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Root Cause Analysis Report on the investigation of a Serious Adverse Incident

Organisation's Unique Case Identifier: Personal Information redacted by the USI

Date of Incident/Event: 2012-2014

HSCB Unique Case Identifier: Personal Information redacted by the USI

Responsible Lead Officer: Mr Anthony Glackin

Designation: Consultant Urologist

Report Author: Review Team

Date report signed off: 02/09/2015

Date submitted to HSCB: 02/09/2015

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

1.0 EXECUTIVE SUMMARY

In August 2012 aged 64 Patient 128 underwent right radical nephrectomy for renal cell carcinoma. Histology revealed a Fuhrman Grade III tumour. Follow-up management plan included regular CT scans and clinical reviews. Patient 128 was reviewed in February 2013. At this time a CT scan was arranged for May 2013, this was to be followed by a clinical review in June 2013.

Patient 128 did have a CT scan in May 2013 as arranged but was not reviewed in June. On 20th August 2014, concerned that Patient 128 might have recurrent disease, Patient 128's GP referred Patient 128 back to the Southern Trust Urology Service. Metastatic recurrence was identified on CT scan.

2.0 THE INVESTIGATION TEAM

Names	TITLES
Anthony Glackin	Consultant Urologist (Chair)
Simon Gibson	Assistant Director Medicine
Katherine Robinson	Booking and Contracts Centre Manager
Paula Fearon	Governance Support

3.0 INVESTIGATION TERMS OF REFERENCE

Terms of Reference for the Serious Adverse Incident Investigation are as follows:

- To carry out a review into the care provided to Patient 128, from June 2012 until September 2014 using the National Patient Safety Agency Root Cause Analysis methodology
- To use a multidisciplinary team approach to the review
- To provide an agreed chronology based on document evidence and staff accounts of events.
- To identify the key contributory factors which may have had an influence or contributed to Patient 128's treatment and care
- To ensure that recommendations are made in line with evidence based practice.
- To set out the findings, recommendations, actions and lessons learnt in an anonymous report
- To adhere to the principles of confidentiality throughout the review.
- To report the findings and recommendations of the review through the Director of Acute Services SHSCT to the staff associated with this incident
- To share the Report with Patient 128

This investigation will adhere to the principles contained within the National Patient

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Safety Agency (NPSA) Policy documents on "*Being Open – Communicating Patient Safety Incidents with Patients and their Carers*".(Appendix 2)
http://www.npsa.nhs.uk/site/media/documents/1456_Beingopenpolicy111.pdf

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The Team applied the NPSA Root Cause Analysis methodology in order to analyse the care given to Patient 128

Review of Records

The review team analysed the following records associated with the case:

- Medical Notes
- Nursing Notes
- Radiology Reports

Discussions with relevant staff

The Investigation of Patient Administration System

Review of Relevant Reports, Procedures, Guidelines

- Serious Adverse Incident Report

The review team also considered the following:

http://www.dhsspsni.gov.uk/serviceframeworkforcancerpreventiontreatmentandcarefulldocument.pdf

Northern Ireland Referral Guidance for Suspected Cancer – Red Flag Criteria Issue date: December 2012
Source: NICE Referral Guidelines for Suspected Cancer; 2005 http://publications.nice.org.uk/referral-guidelines-
for-suspected-cancer-cg27 http://primarycare.hscni.net/

National Cancer Team (2010) Cancer peer review report-Northern Ireland Cancer Network (2010)

http://www.dhsspsni.gov.uk/transforming-your-care-review-of-hsc-ni-final-report.pdf

http://www.macmillan.org.uk/Documents/AboutUs/Research/Researchandevaluationreports/Macmillan-Census-Report-Northernireland.pdf

National Cancer Peer Review Northern Ireland Cancer Network SEPTEMBER 2010
Portland House Bressenden Place London

http://www.macmillan.org.uk/Documents/AboutUs/Research/Researchandevaluationreports/Macmillan-Census-Report-Northernireland.pdf (2014)
(2014)
http://www.northernireland.gov.uk/index/media-centre/news-departments/news-dhssps/news-dhssps-070115-publication-of-the.htm (FEB 2015)

http://www.ncsi.org.uk/what-we-are-doing/risk-stratified-pathways-of-care/

http://www.ncsi.org.uk/wp-content/uploads/howtoguide.pdf

http://www.macmillan.org.uk/Aboutus/Healthandsocialcareprofessionals
/Macmillansprogrammesandservices/RecoveryPackage/RecoveryPackage.aspx

5.0 DESCRIPTION OF INCIDENT/CASE

On 13th June 2012 Patient 128 presented to ED with central abdominal pain and frank haematuria and was referred to the Haematuria Clinic Daisy Hill Hospital. Patient 128 was prioritised as an urgent referral and underwent a diagnostic endoscopy of bladder and

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ultrasound of urinary tract on the 4th July 2012. The ultrasound report stated "No focal defects noted in the liver and spleen. The left kidney and bladder appeared normal. There is a large right renal mass measuring 13.6 x 9.1 cms". The right renal tumour was evident on CT scan of urinary tract (13/07/12) and Renal CT (24/07/12). Renal function assessed by NM Renal DMSA (01/08/12) highlighted a reduction in renal function in the right kidney. There was no evidence of metastatic disease on bone scan (10/08/12).

Dr 1 (Consultant Surgeon) referred Patient 128 to Dr 2 (Consultant Urologist) for surgical management (14/08/14). Following pre-operative assessment and work up Patient 128 was admitted to Craigavon Area Hospital for surgery. Dr 2 performed a right radical nephrectomy (29/08/12), the tumour was adherent to the liver and extended posteriorly to the duodenum. Surgery was complicated by a tear in the vena cava, there was extensive intra-operative bleeding. Patient 128 was transferred to Intensive Care Unit (ICU) following surgery and recovered well, returning to the Ward on 31/08/12 and was discharged on 6th September 2012.
Patient 128's case was discussed at the Multi-disciplinary Team Meeting (MDM) on 6th September 2012. Histology reported features of a conventional clear cell adenocarcinoma, this extended through the renal capsule to involve perinephric fat. The tumour was staged as pT3a Furhman Grade III tumour. The MDM management plan recorded Patient 128 was to be reviewed by Dr 2, have further CT scanning in November 2012 and subsequent MDM discussion.

Patient 128 was reviewed by Dr 2 on 15th September 2012, and a CT request was completed electronically for imaging to be carried out in November 2012.
The CT scan was carried out on 17th January 2013.The radiology report was as follows:

CT Chest and abdomen and pelvis with contrast at 13:38
Clinical history: *Right radical nephrectomy in August 2012 for PT3b renal cell carcinoma.*

Technique: *CT chest, abdomen and pelvis performed following oral and intravenous contrast. Comparison made with previous CT scan examination of 24/07/2012.*

Findings

Lungs are clear. No mediastinal lymphadenopathy seen. Liver show four no. focal lesion. Stones are seen in the gallbladder. Spleen and pancreas appear normal. Right kidney is surgically absent. Prominant subcentimeter lymph nodes are seen in the renal hilar region and potrahepatis region. Left kidney show no focal lesion. Normal urinary bladder. No uterine lesions seen. The pyloric antrum is apparently thick walled. This is nonspecific and could be due to collapse lumen. Clinical co-relation suggested.

Multilevel degenerative changes are seen in the spine.

Conclusion: *Subcentimeter lymph nodes in the right renal hilar/portahepatis region. No metastasis seen.*

Patient 128 was reviewed by Dr 3 (Consultant Urologist) on 8th February 2013 and a further

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CT scan was requested electronically for May 2013, with review planned for June 2013.
Patient 128 had a CT scan of chest abdomen and pelvis on 16th May 2013. The radiology report was as follows:

CT Chest and abdomen and pelvis with contrast at 15:16CT chest, abdomen and pelvis performed following oral and intravenous contrast.

Comparison made with previous CT scan examination of 17/01/2013.

Findings: *Lungs are clear. No hilar or mediastinal lymphadenopathy seen.*

Liver show no focal lesion. Stones seen in the gallbladder. Spleen and pancreas appear normal. Right kidney is surgically absent. Prominent sub centimeter lymph node in the right renal hilar/porta hepatic region but is not significantly enlarged according to size criteria. Left kidney show no focal lesion. Normal urinary bladder. No uterine lesion seen. Diverticular seen in the sigmoid colon. Multilevel degenerative changes are seen in the spine.

Conclusion: *No metastasis or significantly enlarged lymph nodes are seen.*

Radiological reports need to be interpreted within the clinical context and may require discussion and explanation with the patient to avoid misunderstanding.

Patient 128 was next seen on 26th August 2014 in response to a letter received from Patient 128's GP requesting a review as Patient 128 had been "lost to follow up" and now presented with symptoms suggestive of metastatic disease. The patient was noted to have weight loss and fatigue and severe iron deficiency anaemia.
A CT scan on 1st September 2014 revealed multiple abnormalities consistent with local recurrence and metastatic renal cell carcinoma. The report was as follows:

CT Chest and abdomen and pelvis with contrast 11:39

CT chest, abdomen and pelvis performed following oral and intravenous contrast.
Comparison made with previous CT scan examination of 16/05/2013.

Findings

No lung mass lesion seen. There is no hilar or mediastinal lymphadenopathy.

Right kidney is surgically absent. Large perideudenal/mesenteric enhancing mass seen.

6x3.4 cm enhancing, retrocaval mass seen on the medial aspect of liver. Multiple irregular hypodense lesion seen in the segment VI of the liver, the largest measure 6cm in size. Stones seen in the gallbladder. Spleen and pancreas appear normal. Left kidney show no focal lesion. Urinary bladder is empty. No uterine lesion seen. Diverticular disease seen in the sigmoid colon. Multilevel degenerative changes are seen in the spine.

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Conclusion

Recurrent disease.

1. Large perideudenal/mesenteric mass which appear to involve/projecting into the lumen of deudenum. Endoscopy/barium meal examination suggested for further evaluation.

2. Large retrocaval mass on the medial aspect of the liver.

3. Large metastasis in the segment VI of the liver.

Patient 128's care was discussed at the Urology MDM on 4th September 2014. At that meeting a review by Dr 2 was arranged and a direct referral to a Consultant Oncologist (Dr 6) was made for consideration of further management.

Patient 128 was reviewed by Dr 2 on 5th September 2014 and was advised of CT scan results at this time.
Patient 128 was admitted for investigation under Dr 5 (Consultant Urologist on call) on 6th September 2014. During this admission Patient 128 had blood transfusion and a diagnostic OGD and biopsy (09/09/14) which confirmed renal cell carcinoma. Patient 128 was discharged home on 10th September 2014 for oncology review at Belfast City Hospital and for review with Dr 2 at CAH.
Patient 128 was reviewed on 16th September 2014 by Consultant Oncologist (Dr 6) at BCH Oncology clinic.

6.0 FINDINGS

Management 13th June 2012- 6th September 2012
The Review Team is satisfied that Patient 128's initial diagnostic investigations and subsequent surgical intervention were appropriate, timely and met Cancer Guidelines.

When it became apparent that Patient 128 required a nephrectomy Dr 1 (Consultant Surgeon) transferred Patient 128's care to Dr 2 (Consultant Urologist) who specialises in this surgery. Transfer and pre-operative support were carried out correctly. The Review Team noted surgery (29/08/12) was difficult as there was hilar lymph node disease.
Patient 128 was first discussed at a Urology Multi-disciplinary Team Meeting (MDM) after surgery (06/09/12). The Review Team is aware this is neither unusual nor unreasonable.
Patient 128's history, surgery, imaging and histology findings were discussed during MDM so that an appropriate management plan of care could be determined. It was agreed that Patient 128, who was discharged from hospital that day, should be reviewed by Dr 2 who would arrange further CT scanning in November 2012 after which Patient 128's case would again be reviewed at MDM.
Although Patient 128's discharge letter was not dictated until the following April (03/04/13), a letter containing the MDM discussion (6/09/12) and management plan was sent to Patient 128's general practitioner (GP) which invited the GP to make contact if further information was required. The Review Team are satisfied that in this instance relevant information was issued to Patient 128's general practitioner through the MDM Report. The

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Review Team are of the opinion however that it is good practice for a discharge letter to be sent to the GP within a few weeks of patient discharge.

Post-operative Review

Dr 2 reviewed Patient 128 two weeks after surgery (15/09/12). A CT scan was requested on this date to be carried out in November 2012, prior to further discussion at MDM. The Review Team accept this was clinically appropriate.

A GP letter was not generated from this appointment. It is the opinion of the review team that the patient's GP should receive a summary letter following each outpatient appointment.

Request for CT scan November 2012

Dr 2 completed an electronic CT scan referral on 15/09/12. The request specified November 2012. The scan of chest, abdomen and pelvis was not undertaken until 17th January 2013.

The Review Team ascertained that delays of up to 13 weeks were common at this time as the Radiology Department did not have the capacity to process the volume of requests received within the requested timeframes. The Review Team are of the opinion that the six week wait for this CT scan was acceptable and did not adversely impact on Patient 128's follow-up.

Review 8th February 2013

Patient 128 was reviewed by Dr 3 (Consultant Urologist) on a shared clinic code. Clinical codes are generated by each Trust and indicate the specific location, consultant and activity of the clinic. If clinic codes are shared between consultants it is not possible to identify which consultant is ultimately responsible for each patient. The clinic letter to the patient's GP stated the patient was well on review. Although recurrence of renal cancer was not detected, Dr 3 advised that in view of the high risk of recurrence, serial scans were required. Dr 3 confirmed booking a further scan for May 2013 with next review in June 2013.

The Review Team accept that the intention to scan at intervals was appropriate given Patient 128's histology findings and agree it was appropriate to book a further scan for May of that year. Dr 3 indicated Patient 128 would be reviewed in June 2013. The Review Team agreed the timing of this was acceptable as it would allow for the CT findings to be received.

The CT scan was carried out on 16th May 2013. At this time the Trust protocol was that the report which was generated on 17th May 2013 should be sent by hardcopy to Dr 3's secretary for action by Dr 3. The review team could find no record of the CT report of the 16th May 2013 being signed off or actioned in the clinical record.

Dr 3, the consultant who had requested the scan, had left the Trust before the result was generated. An arrangement had not been made to forward such results to another consultant. There had been no formal transfer of cases nor was there a system in place to generate "results worklists" through which outstanding results can be readily visualised and actioned.

Review arrangements for June 2013

Patient 128 was placed on the out-patient review waiting list in use on 8th February 2013. This list did not separate oncology from non-oncology patients. Specific Uro-oncology waiting lists were introduced from mid- February 2013. The Uro-oncology lists were created to provide outpatient sessions specifically for oncology patients. It was

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envisioned this initiative would help to alleviate the recognised delays in Uro-oncology review waiting times, which were of concern to clinicians. Patient 128 was transferred to the appropriate Uro-oncology waiting list before the intended review date of June 2013. Unfortunately, despite the creation of the aforementioned clinics the waiting list remained long. The Review Team have established that it was likely that Patient 128 would not have been called for review until December 2014.

Discussion

The Review Team has considered if robust handover arrangements and results worklist as discussed above (Review 8th February 2013) may have afforded opportunities for Patient 128 to be prioritised for an earlier review.

There is an ongoing regional capacity deficit for Uro-oncology review. At present some consultants actively prioritise "high risk patients" that is patients who are at risk of recurrence and manually prioritise their review date from the computerised waiting list. It is acknowledged that the traditional model of cancer patient review is inefficient and unsustainable (Department of Health 2011). A new model of care for cancer survivors which incorporates a "risk stratification" process to tailor follow-up to the level of care required for the individual; and which takes account of the disease process, treatments and the patients' ability to self-manage has been developed (http://www.ncsi.org.uk/what-we-are-doing/risk-stratified-pathways-of-care/risk-stratification/).

The "Recovery Package" is incorporated into the Regional Transforming Cancer Follow Up" (TCFU) initiative which is being advanced strategically by the Health and Social Care Board in partnership with Macmillan (http://be.macmillan.org.uk/be/s-689-recovery-package.aspx.). It is recognised that the roll out and sustainability of this strategy is dependent on adequate numbers of Clinical Nurse Specialist (CNS) in adult cancer being trained and in post. There is a lack of such CNSs regionally; this is hampering the implementation of TCFU in some specialities (Northern Ireland Cancer Network 2010). A recent census has revealed that with the exception of .6 whole time equivalent CNS for prostate cancer, there are no CNSs specifically for Uro-oncology within Northern Ireland (Macmillan 2014). The Review Team is of the opinion that addressing this deficit in conjunction with implementing a risk stratified model of follow up has the potential to address the current recognised capacity issues which exist in Uro-oncology review.

Communication with Patient 128 regarding pathology and planned follow up post-surgery.

Dr 3's outpatient letter to Patient 128's GP (08/02/13) indicated assurance was given to the patient that there was no evidence of cancer recurrence on that specific date of review (08/02/13). From the medical notes it is unclear what information had been given to Patient 128 regarding diagnosis, follow-up, potential treatments and prognosis. Neither the MDM record of 06/09/12 nor the letters to Patient 128's GP from Dr 2 (dictated 03/04/13) or Dr 3 (dated 08/02/13) indicate what discussions took place with Patient 128.

Discussion

Clear communication with the patient is an integral aspect of cancer care and follow-up. In order to ensure this is effective it is important that practitioners are aware of the

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discussions which have already taken place with the patient so that further communication can be undertaken in a meaningful way. It is also recognised that anxiety can reduce the patient's ability to absorb information. For these reasons it is recommended that a written record of communications is documented within the patient's care record, offered to the patient and copied to the general practitioner; with a detailed treatment summary provided at the end of treatment (National Cancer Survivorship Initiative (NCIS) 2012).

Overarching Standard 21 of the Northern Ireland Cancer Services Framework (2009) states that all cancer patients within Northern Ireland should be assessed by a Clinical Nurse Specialist (CNS) at the time of diagnosis, throughout the cancer journey as necessary and at the end of every treatment stage. As indicated above there are no Uro-oncology CNSs in Northern Ireland. The review team are aware that the concept of Key Worker –that is a 'person who, with the patients' consent and agreement, takes a key role in co-ordinating the patients care and promoting continuity, ensuring the patient knows who to access for information and advice' (NICE, 2004) - is embedded in some cancer specialities within the Southern Trust and that this role is usually undertaken by the CNS. A Key Worker was not identified in Patient 128s Care Records. The Review Team cannot speculate if an identified CNS or Key Worker might have identified Patient 128 for earlier review, however concede the development of this role is central to effective and efficient follow up.

Presentation/Referral August 2014

A faxed referral from Patient 128's GP was received by the Trust on 20th August 2014 raising concerns regarding potential metastatic disease. The Review Team are of the opinion that Patient 128's management plan from this point on has been in line with Cancer Guidelines.

7.0 CONCLUSIONS

This SAI investigation was undertaken to investigate why a follow up patient review which was planned for Patient 128 at the Southern Trust Urology Service in June 2013 did not take place. The review team have concluded that the systems and processes in place for organising follow up appointments were followed. Patient 128 was placed on the correct waiting list for review; however, there was an on-going issue with capacity and demand for this service. Uro-oncology Review Clinics were established to address this in February 2013 however the wait for review remains lengthy. The Review Team have established that Patient 128 would not have been called for review from the newly created waiting list until December 2014 by which time Patient 128 had already been re-referred with symptoms of metastatic disease.

8.0 LESSONS LEARNED

There is a "capacity and demand" issue in regard to follow-up review appointments scheduled for the Uro-oncology Review Clinic Service in the Southern Trust. The numbers of patients, who require review, outnumber the number of appointment slots available to review them at the requested interval. This imbalance has resulted in

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8.0 LESSONS LEARNED

patients being placed on waiting lists for review.

The Uro-oncology waiting list does not stratify the patients with regard to risk of recurrence, or identify those who need to be seen as a priority. There was no formal patient handover arrangement undertaken prior to Dr 3 leaving the Southern Health and Social care Trust. Handover presents an opportunity for the consultant who is leaving to highlight patients who require review in advance of the chronological waiting list schedule. The review team stress formal handover can enhance communication and patient safety but does not negate the need to address the root cause of waiting lists.

All radiology reports require sign off by the responsible clinician, usually a consultant. This provides an opportunity for the individual patient's management plan to be reviewed and altered or actioned if warranted. Due to the lack of formal handover arrangements for Dr 3's caseload this opportunity was lost.

There was a delay in dictating Patient 128's discharge letter post-surgery. In order to enhance seamless care it is important that all relevant information is communicated to primary care/the patient's GP as quickly as possible post patient discharge.

It was not possible to determine from the medical notes the detail of the information Patient 128 had been given regarding cancer diagnosis, follow-up and prognosis. A communication record and named Key Worker are recommended for all cancer patients within Northern Ireland. This facilitates the sign posting of patients so that they can be seen appropriately and in response to changing need as required during follow-up.

9.0 RECOMMENDATIONS AND ACTION PLANNING

Summary of Recommendations

1) The Review Team recommends a robust system for managing overdue Uro-oncology review is established.
2) A handover of patient caseload is required before a consultant leaves the trust. This arrangement must be formalised and robust.
3) All radiology reports must be actioned if required and signed off by an appropriate person.
4) A timely discharge letter should be dictated for every Urology patient.
5) The review team recommends a communication record is designed and instigated for use with Uro-oncology patients and named Key Worker

Table of analysis, recommendations and Action Planning

Summary of Analysis/Findings	Recommendation	Action Planning	Lead	Timeframe
The Urology	A robust system	Designated		Complete

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9.0 RECOMMENDATIONS AND ACTION PLANNING				
Service has a number of Oncology patients who are not being reviewed at the required intervals	must be developed to ensure Urology Oncology patients are reviewed in a timely manner	Urology Review Clinics with specific Oncology Consultant Codes Capacity-Nurse led follow-up for suitable Urology Oncology patients- advance in conjunction with NICaN Guidance	 Martina Corrigan Head of Service ENT Urology and Outpatient Department	 In line with regional progress
The patient caseload of a Consultant leaving the Trust employ is not automatically transferred to another appropriate Consultant within the Trust Clinic codes had been allocated to more than one Consultant which made it difficult to identify caseloads	Robust handover arrangements must be put in place to ensure patients are transferred from a Consultant who is leaving to a suitable Consultant still within the Trust employ Each Consultant should have an exclusive clinic code	The Southern Trust should develop a Policy for Caseload Transfer A task and finish group should be convened to advance this All Urology Consultants have individual tracking codes.	Assistant Directors	3 months Complete
The CT scan of 16th May 2013 was not signed off or actioned by a Consultant.	A mechanism must be put in place to ensure all radiology reports are seen, actioned and signed off by an appropriate person.	NIECR sign off is available. A task and finish group to be set up to undertake work list sign off for all results	Janette Robinson Head of Service for Diagnostics	3 months

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9.0 RECOMMENDATIONS AND ACTION PLANNING				
	Use of facilities on Northern Ireland Care Record (NIECR) is recommended			
There was a delay of 8 months in dictating Patient 128's discharge letter. Information regarding Patient 128's surgery and follow up was however contained within the MDM letter sent to GP.	Discharge letters must be timely. A timeframe for issue of discharge letters should be agreed by the Urology service.	Timeframe for discharge letters to be determined. Barriers, if any to achieving this should be identified and addressed.	Martina Corrigan Head of Service ENT Urology and Outpatient Department	3 Months
it is good practice for a letter to be sent to the GP within a few weeks of every outpatient appointment	Outpatient letters must be timely. A timeframe for issue of discharge letters should be agreed by the Urology service and monitoring process put in place	Timeframe for outpatient letters to be determined. Barriers, if any to achieving this should be identified and addressed.	Martina Corrigan Head of Service ENT Urology and Outpatient Department	
It was unclear from the patient's records the detail of information shared regarding cancer diagnosis prognosis and follow-up.	It is important that a record of consultation is maintained following a patient being given a cancer diagnosis. This should be contained within the care record and the patient offered a copy	Advanced Communication Training for those imparting information- Urology Consultants A task and finish group to be set up to design and implement a communication record.	 Mr Tony Glackin Consultant Urologist	Complete 3 Months
The concept of Key Worker is accepted as an integral aspect of cancer follow-up.	It is recommended that named Key Workers are identified for Uro-	The Trust must continue to work with Northern Ireland Cancer Network	Fiona Reddick Head of Service Cancer	

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9.0 RECOMMENDATIONS AND ACTION PLANNING

Key Workers have been established for some cancer specialities but not others. A Key Worker was not identified for [Patient 128].	oncology patients It is imperative that a Key Worker is identified for every cancer patient to ensure continuity of care.	(NICaN) to ensure equitable services for all cancer groups.	Services and Martina Corrigan Head of Service ENT Urology and Outpatient Department	

10.0 DISTRIBUTION LIST

Following SMT approval the report will be:

- forwarded to the HSCB
- shared with [Patient 128]
- shared with relevant staff to take forward learning.

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Timeline SAI 36624

Date	Time	Event
13/06/12		Referral to Surgical Assessment Unit, Haematuria clinic by Emergency Department XR abdomen and chest
15/06/12		Haematuria clinic Dr 1 (Consultant Surgeon) Added to waiting list GP suspect cancer, **priority**: urgent
04/07/12		Admitted as a day case under Dr 1. Exam: diagnostic endoscope Neoplasm of uncertain or unknown behaviour: Kidney CT scan booked on MDM Urology.
04/07/12	10.08	**US Urinary Tract** No focal defects noted in the liver and spleen. The left kidney and bladder appeared normal. There is a large right renal mass measuring 13.6 x 9.1 cms. Urgent CT referral advised.
13/07/12	13.45	**CT Urinary Tract**
24/07/12	15.27	**CT Renal Tumor Protocol Study.** CT Renal with contrast. Both Kidneys **Indication:** Large right renal tumour. Query metastasis. **Findings:** Right renal tumour is again demonstrated. This arises from the upper pole of the right kidney, and has a maximum diameter of 11 cm and contains a central low density area, possibly necrotic. There is a solitary right renal artery. There is no convincing evidence of any tumour thrombus within the right renal vein or inferior vena cava. **Conclusion:** There is no evidence of any metastatic deposits.
01/08/12	13.50	**NM Renal DMSA** **Conclusion:** Only small functioning part of the right kidney is still seen in its lower pole and markedly reduced split renal function of the right kidney
10/08/12		NM Bone whole body 14:47 **Conclusion:** No evidence of bony mets.
14/08/12		Ref from Dr 1 to Dr 2 (Consultant Urologist) - Urology Clinic, priority – urgent
17/08/12		Patient attended Dr 2 pre op assessment clinic (nurse led)– patient fit eGlomerular Filtration Rate >60. Liver function test (LFT) normal. No cardiovascular co-morbidity. **Plan:** Full blood picture (FBP). U&E, LFT, serum iron, group and hold. Admit Tuesday 28th August for cross match 4 units packed cells. Right radical nephrectomy for 29/08/14
28/08/12		Patient admitted 3 South for - right radical nephrectomy
29/08/12		**Right radical nephrectomy** Locally advanced disease. Right flank incision large tumour mass adherent to liver and extending posterior to second part of duodenum. Tumour surrounding right renal artery and vein. Tear in antero-lateral aspect of inferior cava, excessive intra-operative bleeding prior to and during repair. Transferred to Intensive Care Unit post-Surgery
31/08/12		Transfer to Surgical Ward
06/09/12		Ward referral to Dr 2 clinic, routine Discharged home
06/09/12		Multi-disciplinary Team Meeting (MDM)

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Date	Time	Event
		Large renal cell carcinoma histological features of conventional clear cell adenocarcinoma which extends through renal capsule to involve perinephric fat (pT3a). Furhman Grade 111 tumour. For Review by Dr 2 and arrange further CT scanning November 2012 and subsequent MDM discussion.
15/09/12		**Dr 2 Urology Clinic** Seen by Dr 2 CT request to be carried out November 2012
17/01/13	13.38	**CT Chest and abdomen and pelvis with contrast** **Conclusion:** Sub-centimeter lymph nodes in the right renal hilar/portahepatis region. No metastasis seen.
08/02/13		**Dr 2 Urology Clinic** Seen by Dr 3 (Consultant Urologist) **Follow Up:** CT, REV JUNE 2013 Reviewed today. Had a right radical nephrectomy in August 2012 for a renal cell carcinoma. Histology showed a 98mm clear cell carcinoma. This invaded into perinephric fat, therefore was pT3a, although renal vein was clear. Histology showed a Fuhrman grade III tumour with positive lymphovascular invasion and necrosis. Margins were clear. However, as there was a little intra-abdominal fat, they were close to the resection margin. Patient doing very well and is now back to work. No pain. Recent staging CT scan shows some small nodes at right hilum, which were not significant by size criteria, although will need to be followed up. There was no evidence of metastatic disease. I have reassured the patient today that there is no definite evidence of cancer recurrence. Will obviously need to have serial CTs, given the high risk nature of primary tumour. I have therefore rebooked a CT for May 2013 and have checked routine bloods today. We will review in June 2013.
08/04/13		Discharge letter for 29/08/12 admission dictated 03/04/13 and typed 08/04/13 Dr 2: Surgery and histology and current review plan given Patient underwent Right Radical Nephrectomy on 29/08/12 for locally advanced, renal cell carcinoma of right kidney. Presented with central abdominal pain and episode of frank haematuria. Mass was palpable in right hypochondrium, large right renal tumour measuring 11cm in diameter, was confirmed on CT scanning in July 2012. On CT scan it was noted to have a mild splenomegaly and multiple gall stones. A right flank incision, resecting the cartilaginous tip of the right tenth rib, a large right renal tumour mass was found to be adherent to the liver and extending posterior to the second part of the duodenum. Right renal vein and right renal artery were surrounded by the tumour mass. Unfortunately, right radical nephrectomy was complicated by a long tear in the antero-lateral aspect of the inferior vena cava resulting in excessive intra-operative haemorrhage, prior to and during its repair. Nevertheless, Patient had remarkably uncomplicated post-operative recovery

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Date	Time	Event
		Histological examination of the resection specimen found to have a poorly differentiated, Fuhrman Grade 3, clear cell adenocarcinoma which extended through the renal capsule to involve peri-nephric fat. This tumour is associated with an increased risk of local recurrence and of metachronous metastatic disease. However, as reported by Dr 3 at review in February 2013, there was no evidence of any local recurrence or of metastatic disease on CT scanning in January 2013. Patient due to have further CT scanning performed in May 2013 and I hope to review with the report in June 2013.
16/05/13	15.16	**CT Chest and abdomen and pelvis** with contrast **Conclusion:** No metastasis or significantly enlarged lymph nodes are seen.
14/03/14	10/02	XR Lumbar spine– (requested by GP) There is a background of mild / moderate degenerative change. There is also impression of mild osteopenia; however, no significant insufficiency fracture is convincingly demonstrated. Sacroiliac joints are unremarkable. Note is made of right upper quadrant metallic clips, presumably related to previous surgery.
21/08/14		Letter received by Urology Service from patient's GP dated 20/08/14 – "Thank you for seeing patient lost to follow up from urology following removal of a high grade renal tumor >1year ago. Had normal CT scan March 2013 but no review since despite being told would have frequent checkups. Had two severe episodes of low back pain. First Jan 2014 and most recent August 14. Normal x-ray March 14. Feels weak, nausea and unwell. I am concerned Patient 128 may have metastatic disease or recurrence of tumor. Recall / review of urology cancer patients is a cause for concern as lengthy delays ++++ current Hb 9.1 (was 13.9 1 yr ago). Recent onset acute back pain, no real ppt. In pain no radiation was in bed for 2 days couldn't move. Worse coughing. Thought she was 'dying'. Anxious +++ previous renal cancer (high grade and risk of recurrence). Haematuria. Walks without limp. SLR 80 deg legs hips and knees ok reflexes and power. Lumbar flexion and rotation excellent. Ketoprofen Gel 2.5% 100 gram, Cyclizine tablets 50mgs 30 tablet. FBP and bloods check urine expect urology review as suspected metastatic renal cancer".
21/08/14		**Referral to Dr 2 clinic from General Practitioner**- "Red Flag" referral as GP suspect cancer following triage, urgent. Referred to clinic. Referred to oncology as per MDM. Discharged from clinic on 14/10/14
21/08/14		Ref to Clinic Dr 4 (Consultant Surgeon) anaemia triage, urgent
26/08/14		Patient 128 **reviewed by Dr 2**. Iron Deficiency Amameia CT scan requested and MDM review with reports.
01/09/14		Attended Dr 4 clinic (Consultant Surgeon) Re anaemia– Boarded for OGD and colonoscopy, aware of referral to Urology Service and follow up there re CT scan.
01/09/14	11.39	**CT Chest and abdomen and pelvis** with contrast **Conclusion** Recurrent disease.

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Date	Time	Event
		1. Large peri-duodenal/mesenteric mass which appear to involve/projecting into the lumen of duodenum. Endoscopy/barium meal examination suggested for further evaluation. 2. Large retro-caval mass on the medial aspect of the liver. 3. Large metastasis in the segment VI of the liver.
04/09/14		**Discussed at MDM**
05/09/14		**Dr 2 Review** Reviewed Patient 128 and advised of CT findings and MDM.
06/09/14		**Admitted for blood transfusion and OGD.** 3 Units packed red cells. OGD 09/09/14 –biopsy of probable duodenal carcinoma – previous CT scan – large periduodenal/mesenteric mass which appears to involve/project in to lumen of duodenum. Arrangements for follow up: Oncology review BCH – referred by MDT 04/09/14. Seen 16/09/14 Await pathology results - Histology confirmed renal cell carcinoma Review by Dr 2 CAH OPC- 19/09/14
10/09/14		**Discharged**
16/09/14		**Reviewed Oncology Service**
19/09/14		**Reviewed by Dr 2**
25/09/14		Referral to Oncologist (Dr 6) and discharge from Urology formalised at MDM
		MDM report 25/09/14 Diagnosis: Renal clear cell carcinoma. Laterality: Right Referred due to complaining of central abdominal pain and frank haematuria. On examination, mass in right hypochondrium. Blood and urine – no malignant seen. Ultrasound reported a large right renal mass. Flexible cystoscopy was clear. Diagnosis of probable right renal tumour. CT urinary tract 24/07/12. There was no evidence of any metastatic deposits. DMSA 01/08/12 – only small functioning part of the right kidney was still seen in its lower pole and markedly reduced spilt renal function of the right kidney. Bone scan 10/08/12 – no evidence of bony metastasis. Right radical nephrectomy performed 29/08/12 and histology reported features of a conventional clear cell adenocarcinoma which extended through the renal capsule to involve perinephric fat (pT3a) CT C/A/P 17/01/13 – subcentimeter lymph nodes in the right renal hilar/portahepatis region. No metastasis seen. History There was no evidence of metastatic disease or of significant lymphadenopathy on CT scanning performed in May 2013. Patient was referred again in August 2014 with a one month history of weight loss and fatigue. Was found to have severe iron deficiency anaemia. Patient attended for review 26/08/14. CT chest abdomen and pelvis requested. For review at MDM with reports and for review by Dr 2 on 06/09/14 CT C/A/P, 01/09/14 – 1. large periduodenal / mesenteric mass which appear to involve / projecting into the lumen of duodenum. Endoscopy / barium meal examination

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Date	Time	Event
		suggested for further evaluation. 2. Large retrocaval mass on the medial aspect of liver. 3. Large metastasis in the segment VI of the liver Patient advised of findings of CT scanning at review on 05/09/14. Admission on 06/09/14 arranged for transfusion and for upper GI endoscopy as an inpatient Patient reported that continued to feel better since transfusion, when reviewed on 19/09/14. Her only persistent symptom was of mild nausea. Probable tumour had been found to infiltrate second part of duodenum at OGD on 09/09/14. There was no report of active bleeding. Biopsies have since confirmed renal cell carcinoma. Patient reviewed 16/09/14, when Hb had decreased to 95. For further discussion at MDM on 25/09/14 and discharged from urological review.

Personnel Code

Dr Code	Dr Grade
Dr 1	Consultant Surgeon
Dr 2	Consultant Urologist
Dr 3	Consultant Urologist
Dr 4	Locum Consultant Surgeon
Dr 5	Consultant Urologist
Dr 6	Consultant Oncologist

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Willis, Lisa

From:	Trouton, Heather
Sent:	29 January 2016 12:51
To:	McAlinden, Matthew
Cc:	Mackle, Eamon; Corrigan, Martina; Nelson, Amie; Reid, Trudy
Subject:	FW: Radiology and Patholoy results
Follow Up Flag:	Follow up
Flag Status:	Flagged

Matthew

Could you please send the email below to all the consultant surgeons that I gave you this am ?

Happy to discuss if required
Thanks

Heather

From: Trouton, Heather
Sent: 18 January 2016 14:49
To: Trouton, Heather
Subject: Radiology and Patholoy results

Dear All

Following the outcomes of several SAI's, we are writing to remind all consultants that it is their personal responsibility to have checked and signed all radiology and pathology reports to assure that no serious results are missed.

Any concerns regarding the process of how these get to your attention should be raised with your secretary in the first instance.

Kind regards
Eamon and heather

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

Willis, Lisa

From:	Mackle, Eamon
Sent:	30 March 2016 09:49
To:	Trouton, Heather; Corrigan, Martina; Nelson, Amie; Reid, Trudy
Cc:	Carroll, Ronan
Subject:	RE: Radiology and Patholoy results
Follow Up Flag:	Follow up
Flag Status:	Flagged

Heather

I agree with him re consultant. I check the printed report which has been produced by my secretary.

Eamon

From: Trouton, Heather
Sent: 25 March 2016 16:15
To: Mackle, Eamon; Corrigan, Martina; Nelson, Amie; Reid, Trudy
Cc: Carroll, Ronan
Subject: FW: Radiology and Patholoy results

Dear Eamon

Can you please see response from Michael?

Could you please enquire and advise if this is always the case?

Heather

From: McAlinden, Matthew
Sent: 08 March 2016 17:40
To: Trouton, Heather
Subject: FW: Radiology and Patholoy results

Heather,

See below response from Michael Young.

Thanks,

Matthew

From: Young, Michael
Sent: 08 March 2016 17:38
To: McAlinden, Matthew
Subject: RE: Radiology and Patholoy results

As long as the report is available to the consultant and sec in writing

---

From: McAlinden, Matthew
Sent: 29 January 2016 13:17

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

To: Gilpin, David; Brown, Robin; McArdle, Gerarde; Gudyma, Jaroslaw; Mackle, Eamon; Weir, Colin; Lewis, Alastair; Epanomeritakis, Manos; Yousuf, Imran; Mathers, Helen; McKay, Damian; Neill, Adrian; Hewitt, Gareth; Yoong, Susan; McKeown, Ronan; Murnaghan, Mark; Bunn, Jonathon; Wilson, Brian; McMurray, David; Alam, Ahsan; Patton, David; Doyle, Timothy; Watson, Bruce; Rajkumar, Shan; Hall, Sam; Korda, Marian; McNaboe, Ted; McCaul, David; Reddy, Ekambar; Leyden, Peter; Farnan, Turlough; Young, Michael; O'Brien, Aidan; Haynes, Mark; Glackin, Anthony; Suresh, Ram; ODonoghue, JohnP
Cc: Trouton, Heather
Subject: Radiology and Patholoy results

Dear all,

Please see Email below from Heather for Your information.

Many Thanks,

Matthew Mc Alinden

Personal Secretary to Heather Trouton
Assistant director to Surgery and Elective care
Acute Services
Admin Floor, Craigavon Area Hospital
Personal Information redacted by the USI

From: Trouton, Heather
Sent: 18 January 2016 14:49
To: Trouton, Heather
Subject: Radiology and Patholoy results

Dear All

Following the outcomes of several SAI's, we are writing to remind all consultants that it is their personal responsibility to have checked and signed all radiology and pathology reports to assure that no serious results are missed.

Any concerns regarding the process of how these get to your attention should be raised with your secretary in the first instance.

Kind regards
Eamon and heather

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

Sent: 09 May 2013 16:28
To: Burns, Deborah
Cc: Lappin, Aideen
Subject: Fw: Charts being removed from the Trust by consultants

Debbie

See below can we discuss at 1 - 1
This chart was tracked to his pp drawer but actually wasn't there Anita

From: Forde, Helen
To: Carroll, Anita
Sent: Thu May 09 10:22:03 2013
Subject: FW: Charts being removed from the Trust by consultants
Anita – I've spoken to Martina before about Mr O'Brien taking patient charts home, and yesterday a patient was admitted to MAU and the chart was in Mr O'Brien's house. Pamela has completed an IR1 regarding this.

Could we have a chat at 1 : 1 to see from a Records point of view what else we need to be doing.

I went to speak to Martina today about this but she's not in her office.

Thanks.

Helen Forde
Head of Health Records
Operations Office, Admin Floor, CAH
Direct Line : Personal Information redacted by the USI
Mobile : Personal Information redacted by the USI

From: Forde, Helen
Sent: 09 May 2013 10:16
To: Corrigan, Martina (Personal Information redacted by the USI)
Subject: Charts being removed from the Trust by consultants

Martina – we have spoken before about charts not being available for clinics or admissions as some of the consultants have taken them home. Yesterday a patient was admitted to MAU and after searching Mr O'Brien's office and checking with his secretary it was found that the chart was in Mr O'Brien's house. This has led to a delay in the chart being available for the ward.

We have filled in an IR1 about this incident but I want to raise this issue with you again as this is a problem for the Trust.

Helen Forde
Head of Health Records
Operations Office, Admin Floor, CAH
Direct Line : Personal Information redacted by the USI
Mobile : Personal Information redacted by the USI

Received from Debbie Burns on 09/06/2023. Annotated by the Urology Services Inquiry.

Corrigan, Martina

From:	Burns, Deborah <Personal Information redacted by the USI>
Sent:	13 May 2013 15:09
To:	Corrigan, Martina
Subject:	RE: Charts being removed from the Trust by consultants

IF YOU ENED ANY HELP PLEASE LET ME KNOW

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Corrigan, Martina
Sent: 12 May 2013 16:28
To: Burns, Deborah
Subject: RE: Charts being removed from the Trust by consultants

Debbie,

This has been an ongoing problem for years. The last time that Helen spoke to me about this I spoke to Aidan and advised him of the issues which he did say he would stop it and it did stop for a while but I had asked Helen if it happened again to raise it with me and also to raise an IR1. Unfortunately there are three charts now in Aidan's house and I am unsure if anyone has spoken to him about it direct (I will check with Helen tomorrow).

I am happy to talk to Aidan again but think we may need to involve Robin as CD as well?

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust

Telephone: Personal Information redacted by the USI (Direct Dial)
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Burns, Deborah
Sent: 10 May 2013 19:17
To: Corrigan, Martina
Subject: FW: Charts being removed from the Trust by consultants

Can you give me background on work to date

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Carroll, Anita

Received from Debbie Burns on 09/06/2023. Annotated by the Urology Services Inquiry.

WIT-11963

Mackle, Eamon

From: Corrigan, Martina
Sent: 05 September 2013 07:24
To: Burns, Deborah; Mackle, Eamon
Subject: RE: CHARTS TO CONSULTANT'S HOME

Debbie

I will speak with him again today and then let Robin follow up on this?

One of the things that was said to me before is that he is not the only consultant who brings a chart home, but I suppose with Aidan it is more the amount he brings home and the length of time he keeps them for, I will let you both know how I get on

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Telephone: Personal Information redacted by the USI (Direct Dial)
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Burns, Deborah
Sent: 05 September 2013 06:38
To: Mackle, Eamon; Corrigan, Martina
Subject: FW: CHARTS TO CONSULTANT'S HOME

? We need this addressed
D

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Brown, Robin
Sent: 04 September 2013 21:17
To: Burns, Deborah
Subject: RE: CHARTS TO CONSULTANT'S HOME

I will try to get to meet Aidan week after next. I am Sow next week.

Robin

From: Burns, Deborah
Sent: 03 September 2013 15:11
To: Corrigan, Martina; Mackle, Eamon; Brown, Robin
Subject: FW: CHARTS TO CONSULTANT'S HOME

Received from Mr Eamon Mackle on 12/04/22. Annotated by the Urology Services Inquiry.

I know you have tried before – this is a governance issue – Robin can you discuss again with Mr O'Brien - or do we need to escalate?
D

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Carroll, Anita
Sent: 03 September 2013 10:11
To: Burns, Deborah
Cc: Corrigan, Martina; Forde, Helen
Subject: FW: CHARTS TO CONSULTANT'S HOME

Debbie how do you think its best to deal with this , should the HOS discuss with mr o brien can they arrange to get charts back or do we need to discuss at governance as part of the problem is they aren't even tracked out Happy to discuss Anita

From: Forde, Helen
Sent: 27 August 2013 18:15
To: Trouton, Heather; Corrigan, Martina
Cc: Carroll, Anita
Subject: FW: CHARTS TO CONSULTANT'S HOME

Please see below – Mr O'Brien continues to have charts at home. This is causing problems for records as per Pamela's e-mail. What can be done to resolve this?

Helen Forde
Head of Health Records
Operations Office, Admin Floor, CAH
Direct Line : Personal Information redacted by the USI
Mobile : Personal Information redacted by the USI

From: Lawson, Pamela
Sent: 27 August 2013 11:06
To: Forde, Helen
Subject: CHARTS TO CONSULTANT'S HOME

Helen – can you please raise this issue with the appropriate person? I have been submitting IR1 forms regarding this but the problem is getting worse instead of better.

We are wasting a lot of valuable time searching for charts that are not tracked properly and we are falling behind. Last week was particularly bad and we are short-staffed which doesn't help matters.

Please see list of IR1 forms to date

27/08/13	AOB	3 charts
23/08/13	AOB	2 charts
22/08/13	AOB	3 charts
14/06/13	AOB	1 chart
31/05/13	AOB	2 charts
20/05/13	AOB	1 chart
16/05/13	AOB	1 chart

Received from Mr Eamon Mackle on 12/04/22. Annotated by the Urology Services Inquiry.

08/05/13 AOB 1 chart

Many thanks
Pamela

Pamela Lawson
Health Records Manager (HRM)
CAH, BBPC and STH
Tel Personal Information redacted by the USI
Mob Personal Information redacted by the USI

Received from Mr Eamon Mackle on 12/04/22. Annotated by the Urology Services Inquiry.

Mackle, Eamon

From: Brown, Robin
Sent: 22 September 2013 12:40
To: Corrigan, Martina
Cc: Mackle, Eamon; Trouton, Heather; Nelson, Amie
Subject: RE: Datix Incident Report Number Personal Information redacted by the USI

Personal Information redacted by the USI

Debbie emailed me about this a couple of weeks before I went off Personal Information.
I texted Aidan but he didn't reply
Last time there was a problem like this I drove over to CAH and waited for him to finish a clinic in Thorndale
It did look a bit like an ambush and might have been a bit counter-productive
I think it might be better if I could catch him at the beginning or end of an MDM.
I have an OPD appt on Tuesday morning - What does Aidan do on Tuesdays - Is that his list day?

Irrelevant Information Redacted by the USI

What about the Thursday lunchtime meetings?
I don't know if they are still happening Irrelevant Information Redacted by the USI

Robin

-----Original Message-----
From: Corrigan, Martina
Sent: 21 September 2013 22:05
To: Brown, Robin
Cc: Mackle, Eamon
Subject: FW: Datix Incident Report Number Personal Information redacted by the USI

Robin

Personal Information redacted by the USI

Below is another DATIX received in respect to charts being in Aidan's home. This was the second one last week and I am receiving at least one of these each week as Health Records are continuing to spend time looking for charts that they discover are in Aidan's house.

I would be grateful if you could speak with him as it has now been escalated to Debbie.

Many thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust

Telephone: Personal Information redacted by the USI (Direct Dial)
Mobile: Personal Information redacted by the USI

Received from Mr Eamon Mackle on 12/04/22. Annotated by the Urology Services Inquiry.

Email: Personal Information redacted by the USI

-----Original Message-----
From: Nelson, Amie
Sent: 19 September 2013 16:37
To: Corrigan, Martina
Subject: FW: Datix Incident Report Number Personal Information redacted by USI

-----Original Message-----
From: datix Personal Information redacted by the USI [mailto: Personal Information redacted by the USI]
Sent: 19 September 2013 15:52
To: Nelson, Amie
Subject: Datix Incident Report Number Personal Information redacted by USI

An incident report has been submitted via the DATIX web form.

The details are:

Form number: Personal Information redacted by USI

Description:

chart not found where tracked to. Health Records staff checked all of urology. A lot of Health Records time is wasted looking for these charts that are held in the consultant's home.

Please go to Personal Information redacted by the USI to view and approve it.

Received from Mr Eamon Mackle on 12/04/22. Annotated by the Urology Services Inquiry.

Willis, Lisa

From: Corrigan, Martina
Sent: 08 October 2013 09:52
To: Trouton, Heather
Cc: Carroll, Anita
Subject: RE: UPDATE ON CHART WITH AOB

Follow Up Flag: Follow up
Flag Status: Flagged

Heather

Best time is probably is a Thursday between xray meeting over at 9:30ish and grand ward round at 10ish, or else on a Friday in Thorndale, between patients.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Telephone: Personal Information redacted by USI (Direct Dial)
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

From: Trouton, Heather
Sent: 08 October 2013 08:28
To: Corrigan, Martina
Cc: Carroll, Anita
Subject: FW: UPDATE ON CHART WITH AOB

Martina

I need to talk to Aidan re this when would be the best time?

heather

From: Carroll, Anita
Sent: 07 October 2013 10:58
To: Trouton, Heather
Subject: FW: UPDATE ON CHART WITH AOB

Sorry to keep going on re this but is there anything Eamon could do to assist ?
A

From: Forde, Helen
Sent: 04 October 2013 14:24
To: Carroll, Anita
Subject: FW: UPDATE ON CHART WITH AOB

Here's an example of the extra work that is associated with Mr O'Brien having charts at home.

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

Helen Forde
Head of Health Records
Admin Floor, CAH
Personal Information redacted by USI
Personal Information redacted by USI

From: Lawson, Pamela
Sent: 04 October 2013 14:12
To: Forde, Helen
Subject: FW: UPDATE ON CHART WITH AOB

fyi

From: Mills, Barbara
Sent: 24 September 2013 11:18
To: Lawson, Pamela
Subject: UPDATE ON CHART WITH AOB

Personal Information redacted by USI - AOB due to return from Wales to-morrow and Monica will text him in am. He is off all week but will hopefully bring in this chart in am. Patients apt. to-morrow 15:15 hrs.

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

Willis, Lisa

From: Trouton, Heather
Sent: 14 October 2013 19:01
To: Carroll, Anita
Subject: RE: CHART WITH AOB

Follow Up Flag: Follow up
Flag Status: Flagged

I emailed him with the details but no response.

I will try to get to see him personaly this week.

Heather

From: Carroll, Anita
Sent: 14 October 2013 09:44
To: Trouton, Heather
Subject: FW: CHART WITH AOB

Heather Another one for AOB have you managed to speak to him yet anita

From: Forde, Helen
Sent: 14 October 2013 09:39
To: Carroll, Anita
Subject: FW: CHART WITH AOB

See below – still happening with charts at Mr O'Brien's house. Thanks.

Helen Forde
Head of Health Records
Admin Floor, CAH
Personal Information redacted by the USI

From: Lawson, Pamela
Sent: 14 October 2013 08:36
To: Forde, Helen
Subject: FW: CHART WITH AOB

Another IR1 going in for this one.

P

From: Mills, Barbara
Sent: 14 October 2013 08:32
To: Lawson, Pamela
Subject: RE: CHART WITH AOB

He brought chart in on Friday and its now tracked to his clinic in Armagh for to-day. I had to go up on Friday to speak to Noleen & then had to speak to Sarah out in Thorndale to finally locate chart.

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

From: Lawson, Pamela
Sent: 11 October 2013 09:58
To: Mills, Barbara
Subject: RE: CHART WITH AOB

Any word on this chart Barbara?

P

From: Mills, Barbara
Sent: 09 October 2013 13:26
To: Lawson, Pamela
Subject: CHART WITH AOB

Hi Pamela,
This chart tracked to Monica but not there or in his office. Noleen to ask AOB

Personal Information redacted by the USI

Ta Barbara

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

Willis, Lisa

From: Trouton, Heather
Sent: 12 November 2013 08:43
To: Burns, Deborah
Subject: RE: Mr O'Brien and charts

Follow Up Flag: Follow up
Flag Status: Flagged

Ok

I'll check with Robin today

Heather

From: Burns, Deborah
Sent: 12 November 2013 05:56
To: Carroll, Anita; Trouton, Heather; Corrigan, Martina
Subject: RE: Mr O'Brien and charts

Did the patient get seen? I think if we cant agree with him – John Simpson needs involved. Heather was robin addressing this with him – follow up with robin to check that happened - if it did John is next step D

Debbie Burns
Interim Director of Acute Services
SHSCT
Personal Information redacted by the USI

From: Carroll, Anita
Sent: 11 November 2013 13:28
To: Trouton, Heather; Corrigan, Martina
Cc: Burns, Deborah
Subject: FW: Mr O'Brien and charts

Dear all I know we have discussed before and heather I know you met him Really don't know what we now do A

From: Forde, Helen
Sent: 11 November 2013 13:07
To: Carroll, Anita
Subject: Mr O'Brien and charts

Just to keep you in the loop as this may be going to Debbie, and I've said to Martina.

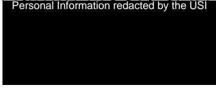
A patient was attending Dr Convery's clinic this morning but the chart was tracked to Mr O'Brien in the Thorndale Unit. When records looked for it his secretary said she thought Mr O'Brien had that chart at home and she would ask him to bring it in for the appointment at 9 am this morning. The chart didn't arrive in records and Dr Convery refused to see the patient without the chart. Pamela went to speak to Dr Convery and ask if he would see the patient as she had got as much information as she could for the appointment.

Mr O'Brien's secretary is off today so eventually Pamela got Mr O'Brien's number and phoned him to enquire about the chart. He had brought it in but had taken it over to the old Thorndale unit to have a letter typed. Pamela then

Received from SHSCT on 02/02/2022. Annotated by the Urology Services Inquiry

went over there this morning and got the chart and then brought it round to Dr Convery, and he informed Pamela that he was going to write to Debbie about this.

Helen Forde
Head of Health Records
Admin Floor, CAH



Received from SHSCT on 02/02/2022. Annotated by the Urology Services Inquiry

in respect of him being the timeliness of red flag triage and its impact on the Cancer 62 day pathway.

49.8 It is also worth noting that in her evidence to Julian Johnston in 2019, Martina Corrigan states that the process was developed by herself, Anita Carroll and Katherine Robinson - with no one else in the room and that this would enable her not to have to monitor triage. I appreciate this is conflicting with other evidence.

49.9 I am also now aware through documentation that a 'Datix' was raised every time a chart could not be found and was located in Mr O'Brien's home. I note the evidence of Helen Forde that I instructed her to cease raising Datix in respect of this issue, in a conversation in a corridor. I have no recollection whatsoever of telling anyone not to complete a datix. I had been the AD for Clinical Governance for the Trust and had revised the governance system and brought in and operationalised the datix reporting system as part of the review. This instruction would not therefore have been in keeping with my views, actions and roles. I met to discuss administrative issues with Mr O'Brien on 20-02-2014. I am completely unaware why I would have waited to August 2014 to ask anyone to stop reporting these occurrences. I believe that the AD for Functional Services was Helen Forde's line manager. Above I have given documentary evidence that each time an issue was escalated to me regarding charts or triage by Anita Carroll, I actioned this. For example, as early as 11-11-2013 in my tenure Anita Carroll emailed myself and Heather Trouton regarding a reported missing chart escalated to her by Helen Forde. On 12-11-13 05.56 am I replied to both asking to escalate to John Simpson, the medical director and inform the clinical director.

49.10 I have been made aware through the evidence of Katherine Robinson that there was a restructuring during my tenure and secretaries/audio typists and other administrative staff from the Directorates were transferred to her management structure. I understand the reasoning was to allow the OSLs more time to concentrate on performance issues and SABA (Service and

Willis, Lisa

From:	Trouton, Heather
Sent:	12 November 2013 08:37
To:	Carroll, Anita; Corrigan, Martina
Cc:	Burns, Deborah
Subject:	RE: Mr O'Brien and charts
Follow Up Flag:	Follow up
Flag Status:	Flagged

Anita

I have spoken both to Mr O'Brien himself and Mr Young as clinical lead for Urology

Mr O,Brien advised that he would cease this practice.

We could ask Mr Brown to discuss with him but I don't think it would have any effect.

hetaher

From: Carroll, Anita
Sent: 11 November 2013 13:28
To: Trouton, Heather; Corrigan, Martina
Cc: Burns, Deborah
Subject: FW: Mr O'Brien and charts

Dear all I know we have discussed before and heather I know you met him Really don't know what we now do A

From: Forde, Helen
Sent: 11 November 2013 13:07
To: Carroll, Anita
Subject: Mr O'Brien and charts

Just to keep you in the loop as this may be going to Debbie, and I've said to Martina.

A patient was attending Dr Convery's clinic this morning but the chart was tracked to Mr O'Brien in the Thorndale Unit. When records looked for it his secretary said she thought Mr O'Brien had that chart at home and she would ask him to bring it in for the appointment at 9 am this morning. The chart didn't arrive in records and Dr Convery refused to see the patient without the chart. Pamela went to speak to Dr Convery and ask if he would see the patient as she had got as much information as she could for the appointment.

Mr O'Brien's secretary is off today so eventually Pamela got Mr O'Brien's number and phoned him to enquire about the chart. He had brought it in but had taken it over to the old Thorndale unit to have a letter typed. Pamela then went over there this morning and got the chart and then brought it round to Dr Convery, and he informed Pamela that he was going to write to Debbie about this.

Helen Forde
Head of Health Records
Admin Floor, CAH
Personal Information redacted by the USI

Received from SHSCT on 02/02/2022. Annotated by the Urology Services Inquiry

Willis, Lisa

From:	Trouton, Heather
Sent:	26 November 2013 11:40
To:	Young, Michael; Brown, Robin
Cc:	Corrigan, Martina; Carroll, Anita
Subject:	FW: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE
Attachments:	image001.png
Follow Up Flag:	Follow up
Flag Status:	Flagged

Dear Both

In confidence please see below.

I personally have spoken to Mr O'Brien about this practice on various occasions and Martina has also much more often. While we very much appreciate Aidan's response, I suspect that without further intervention by his senior colleagues it will happen again.

I also spoke to him not more than 4 weeks ago both about timely triage and having charts at home and he promised me he would deal with both, however we find today that patients are still with him not triaged from August , he would have known that at the time of our conversation yet no action was taken. I am also advised today that a further IR1 form has been lodged by health records as 6 charts cannot be found.

As stated by Aidan we have been very patient and have offered any help in the past with regard to systems and processes to assist Aidan with this task but it has not been taken up and the delays continue.

Despite the fact that patients sitting not triaged from August mean that we have breached the access standard before we even start to look for appointments I am more concerned about the clinical implications for patients who need seen urgently and possibly even needing upgraded to a red flag status.

We really need you to speak with Mr O'Brien both in the capacity of a colleague but also in your capacity of Clinical lead and Clinical Director for Urology as well of course as patient advocates.

I also really need a response within 1 week on how this is being addressed for now and the future or I will be forced to escalate to Debbie and Mr Mackle as Director and AMD for this service. It has already been suggested that Dr Simpson be involved which I have not progressed to date but it may have to come to that unless a sustainable solution can be found.

Thank you for your assistance

Heather

From: Corrigan, Martina
Sent: 26 November 2013 08:02
To: Robinson, Katherine; Glenny, Sharon
Cc: Trouton, Heather
Subject: FW: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Dear both

Please see below – Katherine can you advise if you receive these?

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

Corrigan, Martina

From:	Carroll, Anita Personal Information redacted by the USI
Sent:	12 November 2013 11:58
To:	Burns, Deborah; Trouton, Heather; Corrigan, Martina
Subject:	RE: Mr O'Brien and charts

I think to escalate to Dr Simpson might be worth a try

From: Burns, Deborah
Sent: 12 November 2013 08:40
To: Trouton, Heather; Carroll, Anita; Corrigan, Martina
Subject: RE: Mr O'Brien and charts

SEE MY EMAIL - VIEW?

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Trouton, Heather
Sent: 12 November 2013 08:37
To: Carroll, Anita; Corrigan, Martina
Cc: Burns, Deborah
Subject: RE: Mr O'Brien and charts

Anita

I have spoken both to Mr O'Brien himself and Mr Young as clinical lead for Urology

Mr O,Brien advised that he would cease this practice.

We could ask Mr Brown to discuss with him but I don't think it would have any effect.

hetaher

From: Carroll, Anita
Sent: 11 November 2013 13:28
To: Trouton, Heather; Corrigan, Martina
Cc: Burns, Deborah
Subject: FW: Mr O'Brien and charts

Dear all I know we have discussed before and heather I know you met him Really don't know what we now do A

From: Forde, Helen
Sent: 11 November 2013 13:07
To: Carroll, Anita
Subject: Mr O'Brien and charts

Just to keep you in the loop as this may be going to Debbie, and I've said to Martina.

Received from Debbie Burns on 09/06/2023. Annotated by the Urology Services Inquiry.

Corrigan, Martina

From:	Mackle, Eamon <Personal Information redacted by USI>
Sent:	20 February 2014 11:30
To:	Burns, Deborah
Subject:	Fw: CHARTS AND aob

From: Carroll, Anita
Sent: Wednesday, February 12, 2014 04:47 PM GMT Standard Time
To: Trouton, Heather; Mackle, Eamon
Cc: Corrigan, Martina
Subject: FW: CHARTS AND aob

Sharing as requested
A

From: Lawson, Pamela
Sent: 12 February 2014 16:46
To: Carroll, Anita
Subject: RE: can i have an update on mr o brien ?

Anita – please see below – these are details of the IR1 forms submitted re charts Mr O'Brien has had to bring in from his home for clinics and admissions.

08/05/13 – 1 chart
20/05/13 – 1 chart
16/05/13 – 1 chart
31/05/13 – 2 charts
14/06/13 – 1 chart
22/08/13 – 3 charts
23/08/13 – 2 charts
27/08/13 – 3 charts
30/08/13 – 2 charts
16/09/13 – 1 chart
18/09/13 – 1 chart
20/09/13 – 1 chart
03/10/13 – 6 charts
14/10/13 – 1 chart
15/10/13 – 1 chart – AOB forgot to bring chart in – pages and labels had to be made up for CDSU procedure
15/10/13 – 1 chart
04/11/13 – 1 chart – chart did not arrive in time for clinic
25/11/13 – 6 charts
11/12/13 – 6 charts
08/01/14 – 2 charts
09/01/14 – 2 charts
21/01/14 – 3 charts – not able to get these charts as AOB was out of the country and his secretary was on leave
24/01/14 – 3 charts
12/02/14 – 3 charts

From: Carroll, Anita
Sent: 12 February 2014 16:38

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry.

Willis, Lisa

From: Corrigan, Martina
Sent: 26 October 2014 14:51
To: Trouton, Heather
Subject: RE: NOTES WITH AOB

Follow Up Flag: Follow up
Flag Status: Flagged

Heather

It had improved but I feel it may be slipping again and I will talk to Aidan again

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Trouton, Heather
Sent: 15 October 2014 15:28
To: Corrigan, Martina
Subject: FW: NOTES WITH AOB
Importance: High

Martina

Are you aware that this is still a problem ? has it improved at all ?

Heather

From: Carroll, Anita
Sent: 14 October 2014 14:40
To: Trouton, Heather
Subject: FW: NOTES WITH AOB
Importance: High

From: Forde, Helen
Sent: 14 October 2014 13:52
To: Carroll, Anita
Subject: FW: NOTES WITH AOB
Importance: High

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

See below – still a problem

Helen Forde
Head of Health Records
Admin Floor, CAH
DDI Personal Information redacted by the USI Ext Personal Information redacted by
Personal Information redacted by the USI

'You can follow us on Facebook and Twitter'

From: Lawson, Pamela
Sent: 14 October 2014 13:34
To: Forde, Helen
Subject: FW: NOTES WITH AOB
Importance: High

fyi

From: Lawson, Pamela
Sent: 14 October 2014 13:33
To: Troughton, Elizabeth; Corrigan, Martina
Subject: FW: NOTES WITH AOB
Importance: High

Elizabeth – would you please explain to Mr Glackin that these notes will not be present for the appointment tomorrow as Mr O'Brien has them.

Thanks
Pamela

From: Mills, Barbara
Sent: 14 October 2014 10:36
To: Lawson, Pamela
Subject: NOTES WITH AOB
Importance: High

Hi Pamela,
Personal Information redacted by the USI chart with AOB. Noleen e-mailed him twice –no response. Needed for CAJGPB 15/10/14.

Many Thanks
Barbara

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

Corrigan, Martina

From: Corrigan, Martina
Sent: 07 November 2014 10:55
To: Lawson, Pamela
Cc: Forde, Helen; Loughran, MarieT
Subject: RE: CHARTS REQUIRED BY RECORDS PLEASE

Pamela

Just to advise that Mr O'Brien is on Annual Leave this week but is back on Monday

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Lawson, Pamela
Sent: 07 November 2014 10:50
To: O'Brien, Aidan
Cc: Forde, Helen; Loughran, MarieT; Corrigan, Martina
Subject: CHARTS REQUIRED BY RECORDS PLEASE

Dear Mr O'Brien

Can I ask you please to bring in the following charts asap?

Personal Information redacted by the USI – admission to 2 North 06/11/14

Personal Information redacted by the USI – required for your clinic AAOBU1 on Monday 10th November.

Many thanks
Pamela

Pamela Lawson
Health Records Manager
CAH
Personal Information redacted by the USI

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

Corrigan, Martina

From: Corrigan, Martina
Sent: 07 November 2014 10:54
To: Trouton, Heather
Subject: FW: CHARTS REQUIRED BY RECORDS PLEASE

Heather

Can we have a chat about this as it is becoming a problem again

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Lawson, Pamela
Sent: 07 November 2014 10:50
To: O'Brien, Aidan
Cc: Forde, Helen; Loughran, MarieT; Corrigan, Martina
Subject: CHARTS REQUIRED BY RECORDS PLEASE

Dear Mr O'Brien

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Personal Information redacted by the USI – required for your clinic AAOBU1 on Monday 10th November.

Many thanks
Pamela

Pamela Lawson
Health Records Manager
CAH
Personal Information redacted by the USI

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

-----Original Message-----
From: Forde, Helen <Personal Information redacted by the USI>
Sent: 07 November 2014 11:21
To: Carroll, Anita <Personal Information redacted by the USI>
Cc: Lawson, Pamela <Personal Information redacted by the USI>
Subject: FW: CHARTS REQUIRED BY RECORDS PLEASE

Anita- see below from Pamela who needs a chart that Mr O'Brien has at home. The patient was admitted yesterday – Martina has advised that Mr O'Brien is on leave until Monday – so the patient will be without a chart from yesterday and right through the weekend.

I know you have done everything in your power to resolve this, but from a Records point of view we still need to escalate as if anything did happen at least we are seen to have been escalating.

Could this be raised at the Governance meeting – even not specifically mentioning any name but as something that we need to have guidance developed on that will be shared with the consultants?

Helen Forde
Head of Health Records
Admin Floor, CAH
Personal Information redacted by the USI

'You can follow us on Facebook and Twitter'

From: Lawson, Pamela
Sent: 07 November 2014 10:50
To: O'Brien, Aidan
Cc: Forde, Helen; Loughran, MarieT; Corrigan, Martina
Subject: CHARTS REQUIRED BY RECORDS PLEASE

Dear Mr O'Brien

Can I ask you please to bring in the following charts asap?

Personal Information redacted by the USI – admission to 2 North 06/11/14

Personal Information redacted by the USI – required for your clinic AAOBU1 on Monday 10th November.

Many thanks
Pamela

Pamela Lawson
Health Records Manager
CAH
Personal Information redacted by the USI

TRU-277894

Willis, Lisa

From:	Trouton, Heather
Sent:	22 January 2015 12:08
To:	Young, Michael
Cc:	Corrigan, Martina
Subject:	Confidential FW: AOB CHART
Follow Up Flag:	Follow up
Flag Status:	Flagged

Michael

Can you please see emails below. As you know we have spoken to Aidan about this on a number of occasions. He brings his current charts in and then seems to start the process again.

Would you see if you could find a way of asking him to manage this process a bit better.

We do value all the hours he puts in, that is not the issue , but patient charts do need to be in the hospital for emergency and outpatient attendances.

Your views would be appreciated

Heather

From: Forde, Helen
Sent: 21 January 2015 09:34
To: Corrigan, Martina
Cc: Carroll, Anita
Subject: Fw: AOB CHART

We have a patient in majors in ED this morning and they are requesting the patients chart but we believe the chart is at Mr o'briens home. Just to keep you informed in case there would be any issue.

Sent from blackberry

From: Lawson, Pamela
Sent: Wednesday, January 21, 2015 09:18 AM
To: Forde, Helen
Subject: FW: AOB CHART

Helen

This gentleman is in Majors ED dept and they are requesting his notes.

Notes possibly with Mr O’Brien.

P

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

Willis, Lisa

From:	Carroll, Anita
Sent:	27 January 2015 12:54
To:	Trouton, Heather
Subject:	RE: Aob and charts at home
Follow Up Flag:	Follow up
Flag Status:	Flagged

I know A

-----Original Message-----
From: Trouton, Heather
Sent: 27 January 2015 12:28
To: Carroll, Anita
Subject: RE: Aob and charts at home

I spoke to Mr Young about this last week and he is going to speak to Aidan again.

I will consider the Risk register although with that you are supposed to address the risk and eliminate it. This is down to a personal way of working which seems impossible to stop.

Heather

-----Original Message-----
From: Carroll, Anita
Sent: 27 January 2015 11:55
To: Trouton, Heather; Corrigan, Martina
Cc: Forde, Helen
Subject: Aob and charts at home

Heather

Do you think you ? Should have something on risk register in relation to this

Anita

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

38. If you are a responsible officer within a designated body, you will have extra responsibilities as set out in the relevant regulations[7] and you must take account of any guidance produced by the departments of health[8] or your organisation.

Keeping up to date

All medical professionals

39. You must keep your skills and knowledge up to date in all areas of your work, whether in a clinical or non-clinical setting.

40. You must keep up to date with, and follow, the laws and statutory codes of practice relevant to your particular responsibilities and location[9] and you should get expert advice when you need it. You must be familiar with the relevant guidelines and developments that affect your work and use them to help you with your practice.

Information governance

41. Medical professionals need accurate, up-to-date and accessible information to deliver good and safe care to patients. Patients need to understand how information about them will be collected, stored and used and how their confidentiality and privacy will be protected. Good information governance systems can help to achieve this and contribute to providing high quality and safe care. They can also provide valuable information to allow teams and services to improve the quality and safety of care they deliver. All medical professionals have a role to play in contributing to these systems.

All medical professionals

42. You must keep accurate and clear patient records following the advice in *Good medical practice*.[5] You should make sure that non-clinical records you keep, including financial records, are clear, accurate and up to date.

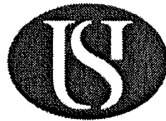
43. You must follow the guidance in *Confidentiality: good practice in handling patient information* on protecting information and disclosing information for patient care or secondary purposes.[10]

44. You should be familiar with, and follow, the confidentiality, data protection and record management policies and procedures where you work and know where to get advice on these issues.

Medical professionals with extra responsibilities

45. If you are responsible for managing patient records or other patient information, you must follow the specific guidance for managers on protecting information set out in *Confidentiality:*

Source: https://www.gmc-uk.org/-/media/documents/leadership-and-management-for-all-doctors---english-48903400.pdf



(ix) Please give details of any discussions you had with Dr Mitchell regarding shared concerns.

Dr. Mitchell, as chair of the Urology MDT raised concerns in 2014 to Mr. O'Brien in relation to a particular case which had been referred to the MDT and was receiving bicalutamide 50mg daily as monotherapy for prostate cancer. At that time, I mentioned to Dr. Mitchell about the historical cases I had remembered from my early years as a consultant in Belfast. This discussion would have taken place at one of our Thursday morning pre-clinic meetings at the Northern Ireland Cancer Centre.

(x) Were you aware of others who had knowledge of these issues or who may have shared similar concerns? Please provide details.

I can't recall any specific discussion but I believe there was a general awareness of the issue amongst the oncology team treating prostate cancer.

(xi) Please identify every occasion on which you escalated concerns regarding Mr O'Brien's prescribing practices in respect of Bicalutamide and identify the individual(s) to whom your concerns were escalated. If it is the case that you did not escalate your concerns, please indicate why.

I did not escalate my concerns as I felt there was no substantial harm to patients from the bicalutamide prescribing I had encountered in my practice.

2. The Inquiry is aware of significant issues around the quoracy of SHSCT Urology MDMs, particularly in terms of Oncology attendance. On this issue, the record of the interview of 4 January 2021 (at TRU-162262) states: 'JOS said that the MDT improved with the attendance of two of the newer consultants about 7 years ago.' Please explain this further and offer any further comments or observations which may assist the Inquiry in understanding this issue.

I do not have a detailed knowledge of the oncology cover at the Southern Trust. This was a general comment in which I was referring to my personal understanding of the oncology presence at the Southern Trust Urology MDT. I understood that oncology cover had been absent or patchy for a period of time but that there had been new oncology consultants appointed who were job-planned to attend the MDT.

3. During the interview referred to above (at TRU-162262), in response to a comment by Dr Hughes to the effect that 'it would seem he [Mr O'Brien] worked in isolation despite being involved in a multi-disciplinary team', it is recorded: 'JOS said that was his impression of Mr AOB.' What led you to have this impression of Mr O'Brien? Please provide full details.

This impression was based on my experience with the cases that had been prescribed bicalutamide 50mg as monotherapy. My view was that an MDT would be unlikely to recommend this therapy and that it was probably the decision of Mr. O'Brien alone.

4. In his Section 21 Statement to the Inquiry, at [WIT-84157] in reference to you and Dr Mitchell, Dr Hughes states: 'They had also written to him [Mr O'Brien] directly about his

SAI Urology Review

Meeting with Dr Joe O'Sullivan
Monday 4 January 2021 via zoom at 11:15

Attendees
Dr Dermot Hughes and Mrs Patricia Kingsnorth

Dermot Hughes (DH)
Dr Joe O'Sullivan (JOS)

DH thanks JOS for meeting with him and explained the process to date regarding the SAI review involving 9 patients (one with penile cancer, 1 testicular cancer, 5 prostate cancers and 2 renal cancers).

He asked if JOS was aware of any issues regarding the practice of Mr AOB?
JOS advised that when he came into post initially about 17 years ago, he had concerns in relation to the use of bicalutamide and that they had frequently challenged him about the treatment. He made recommendations in clinic letters questioning the use of bicalutamide 50mgs instead of the standard 150mgs or LHRH agonist therapy. In the cases he had seen, the dose of bicalutamide would not have resulted in a major detriment to the patient's therapy/outcome and therefore wasn't escalated further. JOS said he was aware that his colleague D M (as MDT Chair) had raised our concerns about AOB's bicalutamide prescribing with the then CD for Oncology, SMcA, probably in 2011.

JOS said that the MDT improved with the attendance of two of the newer consultants about 7 years ago.

DH advised that there were a number of delays of people being referred for oncology/ palliative care.

DH said that there were issues regarding lack of oncologist attending MDM as it was on the same time as lung MDM and that there was inadequate cover for CAH MDM.

JOS agreed he did want it recognised that there was a lot of good work from urologist in CAH and good involvement in MDT in particular he named two consultants Mr MH and Mr AG.

DH wanted to assure JOS that the SAI review will also recognise the good work the MDT are doing and recognised that the concerns relate to one person's practice. It would seem he worked in isolation despite being involved in a multi-disciplinary team. JOS said that was his impression of Mr AOB

Received from SHSCT on 27/09/2022. Annotated by the Urology Services Inquiry.

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice …6… of 2023

Date of Notice: 17 April 2023

Witness Statement of: Dr Darren Mitchell

I, Darren Mitchell, will say as follows:-

1. You were interviewed by Dr Dermot Hughes on 23 February 2021 in relation to the investigation of a number of SAIs concerning former patients of Mr Aidan O'Brien. The record of that interview states as follows (relevant extracts underlined):

'Dr Mitchell advised aware of issues going back decade in relation to hormone therapy prescribing, prescribing outside guidelines, Bicalutamide. Dr Mitchell advised he took over as chair of the regional urology MDM in 2015. He advised that they had challenged Mr OB on his use of bicalutamide as part of the development of clinical guidelines whilst Mr OB was chair of the NICAN urology group in 2015.' [TRU-162276]

(i) Confirm whether the above is an accurate record of the discussion during interview. To the extent that it is not, please identify any alleged inaccuracies and offer clarification of same.

1(i) I accept that this is an accurate record of the discussion during the interview. I would note that I was appointed to regional MDM chair in August 2014.

(ii) Please explicitly state what, to your knowledge or in your view, the 'issues … in relation to

a. hormone therapy prescribing,

b. prescribing outside guidelines,

c. Bicalutamide were.

1(ii) a *hormone therapy prescribing*

Received from Dr Darren Mitchell on 19/05/2023. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

Acute Governance
Darren Mitchell
Telephone call
23.02.2021

PRESENT: **Dr Darren Mitchell**
Dr Dermot Hughes
Mrs P Kingsnorth

Dr Hughes thanked Dr Mitchell for taking time out to talk to him today. Dr Hughes highlighted the reviews concerns identified in the SAI, explaining there was non-adherence to MDT recommendations, non-referral to oncology services for potential curative therapy, prescribing issues.
He asked if there was any knowledge regarding the concerns mentioned.

Dr Mitchell advised aware of issues going back decade in relation to immunotherapy prescribing, prescribing outside guidelines, bicalutamide. Dr Mitchell advised he took over as chair of the cancer group in 2015. He advised that they had challenged Mr OB on his use of bicalutamide. He escalated this to his clinical lead (Chris Hagan) and the decision was made to develop a guideline for the use of ADT in the hope this would address the issues. This guideline was presented when Mr OB was chair of the NICAN urology group and he signed off on the guidelines.

Dr Hughes asked Dr Mitchell to share the guidelines mentioned. Dr Hughes advised a number of patients were to be referred to oncology and this was not done.

Dr Mitchell mentioned a radical bladder cancer case in 2016, Chris Hagan and Gillian Traub noted there was a significant delay in treatment, this case was flagged back to SHSCT.

Dr Hughes advised the review was looking at 9 cases, there are significant findings, delays in treatment and care, MDT recommendations were not implemented, referrals to oncology were never made for potential curative treatment, and patients were not brought back to MDT for review. Dr Hughes advised there were systematic issues. The recommendations will include structured review process of MDT processes. NICE guidelines were not adhered to regarding prescribing of bicalutamide. There was very poor oncology support at MDT, oncology attendance at MDT was rare. Dr Mitchell described issues trying to support the MDT in SHSCT it was a busy practice and they had difficult recruiting to cover this role.

DRAFT

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: Personal Information redacted by the USI
E-mail Personal Information redacted by the USI

Received from Patricia Kingsnorth on 02/06/2023. Annotated by the Urology Services Inquiry.

Urology Services Inquiry

I had been referred a few prostate cancer patients by Mr O'Brien who had been commenced on an unlicensed dose of Bicalutamide hormone therapy prior to referral to oncology.

1(ii) b *prescribing outside guidelines*

The licenced doses for Bicalutamide are either 150mg once daily as a monotherapy, or 50mg once daily when used in combination with hormone therapy injections known as luteinizing hormone releasing hormone agonists. There are no licenced indications that I am aware of for Bicalutamide 50mg once daily as a monotherapy. As such I viewed the used of the Bicalutamide 50mg once daily as a monotherapy as being outside the licenced indications.

Mr O'Brien in his position as chair of the NICAN Urology group in 2015 had asked for guidelines to be written for each urology disease sub-site. I wrote the androgen deprivation therapy guidelines in 2015 to accurately define our regional use of hormone therapy at that stage in line with the licenced indications. I hoped that this would standardise practise with the appropriate of dose Bicalutamide being used within our regional guidance document. Following discussion at the NICAN urology group meeting on a number of occasions in 2015 a final version was sent to Mr O'Brien on 10/10/2016 (***AOB3***)

1(ii) c *Bicalutamide*

As outlined above

(iii) How, in your view, did these issues differ from normal medical practice?

1(iii) Normal practise would have been to prescribe a dose of Bicalutamide that was within the licenced indications or to refer to oncology for discussion and allow the oncology team to discuss treatment options including the use of hormone therapies such as Bicalutamide.

(iv) If they differed, what, if any, action was taken by you or others? If none, why not?

1(iv) Firstly - I emailed Mr O'Brien in November 2014 (***AOB1***) highlighting a case that had been passed to me as the new chair of the regional urology MDM. The patient had been commenced on Bicalutamide 50mg once daily as a monotherapy. In that email I outlined the standard of care that we as oncologists would have offered in terms of hormone therapy. I advised that I was writing the regional guidelines to standardise the approach to hormone therapy prescription across the region, and pasted a link to guidance on off label prescription, good practise recommendations and our responsibilities within that. I offered further discussion on this.

Secondly I wrote the regional guidelines on androgen deprivation therapy and passed these through to Mr O'Brien as the NICAN urology chair and the NICAN urology group for sign off. These guidelines reflected the licenced indications and doses of hormone therapy.

Received from Dr Darren Mitchell on 19/05/2023. Annotated by the Urology Services Inquiry.

WIT-96677
AOB1

Message ID - 6f3e4e1b99884902bd4a2018085386f9 - 146322497
Archived on 20/11/2014 13:52:47. Printed on 18/05/2023 05:19:43.

Time Sent	20/11/2014 13:34:43
Time Received	20/11/2014 13:34:43
Time Archived	20/11/2014 13:52:47
From:	mitchell, darren < Personal Information redacted by the USI >
To	aidan o'brien Personal Information redacted by the USI
Subject:	Patient 126

Aidan –could I ask you to have a look at this case which was passed to me as the regional MDT chair.

Looks like young man with high grade organ confined disease from 2012. From my prospective he w

I'm not aware of any of his co-morbidities or performance status.

As hormonal therapy in this case we would use LHRHa or occasionally Bicalutamide 150mg OD monc

I'm told he has only just been referred for radiotherapy at 2 years after initial MDT presentation.

I'm not aware of supportive research for 24months of neo-adjuvant hormones prior to EBRT but the
6 months of LHRHa prior to EBRT is also recommended in the STAMPEDE protocol for men with high

I'm also told that he was on Bicalutamide 50mg OD for the first year of his management.

The NICAN hormone protocol (in process) would be useful in standardising our therapy across the re

The MRHA site provides information on 'off-label' prescribing and our responsibilities within that.

http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON087990

Happy to discuss this further.

DMM

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3 (iv) Did you seek to discuss this case with Mr O'Brien at any stage? To the extent that the answer is 'yes', please give full details. If no, why not?

3 (iv) Yes – as noted above Mr O'Brien was emailed about the case.

4. A further extract of the record of the interview with Dr Hughes of 23 February 2021, further states the following (at TRU-162277):

'Dr Mitchell advised he emailed the consultant in 2016/17 about his prescribing outside recommended guidelines and highlighting it was his GMC duty to inform patients they were being treated outside the recommended guidelines. The patients were misled.'

4 (i) Provide the Inquiry with a copy of this email and any response(s) received.

4 (i) The email referenced in the interview with Dr Hughes was actually sent in 2014 and has been discussed in section 1. I did not receive any response. (***AOB1***)

4 (ii) Did you take any further action in respect of this apparent concern? To the extent that the answer is 'yes', provide full details. If your answer is no, why not?

4(ii) As per my response in section 1, I wrote the androgen deprivation guidelines and presented these to the NICAN urology group in 2015. When I was made aware of the cases seen by Prof Jain in 2019 and 2020 I spoke to and emailed Mr Haynes. (***AOB4, AOB12***)

4 (iii) The Inquiry notes the statement 'The patients were misled'. Please confirm whether this is your belief and, if so, how and why you consider that patients were misled? If not your belief, why did you say it to Dr Hughes?

4 (iii) I do believe patients were being misled. The hyperlink included in my 2014 email to Mr O'Brien leads to guidance on off-licence prescribing. This outlines our responsibilities as prescribers to use medication within licence and if a decision is made to use a medication outside its licenced indication or dose then good practice would be to make the patient aware of the reason for this decision in their case. In the cases identified in my statement I could see no evidence that the patients had been advised about the off-licence use of Bicalutamide 50mg monotherapy.

The delayed referral to oncology in the cases in my statement meant that these men waited longer than other men in a similar situation to have an oncology opinion.

5 (i) Please give details of any discussions you had with Dr O'Sullivan regarding shared concerns.

5 (i) The discussions with Prof O'Sullivan would have been as part of the joint Thursday morning outpatient case note review. I believe there would have been a number of cases discussed at that meeting with off licence prescription or perceived delayed referral.

Urology Network Site Specific Group Meeting
Friday 18th September 2015
2.30pm-4.30pm, Conference room 4, Linenhall Street, Belfast

Record of Discussion & Agreed Actions

In Attendance **Videoconference**	Aidan O'Brien (SHSCT), Darren Mitchell (BHSCT), Edel Aughey (NICaN), Ali Thwaini (BHSCT), Hugh O'Kane (BHSCT), Ruth Johnston (BHSCT), Colin Mulholland (WHSCT), Wilma Boyd Carson (SET), Robin Gray (PPI Rep), Mark Haines (SHSCT), Gareth McClean (SHSCT), Kate O'Neill (SHSCT)
Apologies	Fiona Reddick (SHSCT), Davinia Lee(BHSCT), Elizabeth England (WHSCT), Teresa Majury (PPI Rep), Harry Lockhart (PPI Rep), Samantha Thompson (BHSCT), Mary Haughey (NICaN), Mary Jo Thompson (PHA/NICaN), Chris Hagan (BHSCT), Kerry Chambers (WHSCT), Declan O'Rourke (BHSCT), Thamra Ayton (BHSCT), Suneil Jain (BHSCT), Pat Sheils (BHSCT), Jacque Warwick (BHSCT)

	Item	Responsibility / Date
	Welcome & Introductions Aidan O'Brien welcomed everyone to the meeting and apologies were recorded as above.	
1.	**Minutes of last meeting** **The minutes of the last meeting were agreed.** **Matters arising:** **i)** Meeting with DLA Advisory Board: Mr O'Brien advised that the meeting with ATOS Director regard the lasting impacts of cancer with a particular focus on fatigue has not yet taken place but will be arranged and he will update the group at the next meeting. **Action point 1:** Mr O'Brien to arrange a meeting with ATOS and to invite key people to attend. ii) Regional Urology meeting: Mr O'Brien provided update. There have been a number of regional meetings but the local meetings have not taken place as yet. Mr O'Brien would be keen that the NICaN network group would take on one of the sub group roles particularly with regard reviewing and updating clinical management guidelines for suitability of	

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	these being implemented in Northern Ireland. Mr O'Brien is keen that the network group agrees local guidelines which can be reported back to the HSCB and the regional Urology group by the end of the year. Mr Ali Thwaini advised that local guidelines need to be manageable for NI but should also be in line with UK / National guidelines. Mr Mark Haines queried whether the role of the group is to offer advice to HSCB regard what is clinically appropriate or if HSCB advise the network group what should be done clinically?	
5.	**Audits:** It was agreed to move agenda item 5 up and Mr O'Brien invited Dr Anna Gavin, NI Cancer Registry, to present an update on the UK wide patient reported outcomes programme for prostate cancer patients. Dr Gavin advised that the programme aims to find out what effect prostate cancer has had on men's physical, emotional and social wellbeing, as well as exploring the impact on their families and will consist of a number of work-streams including dissemination of a UK wide survey, organisational performance and benchmarking, health economics & patient and public involvement. In Northern Ireland, approximately 4,000 men will be surveyed who have been diagnosed with prostate cancer between 18-24 months previously and registered by NI Cancer Registry between 1st July 2012 and 30th June 2014. The survey will cover urinary and bowel functioning, sexual functioning, psychological and social well-being, physical, social and financial concerns. To date, the survey has been developed and ethical approval will be sought after the methodology has been finalised for NI. The expected outcomes include population based patient reported outcomes from UK which will help to identify gaps, organisational performance measured with feedback, toolkit for comparators and to identify factors associated with poor outcomes. Information about the programme was circulated to all members. Mr O'Brien thanked Dr Gavin and queried if the local Research & Development offices should be contacted regarding the research as well as senior personnel within the trusts. There was also some discussion regard how best to correspond with patients living in the different trust areas and there was a suggestion that a cover letter could be issued through NICaN with HSC / Trust logos and the MDT Lead signatures. There was also discussion on the need to ensure death checks are completed through BSO before any correspondence is issued to patients. **Action point 1**: Ms Edel Aughey to liaise with Lisa McWilliams and Mary Jo Thompson regard using a headed cover letter from NICaN for dissemination of the patient surveys.	**Ms Edel Aughey**
2.	**Peer review: feedback** There was discussion around the issues outlined from peer review. The general consensus was that members should work on taking recommendations forward within each of the trust teams including response to immediate / serious concerns raised. In relation to peer review feedback there was a query if a meeting is required to discuss and decide what is feasible in NI and it was agreed that this may require further discussion with the commissioners.	

Received from Dr Darren Mitchell on 19/05/2023. Annotated by the Urology Services Inquiry.

TRU-162276

Southern Health and Social Care Trust

Acute Governance
Darren Mitchell
Telephone call
23.02.2021

PRESENT: **Dr Darren Mitchell**
Dr Dermot Hughes
Mrs P Kingsnorth

Dr Hughes thanked Dr Mitchell for taking time out to talk to him today. Dr Hughes highlighted the reviews concerns identified in the SAI, explaining there was non-adherence to MDT recommendations, non-referral to oncology services for potential curative therapy, prescribing issues.
He asked if there was any knowledge regarding the concerns mentioned.

Dr Mitchell advised aware of issues going back decade in relation to hormone therapy prescribing, prescribing outside guidelines, Bicalutamide. Dr Mitchell advised he took over as chair of the regional urology MDM in 2015. He advised that they had challenged Mr OB on his use of bicalutamide as part of the development of clinical guidelines whilst Mr OB was chair of the NICAN urology group in 2015. Dr Mitchell wrote the regional guidelines for the use of hormone therapy. This was done in the hope this would address the issues around off-licence prescribing of Bicalutamide. This guideline was circulated and presented when Mr OB was chair of the NICAN urology group and he signed off on the guidelines.

Dr Hughes asked Dr Mitchell to share the guidelines mentioned. Dr Hughes advised a number of patients were to be referred to oncology and this was not done.

Dr Mitchell mentioned a radical bladder cancer case in 2016, Chris Hagan and Gillian Traub noted there was a significant delay in treatment whilst waiting for a bone scan, this case was flagged back to SHSCT. Dr Mitchell believes Mr OB was chair of the southern urology MDM at that stage.

Dr Hughes advised the review was looking at 9 cases, there are significant findings, delays in treatment and care, MDT recommendations were not implemented, referrals to oncology were never made for potential curative treatment, and patients were not brought back to MDT for review. Dr Hughes advised there were systematic issues. The recommendations will include structured review process of MDT processes. NICE guidelines were not adhered to regarding prescribing of bicalutamide. There was very poor oncology support at MDT, oncology attendance at MDT was rare. Dr Mitchell described issues

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
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I spoke to Mr McAleer I believe in 2019 at the point of initial discussion with Mr Haynes and then again in 2020 at the point of being asked to contribute to the look back exercise.

(viii) Were you aware of others who had knowledge of these issues or who may have shared similar concerns? Please give full details.

1(viii) I believe the oncologists providing support as part of their job plan to the Craigavon urology service would have routinely been referred cases from Mr O'Brien and may have come across this off license prescribing. This would include Dr Jonathan McAleese, Professor David Stewart and Dr Fionnuala Houghton. I am not aware of any discussions they had if they had concerns.

(ix) Please provide further details in respect of the suggestion that the MDM 'challenged' Mr O'Brien on his use of Bicalutamide in 2015. In particular, please set out:

(a) the nature and form of the said challenge,

(b) who was present or otherwise involved in same, and

(c) Mr O'Brien's response.

Please provide the Inquiry with copies of any relevant contemporaneous documentation (record, note, email, minute or otherwise) relating to this.

1(ix) I believe this to relate to the discussions at the NICAN urology group meeting on the androgen deprivation guidelines that had been circulated to the group. I was chair of the regional urology MDM at that stage and attended the NICAN meeting in that role. I believe I raised the point at the NICAN urology meeting on 3/1/2015 that the androgen deprivation guidelines were to standardise the prescription of hormone therapy and stop the use of off licence Bicalutamide 50mg monotherapy, however the minutes of the NICAN meetings have not recorded this. (***AOB7, AOB8, AOB9***)

I remember there being a prolonged pause following my point, before Mr O'Brien "extended thanks to Dr Darren Mitchell and Dr Suneil Jain for their work in taking this forward"

2 (i) Please confirm whether the Regional Hormone Therapy guidelines referred to were developed in direct response to concerns about Mr O'Brien's prescribing practices in respect of Bicalutamide.

2 (i) The guidelines were in large part written to address concerns over off licence prescription of Bicalutamide 50mg monotherapy by Mr O'Brien.

(ii) To the extent that the answer to (i) above is 'yes', please explain why this approach was taken, explaining how, if at all, it was intended that the guidelines should address the issues/concerns around off-licence prescribing of Bicalutamide.

2 (ii) This approach was taken in the knowledge that Mr O'Brien would be required to formally review and accept the guidelines in his role as NICAN Chair. I was aware that the guidelines would be discussed at a subsequent NICAN Urology meeting and that would both allow me to formally raise the point as outlined 1(ix) and give Mr O'Brien an opportunity to discuss this off licence practise. I hope that the guidelines and the verbal point as 1 (xi) above would be a prompt for Mr O'Brien to address the off-licence prescription of Bicalutamide 50mg monotherapy.

2 (iii) In your view, ought these guidelines have been subject to audit within individual Trusts? Please explain your answer.

2 (iii) These guidelines could have been audited within each trust. If my belief that Mr O'Brien was the only person in the region using Bicalutamide 50mg monotherapy is correct then it would in essence have been an audit of his hormone therapy prescriptions in the southern trust. The guidelines were written to encourage good practice and provide a point of reference if there were future cases identified with this off-licence prescribing.

2 (iv) Please provide any further relevant comments you may have in relation to the development of these guidelines and the process leading to their approval.

2 (iv) I am not aware that the guidelines were ever formally approved by Mr O'Brien.

3 (i) Please provide this patient's HCN.

3. (i) Patient 127

3 (ii) Please explain the significance of this case, giving further details as to the particular concern raised by Mr Hagan and Ms Traub.

3 (ii) Mr Hagan raised concern to Ms Davinia Lee who I believe was the cancer services manager at the time about avoidable delays in the management of a muscle invasive bladder case referred to him from Craigavon. His concern was around multiple discussions at the southern trust MDM prior to the patient being referred for discussion at the regional meeting and he was concerned that the delays would adversely affect the outcome in this case. Mr Hagans email also identified the use of isotope bone scans as being outside the guidance for staging in muscle invasive bladder cancer. (***AOB11***)

3 (iii) How was this case 'flagged back to SHSCT'? Please identify the mechanism by which this was raised with the Southern Trust and identify any relevant individual(s).

3 (iii) This case was flagged back to Mr O'Brien by email on 26th of August 2016 (***AOB10***) suggesting case note review and consideration of shared learning either locally or regionally. The urology MDM co-ordinator Shauna McVeigh at the southern trust was copied to that email.

1 than just writing back to the GP and copying the
2 relevant consultant.
3 47 Q. Now, I know it's a 2008 to 2014 timeframe, things have
4 changed and governance structures have changed, but at
5 that time, what do you think would have been an 10:39
6 appropriate response to what you had come across at
7 that time? What do you think you might have done, or
8 should have done, or could have done?
9 A. I should have discussed it with my Clinical Director at
10 that time. 10:39
11 48 Q. And who was that?
12 A. So there were a number of clinical directors at that
13 time. I think Dr. McAleer, Dr. McAleese would have
14 been two of the -- and Dr. Houston, would have been
15 three of the clinical directors that were in that early 10:40
16 phase.
17 49 Q. You've mentioned the GP letter; would the dosage of
18 Bicalutamide 50 as a monotherapy, would that be widely
19 known among GPs as perhaps an inappropriate drug regime
20 on its own? 10:40
21 A. I don't think so. It's quite niche in terms of its
22 use. So, I wouldn't expect a general practitioner to
23 have picked up that 50mg as a standalone therapy was
24 incorrect, or to have looked at the guidance on dose
25 prescription for patients. So I don't think it was a 10:40
26 GP's responsibility.
27 50 Q. Now, you were starting off your consultancy in 2008; do
28 you recall at that time what the governance processes
29 in place were? Now we have SAIs, IR1s, we've DATIXs.

1.17 The out-patient nursing issue dated back further. Again, as part of issues raised leading to the McClinton Report I had insisted on having two Clinical Nurse Specialists as opposed to just one. The McClinton Report followed through with the suggestion of wider nurse involvement in clinical care (as noted in Q15).

1.18 The Regional Review of 2009 again recommended a further increase in CNS numbers; however, our unit has had issues with filling these posts with appropriately trained staff until recent years (further detail is noted in Q9, 11, 15, 25, and 59).

1.19 Medical staffing skills issues have arisen over the years. These have been few in number and related to a deficiency in clinical ability. These were identified, assessed and remedial action taken (as noted in responses to Q55 and 57).

1.20 Triage of referral letters, both in general and with specific reference to one consultant, has been an issue for a number of the years. The volume of administration associated with triaging referrals has been considered to be the predominant feature. The introduction of triage return timeframes was identified as an issue when combining daily elective care with the expectation of triage at the same time (as noted in more detail in Q9.4, 13.2, 16.6, and 57.20). The unit's response to this was to introduce the Urologist of the Week for on-call and triage and drop the elective work for this particular week.

1.21 It was also regarded that there possibly was potential hidden pathology within the cohort of patients within the referrals. There was an appreciation that there was a long wait to be seen at out-patients. The unit's response to this was to introduce a more advanced, detailed version of triage which involved booking preliminary tests (further detail is noted in Q5.3, 13.2, 13.3, 45.3, 72.6, and 72.8).

1.22 For one consultant, it was apparent that the process of triage has been an issue for a considerable number of years. This is despite discussions at departmental meetings and agreement on process with DoH representatives. This is

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208. On 7 September 2011 Gillian Rankin wrote to the three urologists informing them that no elective cystectomies were to be performed in the Southern Trust. Martina Corrigan, as Head of Service, monitored the in-patient admissions and theatre lists to ensure that no further elective cystectomies were performed. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20110907 Email for Comment Correspondence to Urologists.*

Triage

209. Triage was an issue which was raised with me at various times.

210. When I was Lead Clinician for Out-patients, Mr O'Brien had a folder in his office with referral letters in it. The issue was raised with me by Mrs Hazel Neill, Nurse Manager for Out-patients, at a regular meeting we had. I spoke to Mr O'Brien at the time (I can't recall when exactly, but it was approximately 1996) pointing out that this practice was not acceptable. He informed me that he had checked the letters and had selected any high risk ("Red flag") letters to be seen quickly. He did however assure me that he would clear the backlog. I also informed the CD, Mr Osmond Mulligan, of the practice and of my actions, as well as the General Manager of the Trust Mr John Templeton. My recollection is that Hazel Neill informed me that the triaging was then completed. Prior to the booking centre, my recollection is that the out-patient staff were responsible for booking appointments and kept a check on the return of letters sent for triage.

211. During the period 2007 to 2009 my recollection is that on (I think) 2 occasions I was asked to speak to Aidan O'Brien to complete the triaging process. I can't recall who asked me to do so.

212. On 30 March 2010 Heather Trouton wrote to Aidan O'Brien and Michael Young pointing out that there were 60 referrals untriaged. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20100310 Email Triage*. It turned out that the delay was with Aidan O'Brien's referrals. On (again, I think) 19th

Received from Mr Eamon Mackle on 12/04/22. Annotated by the Urology Services Inquiry.

April 2010 (it was the period of the Icelandic Ash Cloud), Gillian Rankin and myself were made aware by either Heather Trouton and/or Martina Corrigan that Aidan O'Brien had a significant number of untriaged letters. Aidan O'Brien was also planning to go to a European conference the following day and thus the letters would not be triaged for at least a further week. It was agreed with Gillian Rankin that I would inform him that his study leave would be cancelled if the letters weren't triaged. I note that, by the following morning, all the letters had been triaged.

213. On 27 September 2010 Aidan O'Brien wrote to Gillian Rankin regarding the Regional Review and in his letter confirmed that all red flag referrals were being triaged within one week and that by 1 November 2010 all triaging would be performed within one week, as long as there was a maintenance of three consultants in the unit. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20101004 Email Private and Confidential.* My recollection is that, by this stage, the booking centre were keeping a check on letters sent for triage and number being triaged.

214. However, by the end of March 2011, it was found that Aidan O'Brien had a backlog of 129. On 1 April 2011 Michael Young triaged 14 and Mehmood Akhtar triaged 53 of them. On 4 April 2011 62 letters remained to be triaged, the oldest of which was from 1 February. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20110406 Email Urology Triage.* A meeting on 7 April 2011 was held by Gillian Rankin, myself, Heather Trouton with Aidan O'Brien to discuss same. I don't have minutes of the meeting but I believe that, soon after it, Mr Akhtar took responsibility for the triage of red flag referrals. My understanding is that any named red flag referrals to Aidan O'Brien were followed up by the Cancer trackers.

215. The issue regarding triaging was an intermittent problem and, when Martina Corrigan would raise it, then Aidan O'Brien would comply and then after a period relapse again. I have, when gathering information to aid with

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Performance data was also reviewed at the Governance meetings and any concerning trends noted.

[39] How did you ensure that governance systems, including clinical governance, within the unit were adequate? Did you have any concerns that governance issues were not being identified, addressed and escalated as necessary?

125. The systems are as detailed in my answers above from Questions 33 to 38. At the time we thought the systems were effective and that concerns, as they arose, were being escalated and action taken. As such we did not have any significant governance concerns.

126. The issue regarding the number of benign cystectomies being performed was appropriately investigated, the practice was stopped and compliance monitored.

127. Likewise the issue regarding IV fluids & IV antibiotics was escalated and a protocol produced to change practice. Compliance was monitored and any breaches/ potential breaches followed up and stopped.

128. Regarding triage, this was an ongoing problem. The first time I became aware of it was approximately 1996. I spoke to Aidan O'Brien and he assured me that the "red flag" patients were being triaged and, in response to the intervention, he then completed his triage. Intermittently over the years it would be noted that he was behind on triage and, when challenged, would catch up. Heather Trouton and the Directors (Gillian Rankin, Debbie Burns) were aware that he was slow at performing triage but that, when he was challenged, he would do it. I did inform Paddy Loughran and John Simpson of the issue but I admit I didn't raise it as a serious governance concern and neither did they question it as being one. On reflection due the repeated failure to perform timely triage a thorough investigation should have been undertaken.

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INTEGRATED ELECTIVE ACCESS PROTOCOL

EXECUTIVE SUMMARY

APRIL 2008

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

SECTION 1 – CONTEXT

1.1 This protocol has been developed to encompass the elective pathway within a hospital environment. The principles can be applied to primary and community settings, however it is recommended that guidance is developed which recognises the specific needs of the care pathway provided in these settings.

1.2 The length of time a patient needs to wait for hospital treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital services provided by the Trust. Ensuring prompt timely and accurate communications with patients is a core responsibility of the hospital and the wider local health community.

11.4 Robust data quality is essential to ensure accurate and reliable data is held on PAS, to facilitate clinical and clerical training and to support the production of operational and management information.

1.5 An Executive Director should have lead responsibility for implementing the protocol.

1.6 There a number of underpinning principles:

- Patients should be treated on the basis of clinical urgency
- Patients with same clinical urgency should be treated in turn
- Patients added to lists must be ready for assessment/treatment
- Inpatient care should be exception and not the norm
- Booking systems will be developed to ensure convenience for patients
- Capacity will be linked to Service and Budget Agreements

1.7 Booking principles have been developed to support all areas across the elective pathway where appointment systems are used. Offering patient's

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choice of date and time is essential in agreeing and booking appointments with patients and Trusts should ensure that their booking systems enable patients to choose hospital appointments that are convenient for them.

1.8 Facilitating reasonable offers to patients should be seen within the context of robust booking systems being in place. Booking development work within Trusts should be consistent with regional and local targets and provide a framework for consistent regional booking processes.

1.9 All booking processes should be underpinned with the relevant local policies and procedures to provide clarity to operational staff.

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SECTION 2 – MANAGEMENT OF ICATS

2.1 Referrals will be managed through a centralised registration process in the nominated Hospital Registration Offices (HRO's) to receive, register and process all ICATS referrals.

2.2 Where ICATS is in place for a specialty, all referrals should be registered and scanned on the Electronic Referral Management System (ERMS) within 24 hours of receipt. Each ICATS must have a triage rota to ensure every referral is triaged and the next step confirmed within 3 working days of receipt into HRO. Following triage, the outcome will be confirmed by letter to GP and patient within a further 2 working days (5 working days in total from receipt of referral).

2.3 All new patients should be able to book their appointment and the expectation is that follow-up patients should also be able to choose the date and time of appointment. All patients must be offered reasonable notice. A reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and choice of two appointments.

2.4 Patients who have the opportunity to agree the date and time of their appointment, and who DNA, will normally be referred back to the care of their referring clinician. If a patient cancels their appointment, they will be given a second opportunity to attend, which should be within 6 weeks.

2.5 It is essential that leave/absence of ICATS practitioners is organised in line with the Trust's notification of leave protocol. Trusts should have robust policies and procedures that minimise the cancellation/reduction of ICATS clinics.

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2.6 It is essential that Trusts have effective clinical management arrangements in place. Changes in patient details must be updated on ERMS and medical records on the date of the clinic. When the assessment has been completed and a clear decision taken on the next step, patient outcomes must be recorded on ERMS.

2.7 Robust clinic templates should be agreed between clinicians and service managers, with clear processes in place for requests to change templates.

2.8 A continuous process of data quality validation should be in place to ensure data accuracy at all times. Trusts should ensure that all relevant data fields are completed in ERMS. This should be undertaken as a minimum on a monthly basis and ideally on a weekly basis as waiting times reduce.

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SECTION 3 - MANAGEMENT OF OUTPATIENT SERVICES

3.1 There will be dedicated Hospital Registration Offices (HROs) within Trusts to receive, register and process all outpatient referrals. The HROs will be required to register and scan referrals (where appropriate) onto ERMS and PAS.

3.2 There will be dedicated booking functions within Trusts, developed in line with the booking principles outlined in Section 1.7. The booking processes for non-routine groups of patients, or those with additional needs should be designed to identify and incorporate the specific pathway requirements of these patients.

3.3 To promote and ensure equity for patients, referrals into Trusts should be pooled where possible within specialties. Referrals to a specific consultant by a GP should only be accepted where there are specific clinical requirements or stated patient preference.

3.4 All referrals should be received at the HRO and registered within 1 working day of receipt and able to be tracked through the system. GP priority must be recorded at registration. All outpatient referrals will be prioritised and returned to the HRO within 3 working days. Following prioritisation, referrals must be actioned on PAS and appropriate correspondence issued to patients within 1 working day.

3.5 Where clinics take place, or referrals can be viewed less frequently than weekly, a process must be put in place and agreed with clinicians whereby GP prioritisation is accepted, in order to proceed with booking urgent patients.

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

To: Young, Michael [Personal Information redacted by USI]
Cc: Mackle, Eamon [Personal Information redacted by USI] Gibson, Simon [Personal Information redacted by USI]
Sent: Wed Dec 03 09:51:37 2008
Subject: FW: URGENT - Urology ICATS referrals

Dear Michael

What solutions could you propose to this continuing problem?

Kind regards

Simon

Simon Gibson
Assistant Director of Acute Services - Surgery & Elective Care Southern Health & Social Care Trust
[Personal Information redacted by USI]
[Personal Information redacted by USI]

P Please consider the environment before printing this e-mail.

-----Original Message-----
From: Cunningham, Teresa [Personal Information redacted by the USI]
Sent: 02 December 2008 17:22
To: Gibson, Simon; Mackle, Eamon
Subject: URGENT - Urology ICATS referrals
Importance: High

Dear Simon/Eamon

Please see attached a spreadsheet showing the numbers of referrals which have not as yet been triaged.

As you know this problem has been raised on a number of occasions and for a short while, the situation had improved. Mr O'Brien was triaging the referrals last week and I appreciate that he only returned from a week's leave last Monday. Unfortunately however, as we are working to a
6 week target, the current situation is intolerable.
When I ran the PTL's yesterday, there were only 12 patients on the PTL to be appointed for January, because the referrals have not been triaged. This will undoubtedly lead to a panick situation later on this month in the run up to the Christmas holidays, trying to get patients booked. I think it is unfair that undue pressure is being exerted on me to ensure patients are treated within target dates, and subsequenty on the appointments staff, because I put pressure on them to ring patients to get them appointed.

The service is not manageable under these circumstances and I feel I can not continue to manage it unless this issue is properly addressed. If Mr O'Brien is constantly facing difficulties triaging his referrals within the timeframes specified within the IEAP, then we need to put something else in place to faciitate the smooth operation of the service and to ensure that we can offer patients reasonable notice.

I would appreciate if you could let me know what action will now be taken to resolve this problem once and for all.

Regards

Received from Simon Gibson on 27/06/2022. Annotated by the Urology Services Inquiry.

Mackle, MR E

From: Mackle, MR E
Sent: 02 June 2009 13:10
To: 'Simon.Gibson[Personal Information redacted by the USI] Youart, Joy; O'Brien, Aidan
Subject: Request for leave to clear administration

Simon

Thanks for discussing with me Aidan's request to cancel all clinical work during July to allow him to clear the backlog of paperwork.

I have several serious concerns regarding the request:

1. I think approximately 2 years ago the trust funded a similar exercise to allow Aidan to catchup. It was agreed then that this was a one off and it was his responsibility (as per consultant contract) to prevent such a baglog developing again.

2. There are already 3.87 PAs of admin time in his current job plan. This is way in excess of any other consultant in the trust and is excessive when compared to eg Mr AKhtar (Cons Urologist) who has 1.12 PAs in his job plan for admin.

3. To expect the trust to fund the shortfall in clinical activity in light of Aidan's baglog (despite an over generous allowance of PAs in his job plan) would thus be unreasonable. If his colleagues feel that the request from urology is reasonable then I would expect the sessions to be covered at no additional cost from within the speciality.

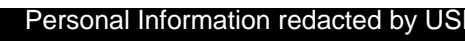
4. If as you state Aidan feels there is now a clinical risk because he has allowed the backlog to develop then there is a serious governance issue regarding his practice. I am copying this email to him so as to get an urgent response to the clinical risk issues he has raised and I may also need to consult with the Medical Director regarding the performance issues raised.

Eamon

Eamon Mackle
Associate Medical Director
Surgery / Elective Care
Southern Trust

Received from Tughans OBO Mr Aidan O'Brien on 26/11/21. Annotated by the Urology Services Inquiry.

AOB-00133


Personal Information redacted by USI

12 June 2009.

Mr. Eamon Mackle,
Associate Medical Director,
Surgery and Elective Care,
Southern Health and Social Care Trust,
Craigavon Area Hospital,
Craigavon,
BT63 5QQ.

Dear Eamon,

Two days ago, I opened and read the copy of the email that you sent to Simon Gibson and to Joy Youart on 02 June 2009, and the accompanying cover slip from you, addressed to me. I did so only then as I had mistakenly gathered from you that it had something to do with the arrangements for ward configuration in July. I was shocked beyond words, appalled and flabbergasted on reading both.

In your email addressed to Simon (and sent to Joy), you thank Simon for discussing with you 'Aidan's request to cancel all clinical work during July to allow him to clear the backlog of paperwork'. I certainly did not make or submit to anyone any request to do so.

These past three months have been the most stressful and distressing that I (and everyone else caring for urological patients) have had to endure since I was appointed 17 years ago. Not only have we had to cope with the imposed loss of our ward, and the fragmentation of inpatient urological services posing a potential existential threat to care, we have also had to cope with the reality of the deliberate lack of information and consultation with those most directly and intimately involved in the delivery of the care. Worse still, we additionally had to cope with the reportage that we had not only been informed and consulted, but were in agreement with the plans. Not only have I endeavoured to seek compromise, I have gone to every length to restore some degree of confidence in the credibility of management, when that was at an unprecedented low.

Then I read your email!

I do believe that it would be reasonable to request and expect an acknowledgement, in writing, that I did not make or submit the request recorded in your email,

Yours Sincerely,

Aidan O'Brien.

Received from Tughans OBO Mr Aidan O'Brien on 26/11/21. Annotated by the Urology Services Inquiry.

Corrigan, Martina

From: Young, Michael Mr <Personal Information redacted by USI>
Sent: 30 March 2010 17:34
To: Trouton, Heather; O'Brien, Aidan
Cc: Mackle, Mr E
Subject: RE: Triage

March 25th is my longest letter !!!!
MY

From: Trouton, Heather
Sent: 25 March 2010 17:14
To: Young, Michael Mr; O'Brien, Aidan
Cc: Mackle, Mr E
Subject: Triage

Michael and Aidan

I really appreciate that you both have been extremely busy in recent weeks and we are grateful for the effort that you have all put in to meet the access standards by the end of March.

However it has been brought to my attention that there are still 60 patient letters that urgently need to be triaged.

Can I request that you give this matter your urgent attention as there may be patient who require an urgent appointment.

Many thanks

Heather.

Received from SHSCT on 02/02/2022. Annotated by the Urology Services Inquiry

63.3 These two issues were defined by the Trust, both of which were brought to my attention at the same time they were raised.

63.4 However, I was also aware that the return of triage letters by Mr O'Brien was slow, as I was aware that completion of triage was a stipulation to allow him to go to the 2010 European Urology Meeting in Barcelona. He was able to complete this task in a short period of time and, as such, I assumed he was just behind and slow in what he was doing. It did raise the concern to me that the Trust took this action at the time and I interpreted this as evidence that they had regarded this as a more chronic issue. However, I was not fully appreciative of that fact at that time.

64. Did you raise any concerns about the conduct/performance of Mr O'Brien? If yes:

(a) Outline the nature of concerns you raised, and why they were raised?
(b) Who did you raise it with and when?
(c) What action was taken by you and others, if any, after the issue was raised?
(d) What was the outcome of raising the issue?
If you did not raise any concerns about the conduct/performance of Mr. O'Brien which were known to you, please explain why you did not?

64.1 Although aware of the episode in 2010, which appeared easily resolved by the prompt completion of Mr O'Brien's triage, it came to my notice when Mr O'Brien, as Lead Clinician for NICaN uro-oncology, was preparing the documentation for the clinical pathways and preparation for the Peer Review in Northern Ireland, that he was behind again on his triage. I had appreciated the significant amount of time preparing this documentation was likely to take. Because of being behind on his triage and knowing it was going to take time to complete the NICaN documentation, I offered to do his triage for a period of time and told him to focus on the NICaN work. I felt the work he was doing was important for both the Trust and Northern Ireland Urology. I think I did this in 2013 for approximately 6 months until his project was completed. Mrs M. Corrigan, Head of Service, was aware of these actions. There

TRU-281926

Urology Triage

Update Monday 4 April 2011

There were a total of 129 letters for triage from Mr O'Brien's office – longest date was 1 February 2011 and these were a mixture of GP and other Consultant referral letters.

On Friday 1 April - Mr Young triaged 14 letters to allow for patients to be sent for ICATS clinics week beginning 4 April.

On Friday 1 April – Mr Akhtar triaged 53 letters which included 3 red flags sent up from Mandeville. From these three 2 were downgraded.

9 were upgraded to red flag and these have been left with Mandeville for appointments at Mr Akhtar's additional clinics next week. Longest wait in this is 3 February.

13 patients to GPWSI (including 1 of the downgraded red flag)
1 patient to stone service
8 patients to LUTS
1 patient was for an urgent appointment at consultant clinic
18 patients for routine consultant clinic (including 1 of the downgraded patients)
2 need to be brought into the ward
1 needs to be discussed at MDT

There are 62 letters still to be triaged by Mr O'Brien –

30 dated February (longest wait is 1 February)
32 dated March (dated from 1 March onwards)

The above figures include internal referrals – consultant to consultant

Received from SHSCT on 02/02/2022. Annotated by the Urology Services Inquiry

Willis, Lisa

From: Corrigan, Martina
Sent: 24 November 2013 17:28
To: O'Brien, Aidan
Cc: McCorry, Monica; Robinson, Katherine; Glenny, Sharon
Subject: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE
Attachments: image003.png

Importance: High

Follow Up Flag: Follow up
Flag Status: Flagged

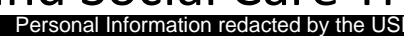
Dear Aidan,

Please advise, this is holding up picking patients for all clinics as these letters have not been triaged and I know that this will need to be escalated early this week if not resolved.

I would be grateful for your action/update

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust

Personal Information redacted by the USI

From: Robinson, Katherine
Sent: 21 November 2013 14:31
To: Corrigan, Martina
Subject: FW: MISSING TRIAGE

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

Personal Information redacted by the USI

From: Browne, Leanne
Sent: 21 November 2013 14:12
To: McCorry, Monica
Cc: Cunningham, Andrea; Robinson, Katherine
Subject: MISSING TRIAGE

Monica

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust

Telephone: Personal Information redacted by USI (Direct Dial)
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

From: O'Brien, Aidan
Sent: 26 November 2013 02:08
To: Corrigan, Martina
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Martina,
I really am so sorry that I have fallen so behind in triaging.
However, whilst on leave, I have arranged all outstanding letters of referral in chronological order, so that I can passed them to CAO via Monica in that order, beginning tomorrow.
I know that I have fallen behind particularly badly (except for red flag referrals which are up to date) and I do appreciate that this causes many staff inconvenience and frustration, and that all have been patient with me!
I can assure you that I will catch up, but am determined to do so in a chronologically ordered fashion,

Aidan

From: Corrigan, Martina
Sent: 24 November 2013 17:28
To: O'Brien, Aidan
Cc: McCorry, Monica; Robinson, Katherine; Glenny, Sharon
Subject: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE
Importance: High

Dear Aidan,

Please advise, this is holding up picking patients for all clinics as these letters have not been triaged and I know that this will need to be escalated early this week if not resolved.

I would be grateful for your action/update

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust

Telephone: Personal Information redacted by USI (Direct Dial)
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

Willis, Lisa

From: Brown, Robin
Sent: 30 November 2013 14:00
To: Young, Michael; Trouton, Heather
Cc: Corrigan, Martina; Carroll, Anita
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE
Attachments: image001.png

Follow Up Flag: Follow up
Flag Status: Flagged

Heather
I wonder if could you call me on the phone to discuss this I had a lengthy one-to-one meeting with AOB in July on this subject and I talked to him again on the phone about it week before last.
I agree that we are not making a lot of headway, but at the same time I do recognise that he devotes every wakeful hour to his work – and is still way behind.
Perhaps some of us – maybe Michael Aidan and I could meet and agree a way forward.
Aidan is an excellent surgeon and I'd be more than happy to be his patient [Personal Information redacted by the USI], so I would prefer the approach to be "How can we help".

Robin

From: Young, Michael
Sent: 26 November 2013 12:35
To: Trouton, Heather; Brown, Robin
Cc: Corrigan, Martina; Carroll, Anita
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Understand
I will speak

From: Trouton, Heather
Sent: 26 November 2013 11:40
To: Young, Michael; Brown, Robin
Cc: Corrigan, Martina; Carroll, Anita
Subject: FW: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Dear Both

In confidence please see below.

I personally have spoken to Mr O'Brien about this practice on various occasions and Martina has also much more often. While we very much appreciate Aidan's response, I suspect that without further intervention by his senior colleagues it will happen again.

I also spoke to him not more than 4 weeks ago both about timely triage and having charts at home and he promised me he would deal with both, however we find today that patients are still with him not triaged from August , he would have known that at the time of our conversation yet no action was taken. I am also advised today that a further IR1 form has been lodged by health records as 6 charts cannot be found.

As stated by Aidan we have been very patient and have offered any help in the past with regard to systems and processes to assist Aidan with this task but it has not been taken up and the delays continue.

Received from Debbie Burns on 09/06/2023. Annotated by the Urology Services Inquiry.

..lis, Lisa

From: Trouton, Heather
Sent: 04 December 2013 18:40
To: Young, Michael; Brown, Robin
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE
Attachments: image001.png

Follow Up Flag: Follow up
Flag Status: Flagged

Michael

I certainly didn't expect it to be sorted within a few days , and to be honest was surprised to be advised that triage was being taken over as I agree it is not fair to ask the other three surgeons to bear this workload. Robin and I had discussed just yesterday and were planning to meet with Aidan next week to fully discuss this issue. I'm sorry that I was given not totally correct information.

Thankyou for helping with the backlog. Happy to discuss further next week to try to come up with a sustainable solution.

Heather

From: Young, Michael
Sent: 03 December 2013 18:57
To: Trouton, Heather; Brown, Robin
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Not sure if the messages have transposed well
Also not sure 'if it is unlikely that Aidan will change' is correct. I do agree however with the chart issue.
I have offered to help out to get the backlog sorted. This should not have been interpreted as a complete take over of the triage. I do not think it acceptable to ask the other consultants to take up this task – this has not been talked about / discussed etc, yet decisions are being made. I do not find this acceptable. You have expected this issue to have been completely sorted within a matter of a few days. I said I would help sort this out and am doing so.

MY

From: Trouton, Heather
Sent: 03 December 2013 17:28
To: Young, Michael; Brown, Robin
Cc: Corrigan, Martina; Carroll, Anita
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Dear Both

Michael, thank you for speaking with Aidan again.

Robin and I had a conversation about this this morning and the only solution we see if it is unlikely that Aidan will change practice is for triage to no longer go to him. I appreciate this will put an increased burden on yourself, Tony and Mr Surresh but it is just too critical to leave as it is.

I believe you have already agreed to do this for the general triage (Martina informs me) which is great and much appreciated.

Received from Mr Eamon Mackle on 12/04/22. Annotated by the Urology Services Inquiry.

Corrigan, Martina

From: Corrigan, Martina Personal Information redacted by the USI
Sent: 24 February 2014 07:45
To: Burns, Deborah; Mackle, Eamon; Young, Michael
Subject: RE: Yesterday

Thanks Debbie,

Michael can we have a chat about how we will manage this operationally with you and the rest of the team?

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Personal Information redacted by the USI

From: Burns, Deborah
Sent: 21 February 2014 19:13
To: Mackle, Eamon; Young, Michael; Corrigan, Martina
Subject: Yesterday

I had a very helpful meeting with Mr O'Brien yesterday (Martina also attended). Mr O'Brien has agreed to not triage new referrals (with exception of those named to himself). He is also to think about if any additional admin support would assist him.

Michael I know this may place an additional burden on the rest of the team but appreciate you accommodating

Thanks for your help with this situation D

Debbie Burns
Interim Director of Acute Services
SHSCT
Personal Information redacted by the USI

Received from SHSCT on 02/02/2022. Annotated by the Urology Services Inquiry

1 I want to ask about this. There has been discussions
2 what was the expectation was. In short form it seems
3 that Mrs. Burns was of the view that this engagement
4 with her was removing triage from Mr. O'Brien in its
5 entirety. 16:29
6 A. Apart from the named --
7 457 Q. Apart from the named referrals?
8 A. Yes.
9 458 Q. But there was no expectation that he would do any
10 other? 16:29
11 A. No, there wasn't, at that stage. And I think the
12 problem is, I did speak to Mr. Young and Debbie's,
13 Mrs. Burns's view from whenever she sent the e-mail was
14 that it would be a team as opposed to just one
15 individual helping out. Mr. Young took it on himself 16:30
16 and didn't, as far as I'm aware, ever discuss it with
17 the team, which would have been, at that stage, maybe
18 Mr. Suresh and Mr. Glackin and himself, I'm trying to
19 think, I have to think about it.
20 459 Q. Sorry, did you say he did discuss it or he didn't? 16:30
21 A. He didn't.
22 460 Q. He didn't?
23 A. No, I don't think so. Mr. Young had helped Mr. O'Brien
24 out on other occasions with doing triage for him
25 whenever -- like and I know it's been mentioned maybe 16:30
26 in Mr. Mackle's evidence, it would have been sort of in
27 or around 2010 time or even pre that. But what I was
28 going to say was Mr. Young took it on himself and then
29 Mr. Young returned it to the Referral & Booking Centre

1 A. Unless it was a named referral, yes.
2 470 Q. And because you had no idea at that point that
3 Urologist of the Week was coming down the tracks in
4 December, was it anticipated that that was temporary,
5 or was that going to continue until triage was caught 16:33
6 up with, or what was the plan?
7 A. The plan was, it was to continue until the foreseeable
8 future. It wasn't to go back to Mr. O'Brien at that
9 stage, or at all, except for the named referrals.
10 471 Q. Did other consultants take on any of that from 16:34
11 Mr. Young at any point, do you know?
12 A. No, because I actually don't believe and they can be
13 asked but I don't believe they realised that Mr. Young
14 had taken that on. I don't believe they had. I think
15 he had done that rather than discuss it with a sort of 16:34
16 do -- a bit like where it talked about the previous
17 consultant had had the issues, it was a team meeting
18 and a team decision and a voluntary. Really and truly
19 what should have happened, what we expected to happen
20 was Mr. Young would have discussed it and then would 16:34
21 have said no, I'm not agreeable to that, or yes, I'll
22 help you out. But that conversation never happened.
23 472 Q. And did the other consultants know that Mr. Young was
24 doing this for Mr. O'Brien?
25 A. I'm not aware that they know. No, I don't think they 16:34
26 did.
27 473 Q. Now, Heather Trouton in her Section 21 - just for the
28 Panel's note, at WIT-12005 at paragraph 60 - calls this
29 an unfair system for the rest of the consultant team.

1 referred name triage?
2 A. That's right, mm-hmm.
3 5 Q. And I just want to feed what you said back to make sure
4 I've understood it before moving on to the default
5 issue. So, at that point, Mr. Young was to take up 10:06
6 Mr. O'Brien's triage duties.
7 A. It was to be the team, but Mr. Young chose to take it
8 up. It was his choice, rather than discuss it with the
9 team, that he would do it himself.
10 6 Q. And was it relayed to Mr. Young from you or Mrs. Burns 10:06
11 that it was expected to be the team?
12 A. It was relayed in the e-mail that Mrs. Burns sent the
13 day after the meeting that it was to be the team. I
14 spoke with Mr. Young after -- I think he asked me to
15 come and see him or I said I was going to come and see 10:07
16 him and I recall speaking to him about it and what he
17 said was, yes, he would speak to the team, but
18 Mr. Young was -- he said "That's going to add a burden
19 to the team", but, he said, "Look, just for now, get
20 all the referrals sent to me instead and then we'll see 10:07
21 how it goes."
22 7 Q. I think your evidence yesterday was that he didn't
23 inform his other colleagues about that --
24 A. As far as I'm aware, I don't think his other colleagues
25 knew. 10:07
26 8 Q. And, subsequently then, Mr. Young stopped doing the
27 triage?
28 A. He did, yes, and after our conversation yesterday
29 evening, I went back and checked, so it was mid

467. At a consultant's meeting on 18 July 2013, it was recorded that "*The current triage process was discussed with its dangers of patients being delayed in triage due to current workloads. Tony has suggested we develop a similar system to that used in Wolverhampton and Guys hospital which we will take forward with our IT and booking centre colleagues*" [AOB-06748]. This demonstrates that others had concerns in relation to the triage system at that time, yet the Trust failed to address and change the system.

468. On 8 October 2013 Ms Trouton noted the serious delay in triage at that stage, whilst understanding the pressures within urology [AOB-06960 – AOB-06962]. I made the Trust aware in an email of 26 November 2013 that I was sorry I was behind in triage and had arranged to catch up on it during leave [TRU-01666-TRU-01672]. Surely the response to that should have been to provide adequate time to carry out the tasks within my job plan, rather than simply raise the issue, know the cause was overwork, yet do nothing substantive to address it, leaving me to address and resolve the backlog while on leave.

469. In early 2014 temporary measures to relieve me of triage commenced [AOB-00611] as Mr Young had agreed to help out at that time [AOB-00646]. That, however, was not only temporary but failed to address the underlying cause, which was progressively exacerbated by the additional burden of my roles with NICaN and with the Trust's Urology MDT and MDM at that time.

470. I was not the only consultant who struggled with the demands of triage whilst on call [see email 13 March 2014 AOB-70484 - AOB-70485].

471. I highlighted a number of issues in relation to red flag triage to colleagues on 16 March 2014 [see AOB-70487 - AOB-70488].

472. In March 2014 I again referred to pressure of work in the context of the referring to the triage backlog [see AOB-70605 - AOB-70606].

Received from Tughans OBO Mr Aidan O'Brien on 02/11/2022. Annotated by the Urology Services Inquiry

1 scan, you have to speak to the person actually to
2 assess their compatibility for MRI scanning.
3
4 I have listened to various narratives with regard to
5 the ability or the practice of my colleagues in the 11:58
6 conduct of triage whilst being urologist of the week,
7 from it being, you know, we don't do that, or they do
8 do that and they do varying things at varying times and
9 so forth. I mean, I think it is somewhat of an irony.
10 I think, you see, the problem is that in the 11:59
11 introduction of urologist of the week, there was
12 undoubtedly a belief that this urologist of the week is
13 going to be the least occupied person of the team
14 because the others are going to be doing all the work
15 and we'll going to be twiddling our thumbs and we'll 11:59
16 have piles of time to do this. Within a short period
17 of time, months, there was a general acceptance, in
18 fact, that this person is the busiest person. You
19 know, I just found that I couldn't do what I felt was
20 required. I felt that there's something fundamentally 11:59
21 wrong, if I just use that simple example, of not
22 dealing with the lady with the recurrent urinary tract
23 infections.
24
25 If you look at - and forgive me, I'll give you the - 12:00
26 yes, Patient 2. Patient 2 is referred in November '18
27 as a routine referral with left epididymal testicular
28 pain. He was triaged by the urologist of the week;
29 kept as routine. If that had remained the case,

1 I don't think that any consultant clinician should be
2 expected, by their employer, to sacrifice so much of
3 their time to meet the expectations of the employer.
4
5 Now, to answer your question more directly, what should 16:01
6 have been the response in 2017, '18, '19? Could we
7 have, as a group of clinicians, sat down in a room and
8 somehow succeeded in getting management to engage with
9 us to at least attempt to understand what those
10 expectations meant for us, the amount of time that was 16:01
11 required to undertake them, and what trade-offs that we
12 could all agree to would be made? But, I mean, I did
13 make a genuine and serious attempt to have those issues
14 that I highlighted, from I would say actually early
15 2015, when I appreciated, and when I made it very clear 16:01
16 that it was impossible for me to complete triage whilst
17 Urologist of the Week, but then more formally in
18 January '17, and again in 2018, to have that real
19 substantive discussion with senior management to
20 address these issues in a sustainable manner, but I 16:02
21 didn't succeed.
22 131 Q. Yes. One of the supports on one view that is available
23 to the clinician is the process of appraisal.
24 A. Mmm.
25 132 Q. And certainly we've heard evidence that when it was 16:02
26 introduced in conjunction with the revalidation
27 process, it was an instrument very much geared towards
28 assisting the professional, the clinician, in their
29 developmental needs, and I think we'll start with that

being maintained by the Appointments Office so that referred patients would be placed on lists awaiting appointments in accordance with the category of urgency indicated by their referrers, in the event that referrals were not triaged and returned.

453. All referral letters were delivered on a daily basis to the Thorndale Unit for collection for triage. I collected all referrals from the Thorndale Unit regularly, usually daily. If working all day on the wards or in theatre as UOW, I would have deferred collection of referrals until the following day. I then brought all the referrals to my office.

454. I continued to triage all red flag referrals, returning them to the Thorndale Unit for collection or, alternatively, delivering them myself to the red flag appointments office. If I had the time to do so, having completed the duties of UOW or while awaiting access to the Emergency Theatre, I would have reviewed non-red flag referrals, particularly to identify any which should evidently have been categorised as red flag on referral. If time was available, I would have triaged whatever number of non-red flag referrals I collected.

455. However, I was unable to undertake triage of all non-red flag referrals which I collected as I did not have the time to do so, as priority was given to the duties of UOW. I do believe that it is important to appreciate that those duties may have had one fully engaged from 9.00 am until midnight or after, if having to operate on a number of acutely ill patients. I found it important to get rest and sleep at that hour as the duties as UOW were unpredictable and resumed at 9.00 am the following morning, at the latest.

456. In any case, I then stored the non-red flag referrals which I had not been able to triage in chronological order in a drawer in the filing cabinet in my office for the following reason. When I did have time when in my office, I checked on my computer the referrals in chronological order to ensure that each had been offered an appointment, or had already attended as an outpatient, or had been admitted

Received from Tughans OBO Mr Aidan O'Brien on 02/11/2022. Annotated by the Urology Services Inquiry

483. Regrettably, they were compromised, for as with me, other consultants were having to make judgement calls and to decide how best to prioritise what was essentially a set of tasks for which there was insufficient time to adequately and satisfactorily complete.

484. I have no doubt that there was inadequate time available to complete triage of all referrals while UOW without compromising the quality of inpatient management or the quality of triage, particularly in the context of increasingly long periods of time awaiting first outpatient appointments, or both. I have no doubt that the chronic, concerning conditions within Ward 3 South demanded more time-consuming vigilance on the part of the UOW. I also do believe that the chronological documentation detailed above reveals a dissonance or disconnect between managerial directorates to an extent that is concerning. Lastly, I also found it consistently the case that the clinician is expected to do it even if he/she has advised that it is impossible.

485. Following my return to work following exclusion in 2017, I continued to conduct triage of red flag referrals as I had always done. However, I had to take one day of annual leave following my UOW week to facilitate complete triage of all referrals. Regrettably, this was at the cost of fewer oncology review clinics each year.

486. As Lead Clinician of the Trust Urology Cancer MDT, I had proposed to my colleagues at an MDT Business Meeting on 12 March 2015 that advanced triage of red flag referrals be undertaken in order to expedite patients along their care pathway. In numerical terms, this represented approximately 20 to 25 red flag referrals, about 20% of the total number of patients referred each week. The cohort of patients being particularly considered were those who probably had prostate cancer, and who could have had prostatic MRI scanning performed prior to their first outpatient consultation when prostatic biopsies could be performed, or soon thereafter. However, my colleagues were unable to commit to doing so, because "*the other duties when urologist on call did not leave adequate time to undertake it"* [see AOB-00839]. As early as four months following the introduction

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

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

571. Thus, the return-to-work plan came to an end at the conclusion of the investigation process.

572. A recommendation was made by the Case Manager for a further action plan to be agreed (with the input of NCAS). I was not approached by the Trust to agree any such plan.

573. The return-to-work plan required the triaging of red flag referrals on a daily basis, and completion of all referrals by 4 pm on the Friday afternoon following my being Urologist of the Week (UOW). I did try to triage all red flag referrals on a daily basis, but it was not always possible, depending upon the demands of UOW. I still found it impossible to complete all triage by 4 pm on the day after completion of UOW, and particularly in the context of ever increasingly longer periods awaiting first outpatient consultations (a point acknowledged by Dr O'Kane in her undated letter to the GMC referring to the 67 day wait for a first appointment [AOB-2271], which rendered the Friday 4 pm deadline all the more unnecessary. In endeavouring to comply, I took off each Friday following UOW as an annual leave day in order to complete as much of the week's triage as possible. However, doing so was at the cost of losing an oncology review clinic as well as a clinic for patients attending for urodynamic studies and flexible cystoscopies.

Received from Tughans OBO Mr Aidan O'Brien on 02/11/2022. Annotated by the Urology Services Inquiry

Southern Health and Social Care Trust

23 March 2016

Mr Aidan O'Brien,
Consultant Urologist
Craigavon Area Hospital

Dear Aidan,

We are fully aware and appreciate all the hard work, dedication and time spent during the course of your week as a Consultant Urologist. However, there are a number of areas of your clinical practice causing governance and patient safety concerns that we feel we need to address with you.

1. **Untriaged outpatient referral letters**

There are currently 253 untriaged letters dating back to December 2014. Lack of triage means we do not know whether the patients are red-flag, urgent or routine. Failure to return the referrals to the Booking Centre means that the patients are only allocated on a chronological basis with no regard to urgency.

2. **Current Review Backlog up to 29 February 2016**

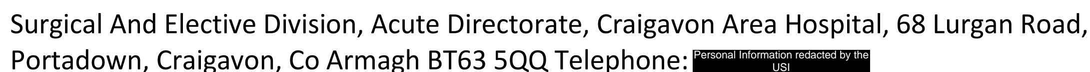
Total in Review backlog = 679

2013	41
2014	293
2015	276
2016	69

We need assurances that there are no patients contained within this backlog that are Cancer Surveillance patients. We are aware that you have a separate oncology waiting list of 286 patients; the longest of whom was to have been seen in September 2013. Without a validation of the backlog we have no assurance that there are not clinically urgent patients on the list. Therefore we need a plan on how these patients will be validated and proposals to address this backlog.

3. **Patient Centre letters and recorded outcomes from Clinics**

Consultant colleagues from not only Urology but also other specialties are frustrated that there is often no record of your consultations/discharges on Patient Centre or in the patients' notes. Validation of waiting lists has also highlighted this issue. If your


Surgical And Elective Division, Acute Directorate, Craigavon Area Hospital, 68 Lurgan Road, Portadown, Craigavon, Co Armagh BT63 5QQ Telephone: Personal Information redacted by the USI

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

1 a lot of work. I think what was challenging was my
2 colleagues knew, for instance, how I did Triage, which
3 was trying to be as efficient as possible. Mr. O'Brien
4 had taken a view that he would phone all of these
5 patients, which inevitably meant that the patients, 15:43
6 when they got phoned, got a very good service because
7 they got essentially a consultation, but it also
8 inevitably took even more time than was required, and
9 so he'd made a choice to do it in a way that took
10 longer than was necessary, and he wasn't willing to 15:43
11 change the way that he did it to take less time and,
12 therefore, enable him to keep on top of it.
13 87 Q. His consideration was that it was necessary to do it in
14 this way because of the demands posed by the waiting
15 lists, if I don't Triage in a deeper, more meaningful 15:43
16 way with this patient, he will be flung on to the, as
17 you said, routine waiting list and unlikely to be seen
18 for an age?
19 A. I mean, ultimately, Triage, as I've reflected earlier,
20 in a system which is not able to meet demand means that 15:44
21 those with routine conditions on the information
22 available to you at Triage, wait many years to be seen.
23 That is inevitable. But to take that mismatch in
24 capacity and demand and turn it into a full telephone
25 consultation for every referral during a week to 15:44
26 mitigate that risk overloads an individual and creates
27 an impossible to deliver workload. At no point had
28 anyone suggested that that was the way it should be
29 done.

Willis, Lisa

From: Carroll, Anita
Sent: 02 May 2014 16:52
To: Trouton, Heather
Subject: FW: Missing Triage

Follow Up Flag: Follow up
Flag Status: Flagged

Don’t panic as you know we are going with gp triage anyway

From: Robinson, Katherine
Sent: 02 May 2014 16:19
To: Browne, Leanne; Carroll, Anita
Cc: Rankin, Christine
Subject: RE: Missing Triage

As you can see these have all been chased several times. Due to the lengthy target now these patients are not due appts yet. When they are we are going to be booking without triage result.

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: Browne, Leanne
Sent: 02 May 2014 16:11
To: Carroll, Anita
Cc: Robinson, Katherine; Rankin, Christine
Subject: Missing Triage

Hi Anita

Can you arrange for the following Urology referrals to be returned from triage as soon as possible please

Hosp

CHI Number

Casenote

Forenames

Surname

Age

Telephone

Telephone Work

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

Willis, Lisa

From: Carroll, Anita
Sent: 09 June 2014 07:43
To: Corrigan, Martina; Trouton, Heather
Subject: Re: Urology Missing Triage

Follow Up Flag: Follow up
Flag Status: Flagged

We are appointing per gp but you prob still need to chase A

From: Corrigan, Martina
Sent: Sunday, June 08, 2014 08:58 PM GMT Standard Time
To: Trouton, Heather
Cc: Carroll, Anita
Subject: Fw: Urology Missing Triage

Heather

Can we have a chat about this. As I am getting no response from Aidan

Thanks

Martina

Martina Corrigan
Head of ENT, Urology & Outpatients
Personal Information redacted by the USI

From: Browne, Leanne
Sent: Friday, June 06, 2014 01:22 PM
To: Corrigan, Martina
Cc: Robinson, Katherine; Rankin, Christine; Coleman, Alana
Subject: RE: Urology Missing Triage

Hi Martina

Mr O'Brien is only getting the referrals named to him, Mr Young is getting the unnamed when Mr O'Brien is on rota

Leanne

From: Corrigan, Martina
Sent: 06 June 2014 13:17
To: Browne, Leanne
Cc: Robinson, Katherine; Rankin, Christine
Subject: RE: Urology Missing Triage

Hi Leanne

Can I check is Mr O'Brien still receiving referrals as I thought they were all to go to Mr Young from beginning of February?

Thanks

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

129. As mentioned above, in 2014, Debbie Burns introduced a new system into the booking office so that patients were placed on the waiting list according to GP grading and in chronological order. The patients would then be upgraded, if necessary, when triage was completed. I was not informed if there was ongoing monitoring of compliance, the results of any monitoring nor did I request any audit of his practice. On reflection, in light of his past history there should have been continuing audit. It was only at the end of 2015 that I was made aware that there appeared to be an issue. His delay in triaging allowed a significant governance risk to arise. The introduction of electronic triage using NIECR in approximately 2018 has increased the governance oversight of the process.

130. The issue re charts at home developed because of Aidan O'Brien's attendance at a urology clinic in Enniskillen. I don't recall being made aware that consultants were transporting the charts back from the clinic rather than the usual method of hospital transport.

131. To the best of my knowledge, pre the introduction of digital dictation, there was no mechanism to monitor that dictation was being done after the clinic other than a secretary flagging it to her line manager. The consultants were given in their job plan 30 minutes at the end of the clinic for dictation, we wrongly assumed the dictation was being performed and the clinic outcomes recorded. I believe that Aidan O'Brien attended the clinic in Enniskillen from 2011 but it was only from approximately 2015 that the issue non-dictation of clinic letters became apparent. Once his colleagues raised concerns with Martina Corrigan, the problem was escalated to Heather Trouton, Esther Gishkori and myself. Esther Gishkori recommended that Richard Wright should be notified. Richard, on having the issues detailed and the past history, advised the approach to be taken to investigate the extent of the issue and to manage it.

[40] How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such as Governance meeting

Received from Mr Eamon Mackle on 12/04/22. Annotated by the Urology Services Inquiry.

66. What actions did you or others take or direct to be taken as a result of these concerns? If actions were taken, please provide the rationale for them. You should include details of any discussions with named others regarding concerns and proposed actions. Please provide dates and details of any discussions, including details of any action plans, meeting notes, records, minutes, emails, documents, etc., as appropriate.

66.1 There had been several reasons to move towards the Urologist of the Week. These were not only recorded as issues by Mr O'Brien but collectively by the department. We had several departmental meetings as part of what we called the 'Blue Sky' approach in 2014 – start with a clean sheet principle ***(Relevant document located at S21 No 55 of 2022, 141a. 20140818 Urology vision pathway 2014 and 141b. The Vision 1 Sept 14 presentation).*** Mr O'Brien was a keen participant in these meetings and with this collective agreement we made. Everyone bought into the process. This allowed more consultant-led decision making on patient care and without the elective activity interfering with triage (there had been thoughts on having elective activity in the afternoons but we all soon appreciated that this was not a good idea). This was an important step for the unit to enhance the service in all aspects including patient safety issues. Mr O'Brien appeared a strong advocate for these changes.

66.2 As noted previously, I appreciated Mr O'Brien had taken on extra work with the documentation relating to NICaN. I offered to help by doing his triage for several months in 2013 to allow him to complete the project. I also helped for a short time the following year with his triage.

66.3 The Booking Office duplicated all the paper referrals so as to have a second record of the referral in case the first was misplaced or not returned. The Booking Office also introduced a default mechanism of a preliminary triage grade as recorded by the person referring the letter but pending amendment to the consultant's assessment later, if necessary. I believe this was introduced in approximately 2014. This initial default triage for the letters assigned to all consultants, and especially Mr

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

O'Brien's, resulted in the red flag and urgent referrals being identified if the letters were not returned within the specified timeframe.

66.4 As previously noted, when the Trust requested the consultants in early 2017 to review the outstanding triage and charts, we engaged with this process promptly and the rationale was to identify if there were any patients at risk from a delay in the screening of letters or to identify if any patients required an early review consult. The follow-up of this process was led by the Trust Management system led by the Directors of Acute Services, Mrs Gishkori and then Mrs McClements. As clinicians, we were not involved in the decision-making process about Mr O'Brien's return to work **(Relevant document located at Relevant to Acute/Evidence after 4 November Acute/Document No 77/Mr M Young/ 20181018 Return to work AP**. This I understand was via the Medical Director and Chief Executive's offices.

66.5 Monitoring of triaged letters and the return time specifically for Mr O'Brien was introduced after his return to work in 2017.

66.6 Monitoring of outstanding dictation for clinics and discharges has recently been introduced as a general policy but I suspect the issues with Mr O'Brien were an initiating factor.

67. As Clinical Lead, did you consider that any concerns raised regarding Mr. O'Brien may have impacted on patient care and safety? If so:

(i) In what way may concerns have impacted on patient care and safety?

(ii) When did any concern in that regard first arise?

(iii) What risk assessment, if any, did you undertake, to assess potential impact? and

(iv) What, if any, steps did you take to mitigate against this? If none, please explain. If you consider someone else was responsible for carrying out a risk assessment or taking further steps, please explain why and identify that person?

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Buckley, LauraC

From:	Corrigan, Martina
Sent:	28 April 2014 15:32
To:	O'Brien, Aidan
Cc:	McCorry, Monica; Trouton, Heather; Carroll, Anita; Robinson, Katherine
Subject:	Urology - 10 04 14 (3).xlsx
Attachments:	Urology - 10 04 14 (3).xlsx
Importance:	High

Aidan,

Please see attached missing triage that has been escalated to me from the booking centre. Monica had advised that you had done quite a bit of triage last week but none of the attached have been returned to the Booking Centre

I would be grateful if you could please arrange for these letters to be triaged and returned to the booking centre as soon as possible.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: Personal Information redacted by USI
Mobile: Personal Information redacted by USI
Email: martina.corrigan Personal Information redacted by USI

Received from Tughans OBO Mr Aidan O'Brien on 26/11/21. Annotated by the Urology Services Inquiry.

Willis, Lisa

From: Carroll, Anita
Sent: 07 June 2014 17:13
To: Corrigan, Martina
Cc: Trouton, Heather
Subject: FW: Urology Missing Triage

Follow Up Flag: Follow up
Flag Status: Flagged

Don't even think it has changed from last week

From: Browne, Leanne
Sent: 06 June 2014 12:00
To: Carroll, Anita
Cc: Robinson, Katherine; Rankin, Christine
Subject: Urology Missing Triage

Hi Anita

This is an updated list of Urology Missing Triage, can you arrange for these referrals to be returned as soon as possible.
We will book the patient regardless of triage when we reach the PTL target date.

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

TRU-277623

Willis, Lisa

From:	Carroll, Anita
Sent:	16 June 2014 14:42
To:	Trouton, Heather; Corrigan, Martina
Cc:	Robinson, Katherine; Browne, Leanne
Subject:	FW: Missing Triage
Follow Up Flag:	Follow up
Flag Status:	Flagged

NOT SURE WHAT YOU CAN DO
But can you speak to mr young ?

From: Browne, Leanne
Sent: 16 June 2014 12:37
To: Carroll, Anita
Cc: Rankin, Christine; Robinson, Katherine
Subject: Missing Triage

Hi Anita

Can you please arrange for the following Urology referrals to be triaged and returned as soon as possible.
When the patient is due an appointment we will book with the referral untriaged.

Thanks

Hosp

CHI Number

Casenote

Forenames

Surname

Age

Telephone

Telephone Work

Spec Code

Cons Code

Priority

Referral Source

Referral Date Only

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

Willis, Lisa

From: Corrigan, Martina
Sent: 05 August 2014 10:06
To: Carroll, Anita
Cc: Trouton, Heather
Subject: RE: Missing Triage

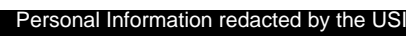
Follow Up Flag: Follow up
Flag Status: Flagged

Anita

These a specifically named referrals to Mr O'Brien. I have spoken to him about these and I will talk to him again about this on Thursday when I am due to meet with him

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital



From: Carroll, Anita
Sent: 04 August 2014 12:54
To: Corrigan, Martina
Cc: Trouton, Heather
Subject: FW: Missing Triage

Martina with mr o brien no longer triaging how does this continue ?

From: Browne, Leanne
Sent: 04 August 2014 11:34
To: Carroll, Anita
Cc: Rankin, Christine; Robinson, Katherine
Subject: Missing Triage

Hi Anita

The list below are referrals not yet received from Urology triage, can you please arrange for them to be triaged and returned as soon as possible. When the patients are due appointments we will book without triage.

Thank you

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

Corrigan, Martina

From: Corrigan, Martina
Sent: 20 November 2014 16:34
To: Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; Suresh, Ram; Young, Michael
Subject: FW: Urology Missing Triage
Attachments: Urology - 14.11.14.xlsx

Importance: High

Dear all

Please see attached there are 206 outstanding triage letters on this list this and this has been escalated to Anita Carroll, Assistant Director, Functional Support and she will most likely escalate to Heather, can I ask if there are any outstanding for you can these please be returned urgently to the booking centre.

You will see the longest outstanding is 263 days and then down to 16 days.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

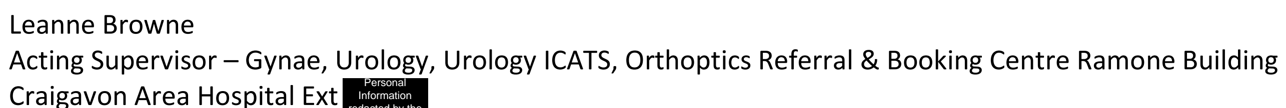
Personal Information redacted by the USI

From: Browne, Leanne
Sent: 20 November 2014 14:53
To: Corrigan, Martina
Subject: Urology Missing Triage

Hi Martina – attached is the up-to-date Urology Missing Triage file.
Can you please arrange for the referrals to be triaged and returned to RBC as soon as possible.

Many thanks

Leanne

Leanne Browne

Acting Supervisor – Gynae, Urology, Urology ICATS, Orthoptics Referral & Booking Centre Ramone Building
Craigavon Area Hospital Ext Personal Information redacted by the USI

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

Stinson, Emma M

From: Young, Michael
Sent: 15 December 2021 09:49
To: Stinson, Emma M
Subject: FW: Personal Information redacted by USI

Section 21

From: Young, Michael
Sent: 22 December 2015 18:35
To: Corrigan, Martina
Subject: RE: Personal Information redacted by USI

This is a r/v case not necessarily a new referal

From: Corrigan, Martina
Sent: 30 November 2015 07:47
To: Young, Michael
Subject: FW: Personal Information redacted by USI
Importance: High

Michael,

Please see attached. I have got 8 more of these similar emails this morning asking for my action. I am only forwarding this to you as an example
and I will really need help at getting this resolved as there are currently 277 not triaged letters from when AOB has been oncall dating back to October 2014!!

I have told the booking centre to continue booking these patients in as their date comes up but just to say that these are letters that have no indication to the booking centre which waiting list they should be on.

I have no doubt that Aidan does look at these whilst he is oncall but it would just appear that he doesn't return them with instructions to the booking centre.

I have no choice but to escalate this to Heather as the longest is going back 58 weeks!

Happy to discuss

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: Personal Information redacted by USI
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

From: Cunningham, Andrea
Sent: 27 November 2015 12:27
To: Corrigan, Martina

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry.

Stinson, Emma M

From: Young, Michael
Sent: 16 December 2021 17:06
To: Stinson, Emma M
Subject: FW: *urgent action required*FW: urology referrals not back from triage

Importance: High

more

-----Original Message-----
From: Corrigan, Martina
Sent: 07 January 2016 16:37
To: Young, Michael
Subject: FW: *urgent action required*FW: urology referrals not back from triage
Importance: High

Michael

If you can help here this would be appreciated? I have emailed Aidan as well.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Muldrew, Angela
Sent: 06 January 2016 16:12
To: Corrigan, Martina
Cc: Clayton, Wendy; rf.appointment
Subject: *urgent action required*FW: urology referrals not back from triage
Importance: High

Hi

See below referrals that we have not received back from triage. Could you please chase these up for us?

Thanks

Angela Muldrew

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry.

As far as I am aware Mr O'Brien was triaging last week and was supposed to be triaging this week but as he is not here Mr Young was doing some of the triaging yesterday and Mr Haynes has triaged all the outstanding referrals that were in the Thorndale unit today and returned them but these referrals were not amongst those returned to us.

Please advise, Caroline

Red Flag Appointments.

Personal Information redacted by the USI

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry.

Young, Michael

From: Corrigan, Martina
Sent: 19 February 2016 10:04
To: Young, Michael
Subject: FW: UROLOGY REFERRALS NOT BACK FROM TRIAGE

Importance: High

Michael

See below – in light of previous conversations I am just escalating to you, I have already forwarded to Aidan, but I am under pressure to get this sorted.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Muldrew, Angela
Sent: 18 February 2016 16:22
To: Corrigan, Martina
Cc: Clayton, Wendy; Reddick, Fiona; rf.appointment
Subject: FW: UROLOGY REFERRALS NOT BACK FROM TRIAGE
Importance: High

Hi Martina

See below referrals that we are waiting coming back from triage. Could you please chase these up for us?

Thanks

Angela Muldrew
RISOH Implementation Officer
Tel. No. Personal Information redacted by the USI

From: Personal Information redacted by the USI
Sent: 18 February 2016 16:08
To: Muldrew, Angela
Subject: UROLOGY REFERRALS NOT BACK FROM TRIAGE

Hi Angela I was just looking at the Urology spreadsheet and I noticed that there are 25 referrals missing from last week, there are another 14 referrals from Monday/Tuesday that have not been triaged yet and are not in the Thorndale Unit, so in total there are 39 referrals unaccounted for, could these be chased up? Mr O'Brien was on triage from last Thursday until yesterday and now Mr O'Donoghue is on triage.

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry.

Corrigan, Martina

From: Mackle, Eamon Personal Information redacted by the USI
Sent: 30 March 2016 19:17
To: Wright, Richard
Subject: Fwd: Confidential letter to AOB - updated March 2016
Attachments: Confidential letter to AOB - updated March 2016.docx; ATT00001.htm

Hi Richard

I met with Aidan and discussed the attached letter which I also gave to him.

Regards

Eamon

Received from SHSCT on 02/02/2022. Annotated by the Urology Services Inquiry

Southern Health and Social Care Trust

23 March 2016

Mr Aidan O'Brien,
Consultant Urologist
Craigavon Area Hospital

Dear Aidan,

We are fully aware and appreciate all the hard work, dedication and time spent during the course of your week as a Consultant Urologist. However, there are a number of areas of your clinical practice causing governance and patient safety concerns that we feel we need to address with you.

1. <u>Untriaged outpatient referral letters</u>

There are currently 253 untriaged letters dating back to December 2014. Lack of triage means we do not know whether the patients are red-flag, urgent or routine. Failure to return the referrals to the Booking Centre means that the patients are only allocated on a chronological basis with no regard to urgency.

2. <u>Current Review Backlog up to 29 February 2016</u>

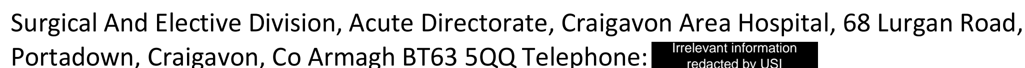
Total in Review backlog = 679

2013	41
2014	293
2015	276
2016	69

We need assurances that there are no patients contained within this backlog that are Cancer Surveillance patients. We are aware that you have a separate oncology waiting list of 286 patients; the longest of whom was to have been seen in September 2013. Without a validation of the backlog we have no assurance that there are not clinically urgent patients on the list. Therefore we need a plan on how these patients will be validated and proposals to address this backlog.

3. <u>Patient Centre letters and recorded outcomes from Clinics</u>

Consultant colleagues from not only Urology but also other specialties are frustrated that there is often no record of your consultations/discharges on Patient Centre or in the patients' notes. Validation of waiting lists has also highlighted this issue. If your


Surgical And Elective Division, Acute Directorate, Craigavon Area Hospital, 68 Lurgan Road,
Portadown, Craigavon, Co Armagh BT63 5QQ Telephone: Irrelevant information redacted by USI

Received from SHSCT on 02/02/2022. Annotated by the Urology Services Inquiry

patient is reviewed at another Urology Clinic a new appointment slot is required due to the lack of documentation.
This lack of documentation combined with no record of clinic outcomes means further investigations/follow-up may not be organised by admin staff.

4. **Patient Notes at home**

This has been an ongoing issue for years and needs addressed urgently. We request that all SHSCT charts that are in your home or in your car be brought to the hospital without further delay.

You will appreciate that we must address these governance issues and therefore would request that you respond with a commitment and immediate plan to address the above as soon as possible.

Yours sincerely,

Eamon Mackle
Associate Medical Director

Heather Trouton
Assistant Director

Surgical And Elective Division, Acute Directorate, Craigavon Area Hospital, 68 Lurgan Road, Portadown, Craigavon, Co Armagh BT63 5QQ Telephone: Irrelevant information redacted by USI

Received from SHSCT on 02/02/2022. Annotated by the Urology Services Inquiry

this response, sought information from Heather Trouton who has shared an email of 4 December 2013 showing that Robin Brown spoke to him in July 2013 and again in November 2013 regarding triage and that Michael Young had offered to help with the backlog. Document located in Section 21 4 of 2022, 20131204 E re Missing Triage.

216. On 21 February 2014 Mrs Debbie Burns wrote to me to say that Martina Corrigan and herself had a meeting with Aidan O'Brien on 20 February 2014 and it is recorded that Aidan O'Brien would only triage named referrals (i.e., referrals that have been sent specifically to him). *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20140221 Email Yesterday.* Debbie Burns also asked Aidan O'Brien to consider if he required any additional administration support. My recollection is that he requested to have no clinics in July to allow him to catch up on his administration.

217. I have, when gathering information to aid with this response, sought information from Martina Corrigan in respect of some matters relating to triage and I understand that Michael Young performed Aidan O'Brien's triage for approximately 6 months in 2014.

218. As it was felt that there was a potential risk to patient safety of delayed triage (albeit that the significance of that risk was not, in my view, properly appreciated at the time), and to mitigate the risk, Debbie Burns in (I believe) 2014 instructed the booking centre to initially record all referrals as per the GP grading pending a completed triage. If referrals were upgraded by the consultant, then they would adjust the waiting lists. My recollection is that at the end of 2015 we became aware of the issue of non-recording of patient outcomes and this triggered further investigation into his practice and the continued issue with triage was identified.

219. On reflection, it is apparent that following this change in practice monitoring of compliance should have continued but no outcomes of any checks were reported to me.

Received from Mr Eamon Mackle on 12/04/22. Annotated by the Urology Services Inquiry.

Patient discussed at Urology MDM on 20th November 2014. Recorded outcome Personal's Re-staging MRI scan has shown organ confined prostate cancer for direct referral to Dr Houghton for Radical Radiotherapy. For OP Review with Mr O'Brien.' Was reviewed by Mr O'Brien in OP on 28th November 2014. No correspondance created from this appointment.
Referral letter from GP received 16th October 2015 stating that Personal had not received any appointments from oncology.

Please go to Personal Information redacted by the USI to view and approve it.

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.