with me and the fact that, you
23 know, there are probably meetings where we suspect that
24 that may be -- you know, may be a feature and we are
25 looking out for it. This was a senior consultant, 12:38
26 a legally qualified support family member in the room.
27 I suppose I was just completely blind-sided by the fact
28 that this was something that would be done.

29 163 Q. The framework allows for the person accompanying

1 someone to a meeting - Mr. O'Brien's son on this
2 occasion - to be legally qualified, but I think the
3 phrase is not to act in that capacity at the meeting.

4 A. Yes.

5 164 Q. Was that your experience, that that -- just for the 12:39
6 purpose of the transcript. I know you are shaking your
7 head.

8 A. No, and I suppose I think I reflected that in my
9 reflections on MHPS. I think I've described it as
10 a distinction without a difference in practice. You 12:39
11 have somebody who is legally qualified coming in to
12 support an individual, in this case actually a close
13 family member which was, again, a further kind of, you
14 know, added complication to the process. But for me in
15 practice and my experiences, it legalises what should 12:39
16 be an internal employment process from the very outset,
17 which I don't believe is helpful.

18 165 Q. As I say, the other meetings that were recorded you had
19 with Mr. O'Brien, 9th February 2017, 30th August 2017,
20 6th November 2017 and 1st October. You said that you 12:40
21 couldn't look at those initially. Have you had the
22 opportunity to read through those subsequent to that?

23 A. Very recently, in fact. It has taken quite a while for
24 me to get to the point of opening those. I just
25 simply didn't want to open them. I felt that for me, 12:40
26 you know, to share them this length down the road was
27 entirely fruitless. I had absolutely no opportunity to
28 determine whether or not it was accurate or otherwise.
29 I suppose I struggled with that for quite a bit of

1 time. I think the thing for me as well is that had the
2 request been made, there were options to -- there were
3 options that -- it would have been something that would
4 not have been -- that would not have been dismissed.
5 We agree this, we do this quite regularly. We don't do 12:41
6 it all the time, again it's a capacity issue. If
7 somebody feels they want a particular hearing or
8 meeting recorded, we facilitate that, and that would
9 have been facilitated that had that request had been
10 made openly. I think it was the covertness and the 12:41
11 underhandedness of this that was really impactful on
12 me.

13 166 Q. If you could move on from that meeting, two days later
14 was the case conference on the 26th. Would you like to
15 take a break now or are you okay? 12:41

16 A. I'm okay.

17 167 Q. There was a meeting on 26th January 2017, the case
18 conference. In proportion for that you prepared
19 a report?

20 A. Yes. 12:42

21 168 Q. You've referred to that at WIT-42065, paragraph 18.13.
22 18.12, sorry, my mistake. You had got feedback from
23 Mr. O'Brien on the issues of concern at the meeting
24 we've just referred to. You say at that paragraph:

25
26 "It was evident that further and fuller investigation
27 of the matter was required. The meeting did not
28 provide sufficient assurance in respect of the
29 concerns". 12:42



Directorate, leading to reduced institutional memory over time; and (ii) the need to prioritise wider Departmental action; neither of which are unusual for a civil service Department.

38. The Department's Workforce Policy Directorate is in the lead on the policy going forward. The Chief Medical Officer's Group will actively contribute as the key Departmental advisory group on medical matters.
39. Subsequent to its introduction, there have been two separate, but ultimately unfinished reviews of MHPS, each led by the Department, but working with HSS bodies/HSC employers. As both of these reviews were unfinished and therefore unimplemented, no action has been taken by the Department in regard to amending MHPS.
40. The information in my statement in relation to the two reviews has come from a trawl of the Department's Content Manager system, using the keyword searches "MHPS" and "Maintaining High Professional Standards". The relevant documents found in this search will be provided to the Inquiry alongside this statement.

Commencement of the 2011–2013 MHPS Review ("the first review")

41. The first thoughts of a review of MHPS seem to have started in July 2009. The basis for the first review proper seems to have been a part of a Confidence in Care programme, led by the Department, as can be seen in an email chain at Appendix 3. Background to the Confidence in Care programme can be found in the Project Initiation Document at DH1/08/67646 and which is provided to the Inquiry at Appendix 3.
42. The email chain starts with an email from Victoria Colville in the Department's Pay and Employment Unit (a Branch within the then Human Resources Directorate) on 19 October 2010 advising the then Deputy Chief Medical Officer, Dr Paddy Woods, and a colleague in the Confidence in Care programme, Jane Lindsay, that the British Medical Association had asked that



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a paper be put together highlighting any issues that employers had with MHPS. The Inquiry will wish to note that Jane Lindsay is now known by her married name of Jane Kennedy and is National Head of the General Medical Council (GMC) Northern Ireland.

43. As to the reason for a review at that time, the Department recently, and in preparation for this statement contacted Jane Kennedy. She advised that there were two reasons for the review: (1) the GB version (see paragraph 20 above) had been updated, while the Northern Ireland version had not and (2) Medical Directors were feeding back that the process was 'clunky' and took too long, as it allowed legal representation for doctors at an early stage of the process, which caused significant delays in addressing the concern. A copy of this email exchange is provided to the Inquiry at Appendix 4.
44. On 19 October 2010, Jane Lindsay responded to Victoria Colville the same day to advise that *"Within the Confidence in Care Programme we have begun looking at MHPS with a view to a revised document that will reflect the changes to medical regulation, namely the role of the Responsible Officer and the implementation of a system of Revalidation"*.
45. A further email in the chain from Jane Lindsay on 21 October stated that *"We will be progressing this work in January - with the intention of gathering feedback on the current document more widely, developing a draft revision and consulting with our workstream members ...this includes the BMA and HR and Medical Directors, as well as internal HR colleagues"*.
46. A further email from Jane Lindsay to Victoria Colville of 12 April 2011 states that there was no update on the revision of MHPS but that it was expected to start work in June 2011. A further version of MHPS with suggested tracked changes made by Jane Lindsay was first saved into Content Manager on 15 July 2011, with a further version first saved into Content Manager on 2 August 2011. Refer to Appendix 5.



concerning its effective implementation, I must therefore rely on what has been reported to the Department by those organisations who have practical experience of its operation during these two unfinished reviews.

Issues identified in the first review

59. With regard to the first review, it has been difficult in the absence of personal recollection in the current staff of the Department to provide an outline of the challenges identified with MHPS in the first review. Current Departmental officials have reviewed the available papers on the Department's Content Manager system in an effort to address this point.
60. It would appear that the first review was taken as an opportunity to update the MHPS document: several versions of a draft MHPS document with tracked changes have been provided to the Inquiry by the Department. For example, the document "*MHPS in the 21st Century v2*" (provided to the Inquiry at Appendix 13) takes the opportunity to suggest the following amendments:
 - (a). Clarification over the treatment of adverse incidents;
 - (b). An update on good investigation practices;
 - (c). Updated definitions of roles and responsibilities in MHPS; and
 - (d). Clarification on steps in the MHPS decision-making process.
61. So far as we are aware, these suggestions appear to have been the thoughts of the reviewers at the time, responding to the issues mentioned by Jane Kennedy above.
62. The legal opinion of 29/3/11 from Paul Epstein QC was available to the reviewers. A copy of the legal opinion is provided to the Inquiry at Appendix 14. It appears to be a legal opinion that was provided to the then Department of Health in England in respect of its MHPS document. It discusses the following questions:



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- (a). Is MHPS automatically part of medical professionals' contracts of employment?
 - (b). Unfairness in the Employment Tribunal: Unfair Dismissal Claims.
 - (c). Particular parts and paragraphs of MHPS and Employment Tribunal fairness.
 - (d). Interim Relief.
63. If these issues were of note to the English Department of Health and its version of MHPS, then these would also have been issues for consideration in respect of the Northern Ireland version.
64. Provided to the Inquiry at Appendix 15, is a letter dated 12 September 2011 from Dr Paddy Woods (former DCMO) to Dr Anne Kilgallen (then Medical Director, Western HSC Trust) outlines the following:

"It was agreed that this [i.e. the revision of MHPS] presented an opportunity to refine the processes and guidance, incorporating lessons learnt from implementation of the current procedures, and from recent events. Initially several key issues have been highlighted requiring further discussion:

 - *separation of preliminary and extended investigation*
 - *definition of the specific role of the Medical Director*
 - *the role of NCAS*
 - *acceptance by HSC Trusts of rotational Trainees involved in disciplinary processes."*
65. Comments from P Flanagan of the Northern HSC Trust of 26 September 2011 (refer to Appendix 16) made a number of comments about the need for:
 - (a). User-friendliness of the document;



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- (b). Clarification on roles and responsibilities around doctors in training;
- (c). Consistent terminology;
- (d). Clarification on the content around formal and informal MHPS processes.

66. Provided to the Inquiry at Appendix 17 is an email from Jane Lindsay to, presumably, the MHPS review team of 15 November 2011 outlines the following:

“Our key aims in developing the framework are:

** Incorporate the learning from those who have used the processes and guidance in HSC organisations*

** Develop the guidance element of the framework to ensure it is fit for purpose, clear to follow and compliments existing organisational policies*

** Highlight the need to ensure robust recording when addressing concerns including decision made and how they were reached.*

** Stress the importance of reviewing investigations at key intervals*

** Ensuring that measures required to protect patients and the public are considered at the commencement and throughout an investigation, and reviewed to ensure they still address identified risks.”*

67. Provided to the Inquiry at Appendix 18 provides a copy of a note of the MHPS Working Group meeting of 18 November 2011 outlined the following points on the MHPS revision work:

- *Current revision of framework is too long and should focus on the formal and informal processes, investigations and roles and responsibilities.*
- *There is a degree of ambiguity in relation to roles and responsibilities when commencing an investigation and subsequent action if required. The role of*



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the Medical Director/Case Manager needs clarification; when should they be intimately involved in cases and when they should be made aware? Their role in relation to decision making is crucial, as is the obligation placed on them to accept and act on the findings of an investigation.

- *Separate section on managing concerns in relation to trainees may be helpful given potential for lack of clarity in relation to role of Employer and that of the Deanery & Responsible Officer. Issues arising where Deanery may have difficulty in securing a placement for a Trainee when there are concerns about his/her performance.*
- *There is a need to highlight the importance of organisational policies for performance management of all employees e.g. disciplinary, capability, health and describe their relationship to the Framework.*
- *Issues in relation to representation need to be addressed, including the consequences of delay arising from early legal representation.*
- *Access to appropriate remediation can prove challenging, and costly, for organisations.*
- *Importance of good management skills is crucial when addressing concerns, perhaps a need for training of senior clinicians in this area when Framework finalised.*
- *Need to define the use of the word investigation throughout the document. May imply formal process when at the beginning of the process we are trying to establish the facts in relation to the concern raised.*
- *Timescales in Framework require revision as often not achievable in practise.*
- *The narrative of processes in the Framework should capture any action taken prior to the formal raising of a concern e.g. the role of the critical friend in having a discussion with a colleague about a concern.*



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68. A copy of email dated 23 November 2011 from Dr Colin Fitzpatrick, is provided at Appendix 19, then lead NCAS adviser for Northern Ireland, to Dr Paddy Woods made the points that:
- *“MHPS would benefit from revision as experience since it was issued has identified a number of areas for improvement. However, we are concerned that awareness of the document and its provisions is not as widespread within HSC managers as we would have hoped. The experience of our advisors is that we frequently have to remind managers of the provisions and processes within MHPS”.*
 - *“A particular concern is the notification and review of exclusions as described in section II. We find that we are generally consulted before exclusion, although this may be after the trust has already made the decision. We are also concerned that regular reviews may not always occur, in particular the formal referral back to NCAS at the third review. I do not know whether the six month report to the Department occurs. It may be that we should have a discussion about how well this process is working.”*
69. Provided to the Inquiry at Appendix 20 is an email from Jane Lindsay to the MHPS working group of 27 January 2012 highlighted the following issue:
- *“At the last meeting of our MHPS working group we discussed the development of a section within the framework that specifically outlined managing concerns in relation to Trainees (see attached meeting note, point 3). The link below will take you to an operational framework developed by NES Scotland...”*
70. Provided to the Inquiry at Appendix 21 is a note of the MHPS Working Group of 8 February 2012 stated:
- *Current guidance requires simplification in relation to processes, timescales and constitution of performance panels. The role of the Medical Director in*



Urology Services Inquiry

the initial stages of an investigation requires clarification as they may be required to sit on a decision-making panel at a later stage.

- *The roles of the employer in ensuring practitioners are 'fit for purpose' and the GMC of ensuring 'fitness to practise' was discussed and key distinctions made. This should be clearer in the Framework.*
- *There are an increasing number of trainees with identified performance concerns requiring Deanery intervention, as well as correspondence from the GMC to the Deanery outlining required intervention for non-trainee medical staff. It was clarified the Deanery has no obligations to respond in relation to non-trainee staff but Margot felt the MOU with Conference of Postgraduate Medical Deans (COPMeD) may indicate otherwise. Margot undertook to share the MOU with Dr Woods.*
- *There was considerable discussion in relation to investigations and the importance of appropriately skilled investigators who have sufficient time to undertake the investigation. It was felt this was crucial to ensure timescales were met and that practitioners who had been excluded were able to return to practice (if appropriate) as soon as possible. The importance of separating investigation from decision making should be clearer in the Framework.*
- *Dr Kilgallen provided a flow chart outlining the key MHPS stages that provided a useful visual aid to the discussions. All agreed that the terms 'formal' and 'informal' in the Framework (used to describe processes and types of investigation) were not helpful and should be removed from the revision.*
- *The issue of legal representation and the implications this presents for a timely resolution to the concern was discussed.*
- *Challenges presented to organisations in relation to the rotational nature of trainees were discussed and it was agreed that if one organisation had*



Urology Services Inquiry

commenced a conduct/performance process with a trainee, they should not rotate to another Trust until the issue had been resolved. NIMDTA are currently revising their framework for the specific aspects of managing concerns in relation to trainees.

- *Presentational issues with the framework were discussed. The Framework will be further revised and circulated to members for comment. Dr Kilgallen will share the next revision with MD colleagues.*

71. Provided to the Inquiry at Appendix 22 is an email from Mervyn Barkley, Belfast HSC Trust, of 13 April 2012 to Dr Paddy Woods raised the following issue:

“The case of Lim v Wolverhampton Hospitals NHS Trust (2011), where the English High Court granted an injunction to prevent the Trust from convening/proceeding with a performance panel until the matter was referred to NCAS and until NCAS had advised that the dr's performance is so fundamentally flawed that no action plan would have a realistic prospect of success (see section IV para 7 of our version of MHPS). The court held that if the Trust proceeded in the absence of such advice from NCAS, it would be in breach of contract. This puts employers in a difficult position. You will know we have discussed the difficulties employers can have in arranging assessments. There can be circumstances, particularly in very small teams in which either the relationship between colleagues has broken down or where the safety concerns are such that we could not allow the practitioner to work or there is some technical reason that an assessment cannot be done in the practitioner's workplace that we have tried to arrange placement in other locations. I know from experience this has proved to be impossible in some cases and leaves both the practitioner and the employer in limbo. One way forward would have been to go straight to a performance panel which one way or another would have resolved the position; it would appear this option is closed off.”

72. Provided to the Inquiry at Appendix 23 is a letter of 15 January 2013 from Dr John Simpson, then Medical Director, Southern HSC Trust, to Jane Lindsay may be of interest to the Inquiry. It makes the following points:



Urology Services Inquiry

- “Referring to a Doctor’s entitlement to be accompanied by a companion, who may be legally qualified but he/she will not be acting in a legal capacity. In reality our experience is that as soon as an investigation is launched the doctor will contact the MDU (often directed by the BMA). The MDU will almost always engage with solicitors who will immediately start a chain of correspondence directly with the Trust HR Manager on the case. Although the doctor will be accompanied at hearing by the MDU, the representative is simply presenting the case on behalf of the solicitors. Therefore in reality the doctor is legally represented from the outset, with solicitors generating a lot of correspondence directly with the HR Managers throughout the investigation. As Trusts don’t generally involve their own legal advisors at an early stage in cases (unless warranted), this correspondence often has to be responded to by (non-legal) HR Manager working with the case investigator on the case.*
- The entitlement for the doctor to be accompanied by a Friend – is there any further guidance around the definition of “friend” as this is fairly vague/broad and could cover just about anyone provided they were not being paid for their assistance. If there was any further clarification on this, even confirming they cannot be paid would be helpful.*
- Timescales - Our experience of our MHPS investigations is that they are generally much longer than the suggested 4 weeks, given often the complexity and necessity to gather suitable evidence including patient records and seeking witness statements. I wonder if there is anything that can add flexibility here whilst maintaining the importance of completing it as quickly as possible – to avoid Trusts running the risk of possibly being criticised for taking much longer than 4 weeks?*
- Para 137 – Termination of employment with procedures incomplete - I feel it is important that this section is clear on the Trust responsibilities. We have recently experienced a number of doctors who left during a formal investigation under MHPS, reasons included temporary contract;*



Urology Services Inquiry

resignation; rotational junior doctor. In our experience, we completed the investigation but felt that it wasn't appropriate for the Trust to take any further action beyond this i.e. take to a clinical performance hearing or refer formally to NCAS given the doctor was no longer employed. In these cases, we had to consider the case and make a decision on referring the information to the appropriate body (i.e. GMC where doctor had left UK or moved to another Trust in UK and NIMDTA for doctor in training). Our legal advisors agreed that it would be very difficult for the Trust to take any different action in these cases. Undoubtedly Trusts should deal with all the concerns and complete the investigation wherever possible but I think it should be clear about the expectations of taking it further and reaching a final decision?/conclusion after they have left employment.

- *Disciplinary and Clinical Performance Hearings - Some of the case law around doctors and MHPS makes reference to independence of panels and I am wondering if there should be further guidance around this to protect Trusts?*
- *Disciplinary and Clinical Performance Hearings – Again some of the case law talks about legal representation in limited circumstances for doctors/dentists as the outcome of the case is argued to substantially influence an employee's right to work in their chosen career – will the revised MHPS provide any guidance on the application of case law on this issue.?*
http://www.medical1journals.com/index.php?option=com_content&view=article&id=219&Itemid=111 .
- *The document written by Paul Epstein from Cloisters is useful to consider in terms of the failings they see in the current MHPS document.*
<http://www.cloisters.com/news-pdf-downloads/maintaining-high-professional1standards-in-modern-nhs-2.pdf> . He refers to for example the lack of definition to be followed in pure conduct cases (which can vary



between employers particularly for gross misconduct) and how case law has therefore drawn comparisons with Part IV (clinical performance hearings)."

73. Provided to the Inquiry at Appendix 24 is a table from the Labour Relations Agency (seemingly from 27 August 2013) details some comments on the revised draft of MHPS. These largely relate to the drafting of the revised draft. However the following comment is of note:

[MHPS] "is much broader than any common or garden grievance procedure. The document must cross reference other professional codes of conduct and performance management systems as well as policies such as whistle-blowing in order to identify which takes precedence and whether or not they are "apt for incorporation".

74. The full suite of documents has been provided to the Inquiry. The twelve documents quoted in preceding paragraphs 60 to 73, seem to provide the most comprehensive list of issues encountered by the review team in the first review.
75. As to why the first review was not completed, the Department has asked Jane Kennedy for her recollection. She advises as follows:

"I think it was a capacity issue in DoH and the system- the new version would have required extensive negotiation with the BMA and we were already working with them to agree updated appraisal documentation to support the implementation of revalidation which was more urgent. It also would have required input from the Medical Directors and HR teams in Trusts – they were also working on preparedness for revalidation beginning "

Issues identified in the second review

76. With respect to the 2018 review, this began following an email from Damian McAlister, then HR Director of the Belfast Trust who wrote to Andrew Dawson, then acting Director of Workforce Policy at the Department of Health with respect to the practical application of the MHPS policy, asking *"that*



consideration be now given to a review of the documentation and its content”.

This exchange is provided to the Inquiry at Appendix 25.

77. Mr McAlister set out a position which suggested that *“while the clear intent of the guidance was being, and had been fulfilled by its operation over time he believed that in reality its practical application in parts had become more difficult.”* A particular concern of Mr McAlister was that the application of the MHPS framework was resulting in cases taking a long and unacceptable amount of time to progress.
78. He suggested a discussion about this at a forthcoming HR Directors’ Forum. Having consulted with Dr Paddy Woods, DCMO, the issue was discussed at a meeting of the HR Directors Forum on 12 February 2018. As the minutes of this meeting indicate, Andrew Dawson, then Acting Director of Workforce Policy at the Department agreed to write to Trusts to request an indication of any issues with the document which would then be forwarded to DCMO for review.
79. Responses were received from Northern, Southern and South Eastern Trusts, and the Business Services Organisation (BSO). The BSO attend the HR Directors’ Forum to represent the smaller HSC organisations. This exchange is provided to the Inquiry at Appendix 12.
80. Provided to the Inquiry at Appendix 12 are comments received from Paula Smyth, HR Director BSO on 5 April 2018, included input from a wide range of HSC colleagues. The BSO response noted that:
 - *“One of the major issues is the difficulty that currently exists around obtaining assessments from NCAS. The department is currently considering introducing a process of remediation for practitioners and are currently in discussions with NIMDTA regarding this.”*
 - *“Does not cover independent contractors. 90% of NI dentists are independent contractors”*



Urology Services Inquiry

83. Provided to the Inquiry at Appendix 12, Tracey Kane responded on behalf of Myra Weir, Director of Human Resources & Corporate Affairs at South Eastern Health & Social Care Trust, on 16 March 2018 and raised just two issues:
- *[MHPS is] “Cumbersome, too many people involved and too many layers which means the process is very lengthy & complex*
 - *Some of the timeframes are unrealistic (too short) given the number of people that need to be consulted”*
84. Provided to the Inquiry at Appendix 12, Gemma Lutton, responded on behalf of Elizabeth Brownlees, Director of Human Resources, Organisation Development and Corporate Communications at NHSCT on 16 March 2018 providing the general comments set out below:
- *“Does MHPS apply to Pharmacists – it is not references and if this is the case it needs to be clearer.*
 - *The general HSS terminology needs to be updated to HSC.*
 - *Clarification of the role of NCAS needed?*
 - *Clarification is required on the role of the Case Investigator when the Trust Disciplinary process is initiated. Normally the Investigating officer is also the presenting officer at the disciplinary hearing however under MHPS, the Case Investigator is purely a fact finding role. Should the presenting officer then be the Case Manager?”*
85. The responses received from Trusts highlighted a number of issues in regards to the policy, its implementation and application. The responses received would suggest three broad issues were identified by Trusts/BSO with respect to the 2005 MHPS Framework.
86. The most common issue raised related to how the framework operated, with a consensus view appearing to be that it took too long to move through the various steps of the MHPS framework. Related to this point, Trusts identified



that the requirements of the process were cumbersome with many of the timescales included within the framework being considered as too constrained or unrealistic.

87. Taken collectively, that would suggest Trusts considered a need to streamline the overall process or number of steps/stages within the framework but equally, be more realistic about the time needed to complete each stage.
88. The most substantial input received in response to the Department's request for input came from the Southern Health and Social Care Trust and this was the overarching theme of their response. The inputs received would have been provided after SHSCT had embarked on and completed the MHPS process with respect to Mr Aidan O'Brien. Mr O'Brien's specific case was not mentioned.
89. The second issue, or area for improvement, that Trusts have identified from reviewing the documentation relating to the limited 2018 review centred on a desire for greater clarity concerning roles, including the role of NCAS during the process; the role of the Case Investigator and the role of the Case Manager.
90. The third significant point raised centred on the coverage of the document in terms of which professional groups were considered to be in scope. The BSO pointed out that it did not include independent practitioners such as General Practitioners. One additional point worth noting here, and one which I would expect a future review of MHPS to consider, is the inclusion of whether MHPS should be extended to also include Pharmacists (not just Doctors and Dentists) directly employed by HSC organisations.
91. Unfortunately, but unavoidably, there was no further action taken after the responses had been submitted to the Department. It should be noted that due to the lack of a Northern Ireland Executive, the Department had no Minister at that time. The Department's Workforce Policy Directorate had to prioritise other matters, notably but not exclusively, a deteriorating industrial relations landscape centred on an inability to meet pay demands in the absence of Ministerial authority. While the industrial relations dispute was suspended in



Southern Health and Social Care Trust

Medical Directorate

15th January 2013

Our Ref: JS/AB/lw

Ms Jane Lindsay
DHSSPS
Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

Dear Jane

Revision of MHPS

Please accept apologies for the delay in responding. I have shared the draft paper with colleagues in Medical HR and would like to make the following comments:

- Referring to a Doctor's entitlement to be accompanied by a companion, who may be legally qualified but he/she will not be acting in a legal capacity. In reality our experience is that as soon as an investigation is launched the doctor will contact the MDU (often directed by the BMA). The MDU will almost always engage with solicitors who will immediately start a chain of correspondence directly with the Trust HR Manager on the case. Although the doctor will be accompanied at hearing by the MDU, the representative is simply presenting the case on behalf of the solicitors. Therefore in reality the doctor is legally represented from the outset, with solicitors generating a lot of correspondence directly with the HR Managers throughout the investigation. As Trust's don't generally involve their own legal advisors at an early stage in cases (unless warranted), this correspondence often has to be responded to by (non-legal) HR Manager working with the case investigator on the case.
- The entitlement for the doctor to be accompanied by a Friend – is there any further guidance around the definition of "friend" as this is fairly vague/broad and could cover just about anyone provided they were not being paid for their assistance. If there was any further clarification on this, even confirming they cannot be paid would be helpful.
- Timescales - Our experience of our MHPS investigations is that they are generally much longer than the suggested 4 weeks, given often the complexity and necessity to gather suitable evidence including patient records and seeking witness statements. I wonder if there is anything that can add flexibility here whilst maintaining the importance of completing it as quickly as possible – to avoid Trusts running the risk of possibly being criticised for taking much longer than 4 weeks?

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ

Tel: Personal Information redacted by the USI /Fax: Personal Information redacted by the USI /Email: Personal Information redacted by the USI

- Para 137 – Termination of employment with procedures incomplete - I feel it is important that this section is clear on the Trust responsibilities. We have recently experienced a number of doctors who left during a formal investigation under MHPS, reasons included temporary contract; resignation; rotational junior doctor. In our experience, we completed the investigation but felt that it wasn't appropriate for the Trust to take any further action beyond this i.e. take to a clinical performance hearing or refer formally to NCAS given the doctor was no longer employed. In these cases, we had to consider the case and make a decision on referring the information to the appropriate body (i.e. GMC where doctor had left UK or moved to another Trust in UK and NIMDTA for doctor in training). Our legal advisors agreed that it would be very difficult for the Trust to take any different action in these cases. Undoubtedly Trusts should deal with all the concerns and complete the investigation wherever possible but I think it should be clear about the expectations of taking it further and reaching a final decision?/conclusion after they have left employment.
- Disciplinary and Clinical Performance Hearings - Some of the case law around doctors and MHPS makes reference to independence of panels and I am wondering if there should be further guidance around this to protect Trusts?
- Disciplinary and Clinical Performance Hearings – Again some of the case law talks about legal representation in limited circumstances for doctors/dentists as the outcome of the case is argued to substantially influence an employee's right to work in their chosen career – will the revised MHPS provide any guidance on the application of case law on this issue.? http://www.medical-journals.com/index.php?option=com_content&view=article&id=219&Itemid=111.
- The document written by Paul Epstein from Cloisters is useful to consider in terms of the failings they see in the current MHPS document. <http://www.cloisters.com/news-pdf-downloads/maintaining-high-professional-standards-in-modern-nhs-2.pdf>. He refers to for example the lack of definition to be followed in pure conduct cases (which can vary between employers particularly for gross misconduct) and how case law has therefore drawn comparisons with Part IV (clinical performance hearings).

Yours sincerely

Personal information redacted by USI

Dr John Simpson
Medical Director

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ

Tel: Personal Information redacted by the USI /Fax: Personal Information redacted by the USI /Email: Personal Information redacted by the USI

Roberts, Naomi

From: Parks, Zoe [Personal Information redacted by the USI]
Sent: 15 March 2018 13:25
To: Hynes, Liz
Cc: Walker, Helen; Toal, Vivienne; Hynds, Siobhan; Mallagh-Cassells, Heather
Subject: Review of Maintaining High Professional Standards Policy.
Attachments: Maintaining High Professional Standards in the Modern HPSS.DOC; SHSCT - Review of MHPS Comments 15.3.18.docx; DRAFT SHSCT - Trust Guideline for Handling Concerns about Doctors Denti....doc

Liz,

Please find attached some comments from the Southern Trust. Please do not hesitate to contact me if you have any queries.

Many thanks

Zoë

Zoe Parks
Head of Medical Staffing HROD
Southern Health & Social Care Trust



[Personal Information redacted by the USI]

My working days are Tuesday-Friday



[Personal Information redacted by the USI]

(Internal: [Personal Information redacted by the USI] – prefix by [Redaction Code 4] if dialling from legacy telephone)

Blackberry

[Personal Information redacted by the USI]

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From: Ferguson, Katherine [Personal Information redacted by the USI]
Sent: 08 March 2018 13:31
To: jacqui.kennedy [Personal Information redacted by the USI]; Toal, Vivienne; Weir, Myra; 'McConnell Ann'; NIAS - Michelle Lemon; Paula Smyth
Cc: angela.muldoon [Personal Information redacted by the USI]; Mallagh-Cassells, Heather; PA to Eamon Molloy; Lorimer, Joelle; HR Secretary; Hana Russell; Dawson, Andrew; Bailie, Marc; Hynes, Liz; Wallace, Doreen
Subject: Review of Maintaining High Professional Standards Policy.

All

Following discussions at the last HRD Forum on the 12th February, the Department agreed to write to HSC Trusts to seek their comments and views on the issues and barriers arising from the above policy document.

I would be grateful if you could send these to me [Personal Information redacted by the USI] for collation prior to the details being forwarded to the CMO's office for consideration by CoP Friday 16th March.

Kind regards

Liz

Liz Hynes

HR Business Partner (Medical and Dental)

*Pay and Employment Unit, Workforce Policy Directorate, Department of Health
and The Board Liaison Group, (BLG), HSC Board*

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email: Personal Information redacted by the USI

email: Personal Information redacted by the USI

Mobile: Personal Information redacted by the USI

***Please note that I usually work for the DoH Monday - Thursday
and BLG on Fridays.***

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Southern Health & Social Care Trust IT Department Irrelevant redacted by the USI

Maintaining High Professional Standards

Comments from Southern Health & Social Care

Having had experience of working with the MHPS Framework the Southern Trust would be keen for the following comments to be considered as part of the review.

- **Ability to take quick, effective action**

It seems a reasonable expectation that Trusts should be able to take quick effective action where there are serious concerns about the misconduct or capability of medical staff. However the nature and complexity of the existing MHPS framework make this extremely difficult. One would expect a “framework” document to be a high level list of principles to guide local policies. However the fact that MHPS is almost 50 pages long makes the document far too prescriptive to act as a framework. In reality it often leads to many legal challenges and consequently cases derailed meaning they can sometimes take years to conclude. Trusts can also often fall foul of the procedures due to the many complexities contained regarding what needs to be done when, by whom - all within very tight deadlines.

The ability of the Trust to take certain decisions is also very limited in some cases. For example it is impossible to take a doctor to a clinical performance hearing unless is if first considered by NCAS and they (normally after having completed a lengthy NCAS assessment) have determined that the doctors performance is “so fundamentally flawed that no educational and/or organisation action plan has a realistic chance of success”. We have had experience of a doctor who clearly fell into this category and was subsequently dismissed from their post – however the case took us years to complete.

The ability to deal fairly but quickly and effectively with a clear case of an underperforming doctor is thus severely hampered by this requirement – particularly when issues arise early in employment given probationary periods are not a common feature in medical/dental contracts. MHPS also includes a recommendation of dealing with mixed conduct and capability issues via the capability route. This is not always helpful as we feel strongly that misconduct is clearly best dealt with through a misconduct route.

- **Achievable Timescales**

Despite extensive procedural requirements, MHPS sets timescales that Trusts can very rarely comply with. Timescales are dotted throughout the document in the context of investigations, exclusions and panels which require line by line attention and often are totally unachievable. This is also problematic when it is set within the context of the enormous list of senior officers required to participate, particularly on

capability and appeal panels with multiple external members required. The inclusion of legal representation throughout the process is also out-with what is afforded to all other NHS employees. Again the entitlement to professional legal representation throughout leads to many cases being delayed and disrupted by solicitor letters and legal argument.

It is important that Trusts can take quick, effective and appropriate action when there are serious concerns about a doctors' performance or conduct. Confidence and trust in the capability and conduct of our medical staff must be at the heart of everything that we do. The recent findings of Mr Justice O'Hara's report only serve to emphasise this. MHPS therefore needs to be reviewed urgently to ensure this remains an absolute priority and the aim should be for a procedure that is succinct, easy to interpret and proportionate to encourage frequent use for quick, early corrective or conclusive action. The Southern Trust has developed their own internal document to clarify and promote the informal stage – which is appended to this document for your information.

Roberts, Naomi

From: Toal, Vivienne <[redacted] Personal Information redacted by the USI >
Sent: 15 March 2018 13:52
To: Parks, Zoe; Hynes, Liz
Cc: Walker, Helen; Hynds, Siobhan; Mallagh-Cassells, Heather
Subject: Re: Review of Maintaining High Professional Standards Policy.

Liz

Can I also add to this that I have some difficulty with the role of the NED in MHPS cases - the document is not clear and at times we have got completely muddled as to what their role actually is and how far they can go when contacted by a doctor going through a process. I think this needs explored as part of any review.

Vivienne

Sent from my Samsung Galaxy smartphone.

----- Original message -----

From: "Parks, Zoe" <[redacted] Personal Information redacted by the USI >
Date: 15/03/2018 13:24 (GMT+00:00)
To: "Hynes, Liz" ([redacted] Personal Information redacted by the USI)" <[redacted] Personal Information redacted by the USI >
Cc: "Walker, Helen" <[redacted] Personal Information redacted by the USI >, "Toal, Vivienne" <[redacted] Personal Information redacted by the USI >, <[redacted] Personal Information redacted by the USI >, "Hynds, Siobhan" <[redacted] Personal Information redacted by the USI >, "Mallagh-Cassells, Heather" <[redacted] Personal Information redacted by the USI >
Subject: Review of Maintaining High Professional Standards Policy.

Liz,

Please find attached some comments from the Southern Trust. Please do not hesitate to contact me if you have any queries.

Many thanks

[redacted] Personal Information redacted by the USI

Zoe Parks
Head of Medical Staffing HROD
Southern Health & Social Care Trust



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Blackberry [redacted] Personal Information redacted by the USI

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for some improvement on the part of Mr O'Brien since his return to work in early 2017); and in part the recommendation in respect of a review was overtaken by Dr O'Kane and Mr Devlin's Champion Review⁹⁹.

- f. On one reasonable view¹⁰⁰, the MHPS process provided a false sense of security in that, because of its focus on the 4 areas mentioned above, it provided a false reassurance that there were no issues in Mr O'Brien's clinical practice whereas, as became evident from the issues that came to a head in 2020 (with which Chapter 5 is concerned), such issues did exist.
- g. Finally in this regard, it is important to note that many of the structural problems with the MHPS system more broadly, as well as having been exposed in the corpus of evidence heard by the Inquiry between Day 20 and Day 39, had already been highlighted in consultation responses by the Trust (and by other Trusts) to the Department in each of 2011 and 2018¹⁰¹.

4.40 The Julian Johnson SAIs (in respect of Patients 11 to 15) were triggered by the SAI¹⁰² in respect of Patient 10 and the investigations carried out in late 2016 to ascertain if there were other cases like that of Patient 10. Whilst the Patient 10 SAI arose out of an IR1 in January 2016, was able to feed some of its learning back to the Trust to be factored into decision-making regarding Mr O'Brien in late 2016, and was completed by March 2017, the other 5 related SAIs took too long to be completed¹⁰³. That said, whether they ultimately added significantly to what was already known about (or being done to address) deficits associated with Mr O'Brien is debatable.

⁹⁹ WIT-46954; See the written evidence of Dr O'Kane at WIT-44995 para 8..

¹⁰⁰ Articulated, for example, by Maria O'Kane in her evidence at TRA-11620.

¹⁰¹ See WIT-42399 to WIT-42401, WIT-42998, WIT-43009 to WIT-43031, TRA-03410 from line 24, for some of the material on this.

¹⁰² PAT-000001 to PAT-000011.

¹⁰³ They were not signed off until 22 May 2020 – see TRU-161175.



consideration by CoP Friday 16th March". This exchange is provided to the Inquiry at Appendix 11.

54. The deadline appears to have been extended as responses were received from the Northern, Southern and South Eastern Trusts, and the Business Services Organisation, over a period up to 5 April 2018. All relevant correspondence is provided to the Inquiry at Appendix 12.
55. Unfortunately, it does not appear that any further work was carried out in pursuance of the second review. Like all senior civil service posts in the Department, the Human Resources/Workforce Policy Director has a very wide remit and must constantly prioritise the matters on which they devote their time and attention, and that of their subordinates. The Directorate faces many competing priorities including, issues of pay, terms and conditions, industrial relations dispute resolution, commissioning of pre-registration training, workforce planning, development and implementation of strategies and even the management of the Department's public appointments programme.

Issues reported to the Department regarding MHPS

56. Paragraph 9 of the Inquiry's Section 21 notice asks: "*With regard to the implementation and application of the MHPS Framework generally, what challenges have been identified by the Department concerning its effective implementation in practice? What action has been taken by the Department to address same? What future action may be required to, if necessary, strengthen the policy?*"
57. As outlined above, two separate reviews of the policy commenced in 2011 and 2018 respectively. Ultimately these reviews did not proceed to a conclusion and no changes were made to the MHPS Framework.
58. The Department has only a limited role in the application of MHPS and therefore limited direct knowledge of how HSC employers operate it in practice, beyond what was identified in the two unfinished reviews. In identifying issues