From:	Boyce, Tracey
To:	Gishkori, Esther
Cc:	Stinson, Emma M
Subject:	FW: Emailing: sc of partial SAI
Date:	09 November 2016 15:39:05
Attachments:	sc of partial SAI.pdf
Importance:	High
Sensitivity:	Confidential

Hi Esther
I had my weekly update with the governance leads today and they shared a draft of an SAI that is nearing completion as they are concerned about its implications - I have attached the first page to give you the gist. I think we may need to discuss this one with Richard as the cause seems to be directly attributable to one of the consultants (AOB)?

Basically this lady's GP sent in a referral in relation to an incidental finding on a CT in relation to her kidneys - it came in as routine.
The urologist consultant of the week collected that week's letters to do triage, as per the urology arrangements but from what the investigation team has found out that letter was never seen again and no instruction were received re triage appointment booking.

Apparently this had happened before with this consultant so the booking team's way of dealing with these type of 'lost letters' was to book them a routine appointment (because letters were lost before they had started keeping copies to work from). As a result there was a 16 month delay in diagnosing this ladies renal carcinoma. The triage consultant is meant to look at the CT as part of triage process but the SAI team found that it hadn't been looked at. The urologist on the SAI team has said if it had been reviewed at triage it would have been immediately obvious it was a tumour. (there was also an issue in relation to the reporting of a subsequent MRI back in 2014 that meant the GP or breast team did not pick up that it was potentially a red-flag or urgent referral was needed)

Although this was an SAI about a single case it has come to light that the other 7 urology referral letters received that week are also missing - as an initial action I have asked Trudy and Connie to try and track them via PAS to check they have been seen and pull their notes if necessary. I haven't asked the question yet whether we know if any more of that consultants weeks triage letters have been lost - but it is probably something we need to discuss.

I am conscious that I haven't spoken to Ronan about this yet as AOB's AD - but I wanted to get your take on it before I shared it with anyone else.

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy
Personal Information redacted by the USI

Gibson, Simon

From: Richard.Wright[Personal Information redacted by the USI]
Sent: 30 November 2016 09:36
To: Esther.Gishkori[Personal Information redacted by the USI]
Cc: Vivienne.Toal[Personal Information redacted by the USI]
Subject: Confidential

Hi Esther.
Thank you for keeping me informed of some of the issues that have come to light from an ongoing SAI investigation re Mr OBrien.
I'm sure you are as disappointed as I am that there seem to be outstanding issues with regard to his behaviour. Can your team provide reassurance that the immediate issues re patients notes have been rectified and update me as to the state of the SAI investigation as at first glance it appears there may have been a patient data breach to be considered?
Clearly In my role as data guardian I need to be informed if there has indeed been a breach.
Have we clearly established why Mr OBrien is on leave? if he is on leave has a sick line be submitted? If not can we refer him to occupational health to establish his current status?
Regards Richard

Sent from my iPad

Gibson, Simon

From: Wright, Richard [redacted]
Sent: 06 December 2016 10:52
To: Gishkori, Esther
Subject: RE: Confidential

Thanks Esther. That sounds very reasonable. Any ideas when that is likely to be? Richard

-----Original Message-----
From: Gishkori, Esther
Sent: 06 December 2016 09:31
To: Wright, Richard
Cc: Toal, Vivienne
Subject: RE: Confidential

Dear Richard,
I can confirm that Mr O'Brien has [redacted] that sick lines are being submitted appropriately. I do not think that an occupational health referral is indicated at this point although it may well be in the coming weeks as Mr O'Brien is likely to return before he is well. We shall see in due course.

Patient notes are being returned as requested from Mr O'Brien however, Trudy Reid (governance facilitator) is not sure if all notes taken off the premises have been returned. The governance team are in the process of checking this out. It is difficult to be completely sure until notes cannot be found but we are doing our best.

The SAI review continues and will no doubt produce its own recommendations.

I have been having conversations in relation to Mr O'Brien's "return to work" interview. We thought that this would be a good time to set out the ground rules from the start.
Since Colin and Charlie are both off [redacted], Mark wondered if you and I could do this. Since there are both professional and operational issues here, I feel that this is entirely reasonable.

Will chat to you about it as we will have until the new year to think about it.

Best,
Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office [redacted] Mobile [redacted]
[redacted]

-----Original Message-----
From: Wright, Richard
Sent: 30 November 2016 09:36
To: Gishkori, Esther
Cc: Toal, Vivienne
Subject: Confidential

Hi Esther.

HSC Southern Health and Social Care Trust

15 December 2016

Dear Tracey

As you are aware the SAI review and report in relation to Patient 10 reference number Personal Information redacted by the USI is complete.

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

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

Discussed c Karen Tracey
Esther 20/12/16

Hand delivered to TB
Friday 16/12/16

Issues and Themes of concern include:

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

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

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

If you have any further questions, do not hesitate to contact me directly.
Sincerely
Connie

Mrs Connie Connolly
Lead Nurse Acute Governance

From:	Carroll, Ronan
To:	Wright, Richard; Kerr, Vivienne; Gishkori, Esther; Gibson, Simon; Boyce, Tracey
Subject:	FW: Backlog report - no clinic outcomes
Date:	23 December 2016 10:24:54
Attachments:	Backlog Report - no clinic outcomes as per 15.12.16.xlsx
Importance:	High

Please see updated position re AoB backlog of undictated clinics

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

From: Carroll, Anita
Sent: 22 December 2016 13:59
To: Carroll, Ronan
Subject: FW: Backlog report - no clinic outcomes
Importance: High

Maybe we can get a chat about this

From: Robinson, Katherine
Sent: 20 December 2016 17:07
To: Carroll, Anita
Subject: FW: Backlog report - no clinic outcomes
Importance: High

See attached list. This is a list of clinics that Mr O,Brien has not dictated on and hence no outcome for some of these patients. There is a risk that something could be missed so I am escalating to you, although I know that a lot of the time Mr O'Brien knows himself what is to happen with patients. Unfortunately this was not highlighted on the backlog report. The secretary assumed we knew because there have always been issues with this particular consultant's admin work from our perspective.

As learning from this discovery I have asked all secretaries to provide this information on the backlog report so that we fully understand the whole picture of what is outstanding in each specialty. The secretary also advises that at present Mr O'Brien is working on some of his backlogged admin work as he is off sick recovering.

Regards

K

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: Cunningham, Andrea
Sent: 19 December 2016 13:09
To: Robinson, Katherine
Subject: FW: Backlog report - no clinic outcomes
Importance: High

Update as discussed.

Regards
Andrea

Andrea Cunningham
Service Administrator
Ground Floor
Ramone Building
CAH

E: Personal Information redacted by USI
T: Personal Information redacted by USI

From: Elliott, Noleen
Sent: 15 December 2016 14:04
To: Cunningham, Andrea
Subject: Backlog report - no clinic outcomes

Andrea,

Please find attached list of clinics with no outcomes completed as per 15th December 2016.

Noleen

Mrs Noleen Elliott
Mr O'Brien's Secretary
Level 2
CRAIGAVON AREA HOSPITAL
Tel No: Personal Information redacted by USI

DATE	CLINIC	CLINIC CODE
24/11/2014	SWAH	EUROAOB
22/12/2014	SWAH	EUROAOB
12/01/2015	SWAH	EUROAOB
23/02/2015	SWAH	EUROAOB
09/03/2015	SWAH	EUROAOB
13/04/2015	SWAH	EUROAOB
11/05/2015	SWAH	EUROAOB
22/06/2015	SWAH	EUROAOB
06/07/2015	SWAH	EUROAOB
28/09/2015	SWAH	EUROAOB
19/10/2015	SWAH	EUROAOB
02/11/2015	ARMAGH CLINIC	AAOBU1
06/11/2015	URODYNAMICS CLINIC	CAOBUDS
24/11/2015	NEW CLINIC	CAOBTDU
30/11/2015	SWAH	EUROAOB
04/12/2015	URODYNAMICS CLINIC	CAOBUDS
07/12/2015	ARMAGH CLINIC	AAOBU1
22/12/2015	NEW CLINIC	CAOBTDU
08/01/2016	UROONCOLOGY CLINIC	CAOBUO
11/01/2016	SWAH	EUROAOB
15/01/2016	UROONCOLOGY CLINIC	CAOBUO
08/02/2016	SWAH	EUROAOB
07/03/2016	SWAH	EUROAOB
21/03/2016	ARMAGH CLINIC	AAOBU1
01/04/2016	UROONCOLOGY CLINIC	CAOBUO
04/04/2016	REVIEW CLINIC - CAH	CAOBTDUR
08/04/2016	UROONCOLOGY CLINIC	CAOBUO
15/04/2016	UROONCOLOGY CLINIC	CAOBUO
18/04/2016	ARMAGH CLINIC	AAOBU1
19/04/2016	NEW CLINIC	CAOBTDU
22/04/2016	UROONCOLOGY CLINIC	CAOBUO
22/04/2016	URODYNAMICS CLINIC	CAOBUDS
29/04/2016	UROONCOLOGY CLINIC	CAOBUO
29/04/2016	URODYNAMICS CLINIC	CAOBUDS
03/05/2016	REVIEW CLINIC - CAH	CAOBTDUR
06/05/2016	URODYNAMICS CLINIC	CAOBUDS
23/05/2016	REVIEW CLINIC - CAH	CAOBTDUR
27/05/2016	UROONCOLOGY CLINIC	CAOBUO
27/05/2016	URODYNAMICS CLINIC	CAOBUDS
03/06/2016	URODYNAMICS CLINIC	CAOBUDS
10/06/2016	UROONCOLOGY CLINIC	CAOBUO
13/06/2016	ARMAGH CLINIC	AAOBU1
20/06/2016	SWAH	EUROAOB
04/07/2016	REVIEW CLINIC - CAH	CAOBTDUR
22/07/2016	UROONCOLOGY CLINIC	CAOBUO
26/07/2016	NEW CLINIC	CAOBTDU
09/08/2016	NEW CLINIC	CAOBTDU
12/08/2016	UROONCOLOGY CLINIC	CAOBUO
19/08/2016	UROONCOLOGY CLINIC	CAOBUO

19/08/2016	URODYNAMICS CLINIC	CAOBUDS
22/08/2016	SWAH	EUROAOB
19/09/2016	SWAH	EUROAOB
07/10/2016	URODYNAMICS CLINIC	CAOBUDS
11/10/2016	NEW CLINIC	CAOBTDU
14/10/2016	URODYNAMICS CLINIC	CABOUDS
14/10/2016	UROONCOLOGY CLINIC	CAOBUO
21/10/2016	URODYNAMICS CLINIC	CAOBUDS
28/10/2016	URODYNAMICS CLINIC	CAOBUDS
28/10/2016	UROONCOLOGY CLINIC	CAOBUO
04/11/2016	URODYNAMICS CLINIC	CAOBUDS
04/11/2016	UROONCOLOGY CLINIC	CAOBUO

Toal, Vivienne

From: Gibson, Simon <Personal Information redacted by USI>
Sent: 21 December 2016 12:11
To: Toal, Vivienne
Subject: FW: AOB

See below for context

Kind regards

Simon

Simon Gibson
Assistant Director - Medical Directors Office Southern Health & Social Care Trust
Personal Information redacted by USI
Mobile: Personal Information redacted by USI
DHH: Personal Information redacted by USI Ext Personal Information redacted by

-----Original Message-----
From: Gibson, Simon
Sent: 21 December 2016 11:45
To: Wright, Richard
Subject: RE: AOB

Dear Richard

Yes. I will come in to DHH and web-cam in; I think we should involve Viv, she is in CAH and free all day.

2.30pm?

Kind regards

Simon

Simon Gibson
Assistant Director - Medical Directors Office Southern Health & Social Care Trust
Personal Information redacted by USI
Mobile: Personal Information redacted by USI
DHH: Personal Information redacted by USI Ext Personal Information redacted by

-----Original Message-----
From: Wright, Richard
Sent: 21 December 2016 11:26
To: Gibson, Simon
Subject: AOB

Hi Simon. Esther rang me re worrying developments re AOB and lost notes. Ronan is to report tomorrow with preliminary findings. I will come in tomorrow. If you are about could we set up a meeting with Ronan and if possible

Mark Haynes to consider findings (Esther is off) and next steps. I don't think we can wait for the formal completion of SAI . Regards Richard

Sent from my iPad

Southern Health & Social Care Trust

Oversight Committee
22nd December 2016

Present:
Dr Richard Wright, Medical Director (Chair)
Vivienne Toal, Director of HROD
Ronan Carroll, on behalf of Esther Gishkori, Director of Acute Services

In attendance:
Simon Gibson, Assistant Director, Medical Director's Office
Malcolm Clegg, Medical Staffing Manager
Tracey Boyce, Director of Pharmacy, Acute Services Directorate

Dr A O'Brien

Context
On 13th September 2016, a range of concerns had been identified and considered by the Oversight Committee in relation to Dr O'Brien. A formal investigation was recommended, and advice sought and received from NCAS. It was subsequently identified that a different approach was to be taken, as reported to the Oversight Committee on 12th October.

Dr O'Brien was scheduled to return to work on 2nd January following a period of Personal Information redacted leave, but an ongoing SAI has identified further issues of concern.

Issue one
Dr Boyce summarised an ongoing SAI relating to a Urology patient who may have a poor clinical outcome due to the lengthy period of time taken by Dr O'Brien to undertake triage of GP referrals. Part of this SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason. It was noted as part of this investigation that Dr O'Brien had been undertaking dictation whilst he was on Personal Information redacted leave.

Ronan Carroll reported to the Oversight Committee that, between July 2015 and Oct 2016, there were 318 letters not triaged, of which 68 were classified as urgent. The range of the delay is from 4 weeks to 72 weeks.

Action
A written action plan to address this issue, with a clear timeline, will be submitted to the Oversight Committee on 10th January 2017
Lead: Ronan Carroll/Colin Weir

Issue two

An issue has been identified that there are notes directly tracked to Dr O'Brien on PAS, and a proportion of these notes may be at his home address. There is a concern that some of the patients seen in SWAH by Dr O'Brien may have had their notes taken by Dr O'Brien back to his home. There is a concern that the clinical management plan for these patients is unclear, and may be delayed.

Action

Casenote tracking needs to be undertaken to quantify the volume of notes tracked to Dr O'Brien, and whether these are located in his office. This will be reported back on 10th January 2017
Lead: Ronan Carroll

Issue three

Ronan Carroll reported that there was a backlog of over 60 undictated clinics going back over 18 months. Approximately 600 patients may not have had their clinic outcomes dictated, so the Trust is unclear what the clinical management plan is for these patients. This also brings with it an issue of contemporaneous dictation, in relation to any clinics which have not been dictated.

Action

A written action plan to address this issue, with a clear timeline will be submitted to the Oversight Committee on 10th January 2017
Lead: Ronan Carroll/Colin Weir

It was agreed to consider any previous IR1's and complaints to identify whether there were any historical concerns raised.
Action: Tracey Boyce

Consideration of the Oversight Committee

In light of the above, combined with the issues previously identified to the Oversight Committee in September, it was agreed by the Oversight Committee that Dr O'Briens administrative practices have led to the strong possibility that patients may have come to harm. Should Dr O'Brien return to work, the potential that his continuing administrative practices could continue to harm patients would still exist. Therefore, it was agreed to exclude Dr O'Brien for the duration of a formal investigation under the MHPS guidelines using an NCAS approach.

It was agreed for Dr Wright to make contact with NCAS to seek confirmation of this approach and aim to meet Dr O'Brien on Friday 30th December to inform him of this decision, and follow this decision up in writing.
Action: Dr Wright/Simon Gibson

The following was agreed:
Case Investigator – Colin Weir
Case Manager – Ahmed Khan

From: Boyce, Tracey
Sent: 22 December 2016 10:31
To: Carroll, Ronan; Gishkori, Esther; Wright, Richard
Subject: FW: Copy of Urology - AOB missing triage.xlsx
Attachments: Copy of Urology - AOB missing triage.xlsx; Level 2 HSC RCA Report Patient 10 Draft Six for litigation.docx; Timeline in preparation for screening [redacted] Summary of key points of concern Patient 10 [redacted] docx

Hi
Please find attached the final draft SAI report for our discussions today and also the spreadsheet of outstanding triage as created by the secretarial team.

I have also created a shortened summary of the letter sent to myself and Esther by the SAI review team – attached

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy
Personal Information redacted by USI
[redacted]

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

From: Connolly, Connie
Sent: 20 December 2016 17:08
To: Boyce, Tracey
Cc: Reid, Trudy
Subject: Copy of Urology - AOB missing triage.xlsx

Tracey- as discussed
Connie

UROLOGY

Hosp	CHI Number	Casenote	Forenames	Surname	Age	Telephone	Telephone Work	Telephone Mobile	Spec Code	Cons Code	Priority	Referral Source	Reason for Referral	Referral Date Only	Current Date	Date Booked (Y/N)	Appt Date	Non Clinical Comments	Clinic Identifier/Code	WL Code	WL Cnc Code	Weeks Waiting
CAH	Personal Information redacted by the USI				95	Personal Information redacted by the USI			URO	AOB	ROUTINE	OC	ADV	28/07/2015	28/07/2015	N		AC 300316 *MTNL - AOB ONLY* LTR IN FOLDER		CU2N		72
CAH					23				URO	AOB	ROUTINE	GPR	ADV	27/08/2015	27/08/2015	N		AC 300316 *MTNL*		CU2N		68
CAH					78				URO	AOB	ROUTINE	GPR	ADV	27/08/2015	27/08/2015	N		AC 300316 *MTNL*		CU2N		68
CAH					43				URO	AOB	ROUTINE	GPR	ADV	27/08/2015	27/08/2015	N		AC 300316 *MTNL*		CU2N		68
CAH					17				URO	AOB	ROUTINE	GPR	ADV	27/08/2015	27/08/2015	N		AC 300316 *MTNL*		CU2N		68
CAH					39				URO	AOB	ROUTINE	GPR	ADV	27/08/2015	27/08/2015	N		AC 300316 *MTNL*		CU2N		68
CAH					72				URO	GURO	ROUTINE	OC	ADV	27/08/2015	27/08/2015	N		AC 300316 *MTNL*		EURONR		68
CAH					22				URO	AOB	ROUTINE	GPR	ADV	28/08/2015	28/08/2015	N		AC 300316 *MTNL*		CU2N		68
CAH					30				URO	AOB	ROUTINE	GPR	ADV	28/08/2015	28/08/2015	N		AC 300316 *MTNL*		CU2N		68
CAH					73				URO	AOB	ROUTINE	GPR	ADV	01/09/2015	01/09/2015	N		AC 310316 *MTNL*		CU2N		67
CAH					29				URO	AOB	ROUTINE	GPR	ADV	01/09/2015	01/09/2015	N		AC 310316 *MTNL*		CU2N		67
CAH					58				URO	AOB	ROUTINE	GPR	ADV	01/09/2015	01/09/2015	N		AC 310316 *MTNL*		CU2N		67
CAH					31				URO	AOB	ROUTINE	GPR	ADV	01/09/2015	01/09/2015	N		AC 310316 *MTNL*		CU2N		67
CAH					51				URO	AOB	ROUTINE	GPR	ADV	01/09/2015	01/09/2015	N		AC 310316 *MTNL*		CU2N		67
CAH					74				URO	AOB	ROUTINE	GPR	ADV	01/09/2015	01/09/2015	N		AC 310316 *MTNL*		CU2N		67
CAH					47				URO	GURO	ROUTINE	GPR	ADV	01/09/2015	01/09/2015	N		AC 310316 *MTNL*		EURONR		67
CAH					54				URO	AOB	ROUTINE	GPR	ADV	02/09/2015	02/09/2015	N		AC 310316 *MTNL*		CU2N		67
CAH					76				URO	AOB	ROUTINE	OC	ADV	10/09/2015	10/09/2015	N		AC 310316 *AOB ONLY - MTNL*		CU2N		66
CAH					14				URO	AOB	ROUTINE	OC	ADV	11/09/2015	11/09/2015	N		AC 310316 *MTNL - AOB ONLY* LTR IN FOLDER		CU2N		66
CAH					69				URO	AOB	ROUTINE	OC	ADV	23/09/2015	23/09/2015	N		AC 310316 *MTNL - AOB ONLY*		CU2N		64
CAH					34				URO	AOB	ROUTINE	GPR	ADV	30/09/2015	30/09/2015	N		AC 310316 *MTNL - AOB ONLY*		EURONR		63
CAH					35				URO	AOB	ROUTINE	AE	ADV	01/10/2015	01/10/2015	N		AC 310316 *MTNL*		CU2N		63
CAH					50				URO	AOB	ROUTINE	GPR	ADV	01/10/2015	01/10/2015	N		AC 310316 *MTNL*		CU2N		63
CAH					70				URO	AOB	ROUTINE	GPR	ADV	01/10/2015	01/10/2015	N		AC 310316 *MTNL*		CU2N		63
CAH					77				URO	GURO	ROUTINE	GPR	ADV	01/10/2015	01/10/2015	N		AC 310316 *MTNL*		EURONR		63
CAH					35				URO	RJB	ROUTINE	GPR	ADV	01/10/2015	01/10/2015	N		AC 310316 *MTNL*		CRJBUN		63
CAH					81				URO	AOB	ROUTINE	GPR	ADV	02/10/2015	02/10/2015	N		AC 310316 *MTNL*		CU2N		63
CAH					43				URO	AOB	ROUTINE	GPR	ADV	02/10/2015	02/10/2015	N		AC 310316 *MTNL*		CU2N		63
CAH					68				URO	AOB	ROUTINE	GPR	ADV	02/10/2015	02/10/2015	N		AC 310316 *MTNL*		CU2N		63
CAH					48				URO	AOB	ROUTINE	GPR	ADV	02/10/2015	02/10/2015	N		AC 310316 *MTNL*		CU2N		63
CAH					28				URO	AOB	ROUTINE	GPR	ADV	02/10/2015	02/10/2015	N		AC 310316 *MTNL*		CU2N		63
CAH					40				URO	RJB	ROUTINE	GPR	ADV	02/10/2015	02/10/2015	N		AC 310316 *MTNL*		CRJBUN		63
CAH					70				URO	AOB	ROUTINE	AE	ADV	05/10/2015	05/10/2015	N		AC 310316 *MTNL*		CU2N		62
CAH					66				URO	GURO	ROUTINE	GPR	ADV	05/10/2015	05/10/2015	N		AC 310316 *MTNL*		EURONR		62
CAH					72				URO	AOB	ROUTINE	GPR	ADV	06/10/2015	06/10/2015	N		AC 310316 *MTNL*		CU2N		62
CAH					68				URO	AOB	ROUTINE	GPR	ADV	06/10/2015	06/10/2015	N		AC 310316 *MTNL*		CU2N		62
CAH					51				URO	AOB	ROUTINE	GPR	ADV	06/10/2015	06/10/2015	N		AC 310316 *MTNL*		CU2N		62
CAH					32				URO	AOB	ROUTINE	GPR	ADV	06/10/2015	06/10/2015	N		AC 310316 *MTNL*		CU2N		62
CAH					4				URO	AOB	ROUTINE	GPR	ADV	07/10/2015	07/10/2015	N		AC 310316 *MTNL*		CU2N		62

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

CAH	Personal Information redacted by the USI	72	Personal Information redacted by the USI	URO	AOB	ROUTINE	OH	ADV	07/10/2015	07/10/2015	N		AC 310316 *MTNL - ANY CONS*		CU2N		62
CAH		49		URO	AOB	ROUTINE	OH	ADV	23/10/2015	23/10/2015	N		AC 310316 *MTNL - SEE AOB* LTR IN FOLDER		CU2N		60
CAH		0		URO	AOB	ROUTINE	GPR	ADV	12/11/2015	12/11/2015	N		AC 140416 *MTNL*		CU2N		57
CAH		40		URO	AOB	ROUTINE	GPR	ADV	12/11/2015	12/11/2015	N		AC 140416 *MTNL*		CU2N		57
CAH		69		URO	AOB	ROUTINE	GPR	ADV	12/11/2015	12/11/2015	N		AC 140416 *MTNL*		CU2N		57
CAH		52		URO	AOB	ROUTINE	GPR	ADV	12/11/2015	12/11/2015	N		AC 140416 *MTNL*		CU2N		57
CAH		64		URO	AOB	ROUTINE	GPR	ADV	12/11/2015	12/11/2015	N		AC 140416 *MTNL*		CU2N		57
CAH		65		URO	AOB	ROUTINE	GPR	ADV	12/11/2015	12/11/2015	N		AC 140416 *MTNL*		CU2N		57
CAH		32		URO	AOB	ROUTINE	GPR	ADV	12/11/2015	12/11/2015	N		AC 140416 *MTNL*		CU2N		57
CAH		90		URO	AOB	ROUTINE	GPR	ADV	12/11/2015	12/11/2015	N		AC 140416 *MTNL*		CU2N		57
CAH		31		URO	AOB	ROUTINE	AE	ADV	12/11/2015	12/11/2015	N		AC 140416 *MTNL*		CU2N		57
CAH		64		URO	AOB	ROUTINE	GPR	ADV	12/11/2015	12/11/2015	N		AC 140416 *MTNL*		CU2N		57
CAH		31		URO	AOB	ROUTINE	GPR	ADV	12/11/2015	12/11/2015	N		AC 140416 *MTNL*		CU2N		57
CAH		53		URO	RJB	ROUTINE	OC	ADV	12/11/2015	12/11/2015	N		AC 140416 *MTNL*		CRJBUN		57
CAH		27		URO	AOB	ROUTINE	GPR	ADV	13/11/2015	13/11/2015	N		AC 140416 *MTNL*		CU2N		57
CAH		82		URO	AOB	ROUTINE	GPR	ADV	13/11/2015	13/11/2015	N		AC 140416 *MTNL*		CU2N		57
CAH		23		URO	GURO	ROUTINE	GPR	ADV	13/11/2015	13/11/2015	N		AC 140416 *MTNL*		EURONR		57
CAH		47		URO	GURO	ROUTINE	GPR	ADV	13/11/2015	13/11/2015	N		AC 140416 *MTNL*		EURONR		57
CAH		42		URO	GURO	ROUTINE	GPR	ADV	13/11/2015	13/11/2015	N		AC 140416 *MTNL*		EURONR		57
CAH		84		URO	RJB	ROUTINE	GPR	ADV	13/11/2015	13/11/2015	N		AC 140416 *MTNL*		CRJBUN		57
CAH		42		URO	AOB	ROUTINE	OC	ADV	16/11/2015	16/11/2015	N		AC 140416 *MTNL* ANY CONS		CU2N		56
CAH		61		URO	AOB	ROUTINE	GPR	ADV	16/11/2015	16/11/2015	N		AC 140416 *MTNL*		CU2N		56
CAH		9		URO	AOB	ROUTINE	GPR	ADV	16/11/2015	16/11/2015	N		AC 140416 *MTNL*		CU2N		56
CAH		47		URO	AOB	ROUTINE	GPR	ADV	16/11/2015	16/11/2015	N		AC 140416 *MTNL*		CU2N		56
CAH		46		URO	AOB	ROUTINE	GPR	ADV	16/11/2015	16/11/2015	N		AC 140416 *MTNL*		CU2N		56
CAH		65		URO	RJB	ROUTINE	GPR	ADV	16/11/2015	16/11/2015	N		AC 140416 *MTNL*		CRJBUN		56
CAH		75		URO	RJB	ROUTINE	GPR	ADV	16/11/2015	16/11/2015	N		AC 140416 *MTNL*		CRJBUN		56
CAH		69		URO	AOB	ROUTINE	GPR	ADV	17/11/2015	17/11/2015	N		AC 140416 *MTNL*		CU2N		56
CAH		39		URO	AOB	ROUTINE	GPR	ADV	17/11/2015	17/11/2015	N		AC 140416 *MTNL*		CU2N		56
CAH		57		URO	AOB	ROUTINE	GPR	ADV	17/11/2015	17/11/2015	N		AC 140416 *MTNL*		CU2N		56
CAH		45		URO	AOB	ROUTINE	GPR	ADV	17/11/2015	17/11/2015	N		AC 140416 *MTNL*		CU2N		56
CAH		54		URO	GURO	ROUTINE	GPR	ADV	17/11/2015	17/11/2015	N		AC 140416 *MTNL*		EURONR		56
CAH		38		URO	RJB	ROUTINE	GPR	ADV	17/11/2015	17/11/2015	N		AC 140416 *MTNL*		CRJBUN		56
CAH		67		URO	AOB	ROUTINE	GPR	ADV	18/11/2015	18/11/2015	N		AC 140416 *MTNL*		CU2N		56
CAH		46		URO	RJB	ROUTINE	GPR	ADV	18/11/2015	18/11/2015	N		AC 140416 *MTNL*		CRJBUN		56
CAH		48		URO	GURO	ROUTINE	OC	ADV	04/02/2016	04/02/2016	N		AC 240516 *MTNL*		EURONR		45
CAH		80		URO	GURO	URGENT	GPU	ADV	09/02/2016	09/02/2016	N		AC 110216 NEW LTR 250316 MTNL		EURONU		44
CAH		44		URO	AOB	ROUTINE	GPR	ADV	11/02/2016	11/02/2016	N		AC 140416 *MTNL*		CU2N		44
CAH		79		URO	AOB	ROUTINE	GPR	ADV	11/02/2016	11/02/2016	N		AC 140416 *MTNL*		CU2N		44
CAH		37		URO	AOB	ROUTINE	GPR	ADV	11/02/2016	11/02/2016	N		AC 140416 *MTNL*		CU2N		44

CAH	Personal Information redacted by the USI	53	Personal Information redacted by the USI		URO	AOB	ROUTINE	GPR	ADV	11/02/2016	11/02/2016	N		AC 140416 *MTNL*		CU2N		44
CAH		85			URO	AOB	URGENT	OH	ADV	11/02/2016	11/02/2016	N		AC 140416 *MTNL* ANY CONS		CU2NU		44
CAH		78			URO	AOB	URGENT	GPU	ADV	11/02/2016	11/02/2016	N		AC 140416 *MTNL*		CU2NU		44
CAH		57			URO	GURO	ROUTINE	GPR	ADV	11/02/2016	11/02/2016	N		AC 140416 *MTNL*		EURONR		44
CAH		65			URO	GURO	URGENT	GPU	ADV	11/02/2016	11/02/2016	N		AC 140416 *MTNL*		EURONU		44
CAH		73			URO	GURO	URGENT	GPU	ADV	11/02/2016	11/02/2016	N		AC 140416 *MTNL*		EURONU		44
CAH		35			URO	AOB	ROUTINE	GPR	ADV	12/02/2016	12/02/2016	N		AC 140416 *MTNL*		CU2N		44
CAH		60			URO	AOB	ROUTINE	OC	ADV	12/02/2016	12/02/2016	N		AC 140416 *MTNL* SEE AOB		CU2N		44
CAH		38			URO	AOB	ROUTINE	GPR	ADV	12/02/2016	12/02/2016	N		AC 140416 *MTNL*		CU2N		44
CAH		50			URO	AOB	URGENT	GPU	ADV	12/02/2016	12/02/2016	N		AC 140416 *MTNL*		CU2NU		44
CAH		27			URO	AOB	URGENT	GPU	ADV	12/02/2016	12/02/2016	N		AC 140416 *MTNL*		CU2NU		44
CAH		70			URO	AOB	URGENT	GPU	ADV	12/02/2016	12/02/2016	N		AC 140416 *MTNL*		CU2NU		44
CAH		46			URO	AOB	ROUTINE	GPR	ADV	15/02/2016	15/02/2016	N		AC 140416 *MTNL*		CU2N		43
CAH		35			URO	AOB	ROUTINE	GPR	ADV	15/02/2016	15/02/2016	N		AC 140416 *MTNL*		CU2N		43
CAH		14			URO	AOB	ROUTINE	GPR	ADV	15/02/2016	15/02/2016	N		AC 140416 *MTNL*		CU2N		43
CAH		18			URO	AOB	ROUTINE	GPR	ADV	15/02/2016	15/02/2016	N		AC 140416 *MTNL*		CU2N		43
CAH		49			URO	AOB	ROUTINE	GPR	ADV	15/02/2016	15/02/2016	N		AC 140416 *MTNL*		CU2N		43
CAH		24			URO	AOB	ROUTINE	GPR	ADV	15/02/2016	15/02/2016	N		AC 140416 *MTNL*		CU2N		43
CAH		56			URO	AOB	ROUTINE	GPR	ADV	15/02/2016	15/02/2016	N		AC 140416 *MTNL*		CU2N		43
CAH		55			URO	AOB	ROUTINE	GPR	ADV	15/02/2016	15/02/2016	N		AC 140416 *MTNL*		CU2N		43
CAH		62			URO	AOB	URGENT	GPU	ADV	15/02/2016	15/02/2016	N		AC 1407416 *MTNL*		CU2NU		43
CAH		49			URO	AOB	URGENT	GPU	ADV	15/02/2016	15/02/2016	N		AC 140416 *MTNL*		CU2NU		43
CAH		49			URO	AOB	ROUTINE	GPR	ADV	16/02/2016	16/02/2016	N		AC 140416 *MTNL*		CU2N		43
CAH		8			URO	AOB	ROUTINE	GPR	ADV	16/02/2016	16/02/2016	N		AC 160216 *MTNL*		CU2N		43
CAH		51			URO	AOB	ROUTINE	GPR	ADV	16/02/2016	16/02/2016	N		AC 140416 *MTNL*		CU2N		43
CAH		36			URO	AOB	ROUTINE	GPR	ADV	16/02/2016	16/02/2016	N		AC 140416 *MTNL*		CU2N		43
CAH		41			URO	AOB	URGENT	OH	ADV	16/02/2016	16/02/2016	N		AC 140416 *MTNL*		CU2NU		43
CAH		21			URO	AOB	URGENT	GPR	ADV	16/02/2016	16/02/2016	N		AC 140416 *MTNL*		CU2NU		43
CAH		58			URO	AOB	URGENT	GPU	ADV	16/02/2016	16/02/2016	N		AC 140416 *MTNL*		CU2NU		43
CAH		56			URO	GURO	URGENT	OC	ADV	07/03/2016	07/03/2016	N		AC 080616 MTNL		EURONU		40
DHH		80			URO	AOB	URGENT	OC	ADV	16/03/2016	16/03/2016	N		AC 040616 MTNL *SEE AOB		CU2NU		39
CAH		38			URO	AOB	URGENT	GPU	ADV	21/03/2016	21/03/2016	N		AC 240516 MTNL SEE AOB		CU2NU		38
CAH		59			URO	AOB	ROUTINE	GPR	ADV	24/03/2016	24/03/2016	N		AC 080616 MTNL		CU2N		38
CAH		72			URO	AOB	ROUTINE	GPR	ADV	24/03/2016	24/03/2016	N		AC 080616 MTNL		CU2N		38
CAH		48			URO	AOB	ROUTINE	GPR	ADV	24/03/2016	24/03/2016	N		AC 040616 MTNL		CU2N		38
CAH		20			URO	AOB	ROUTINE	GPR	ADV	24/03/2016	24/03/2016	N		AC 040616 MTNL		CU2N		38
CAH		44			URO	AOB	ROUTINE	GPR	ADV	24/03/2016	24/03/2016	N		AC 080616 MTNL		CU2N		38
CAH		74			URO	AOB	ROUTINE	GPR	ADV	24/03/2016	24/03/2016	N		AC 040616 MTNL		CU2N		38
CAH		63			URO	AOB	ROUTINE	GPR	ADV	24/03/2016	24/03/2016	N		AC 040616 MTNL		CU2N		38
CAH		70			URO	AOB	ROUTINE	GPR	ADV	24/03/2016	24/03/2016	N		AC 040616 MTNL		CU2N		38

CAH	Personal Information redacted by the USI	24	Personal Information redacted by the USI	URO	AOB	ROUTINE	GPR	ADV	24/03/2016	24/03/2016	N		AC 040616 MTNL		CU2N		38
CAH		38		URO	AOB	ROUTINE	GPR	ADV	24/03/2016	24/03/2016	N		AC 040616 MTNL		CU2N		38
CAH		78		URO	AOB	URGENT	GPU	ADV	24/03/2016	24/03/2016	N		AC 080616 MTNL		CU2NU		38
CAH		69		URO	AOB	URGENT	GPU	ADV	24/03/2016	24/03/2016	N		AC 040616 MTNL		CU2NU		38
CAH		42		URO	AOB	ROUTINE	GPR	ADV	25/03/2016	25/03/2016	N		AC 160816 MTNL		CU2N		38
CAH		78		URO	AOB	ROUTINE	GPR	ADV	25/03/2016	25/03/2016	N		AC 040616 MTNL		CU2N		38
CAH		81		URO	AOB	ROUTINE	GPR	ADV	25/03/2016	25/03/2016	N		AC 040616 MTNL		CU2N		38
CAH		40		URO	AOB	ROUTINE	GPR	ADV	25/03/2016	25/03/2016	N		AC 040616 MTNL		CU2N		38
CAH		36		URO	GURO	ROUTINE	GPR	ADV	25/03/2016	25/03/2016	N		AC 040616 MTNL		EURONR		38
CAH		39		URO	AOB	ROUTINE	GPR	ADV	30/03/2016	30/03/2016	N		AC 080616 MTNL		CU2N		37
CAH		68		URO	AOB	ROUTINE	GPR	ADV	30/03/2016	30/03/2016	N		AC 160816 MTNL		CU2N		37
CAH		76		URO	AOB	ROUTINE	GPR	ADV	30/03/2016	30/03/2016	N		AC 160816 MTNL		CU2N		37
CAH		47		URO	AOB	ROUTINE	GPR	ADV	30/03/2016	30/03/2016	N		AC 080616 MTNL		CU2N		37
CAH		23		URO	AOB	ROUTINE	GPR	ADV	30/03/2016	30/03/2016	N		AC 160816 *MTNL*		CU2N		37
CAH		85		URO	AOB	URGENT	GPU	ADV	30/03/2016	30/03/2016	N		AC 160816 MTNL		CU2NU		37
CAH		67		URO	AOB	URGENT	GPR	ADV	30/03/2016	30/03/2016	N		AC 080616 MTNL **NEW REF 250716 URGENT** **DNS NCCT**		CU2NU		37
CAH		67		URO	AOB	URGENT	GPU	ADV	30/03/2016	30/03/2016	N		AC 160816 MTNL		CU2NU		37
CAH		39		URO	AOB	URGENT	GPU	ADV	30/03/2016	30/03/2016	N		AC 160816 *MTNL*		CU2NU		37
CAH		55		URO	AOB	URGENT	GPU	ADV	30/03/2016	30/03/2016	N		AC 160816 *MTNL*		CU2NU		37
CAH		61		URO	AOB	ROUTINE	OC	ADV	19/04/2016	19/04/2016	N		AC 250516 NAMED AOB *MTNL*		CU2N		34
CAH		34		URO	AOB	ROUTINE	GPR	ADV	21/04/2016	21/04/2016	N		AC 250516 *MTNL* SEE AOB		CU2N		34
CAH		34		URO	AOB	ROUTINE	GPR	ADV	25/04/2016	25/04/2016	N		AC 250516 SEE AOB *MTNL*		CU2N		33
CAH		63		URO	AOB	ROUTINE	OC	ADV	25/04/2016	25/04/2016	N		AC 090816 *MTNL* SEE AOB		CU2N		33
CAH		70		URO	GURO	ROUTINE	GPR	ADV	04/05/2016	04/05/2016	N		AC 090816 *MTNL*		EURONR		32
CAH		30		URO	AOB	ROUTINE	GPR	ADV	05/05/2016	05/05/2016	N		AC 090816 *MTNL*		CU2N		32
CAH		82		URO	AOB	ROUTINE	GPR	ADV	05/05/2016	05/05/2016	N		AC 090816 *MTNL*		CU2N		32
CAH		35		URO	AOB	ROUTINE	OC	ADV	05/05/2016	05/05/2016	N		AC 090816 *MTNL* ANY CONS		CU2N		32
CAH		53		URO	AOB	URGENT	GPU	ADV	05/05/2016	05/05/2016	N		AC 090816 *MTNL*		CU2NU		32
CAH		94		URO	AOB	URGENT	GPU	ADV	05/05/2016	05/05/2016	N		AC 090816 *MTNL*		CU2NU		32
CAH		22		URO	AOB	URGENT	GPU	ADV	05/05/2016	05/05/2016	N		AC 090816 *MTNL*		CU2NU		32
CAH		67		URO	GURO	ROUTINE	GPR	ADV	05/05/2016	05/05/2016	N		AC 090816 *MTNL*		EURONR		32
CAH		80		URO	AOB	ROUTINE	GPR	ADV	06/05/2016	06/05/2016	N		AC 0908146 *MTNL*		CU2N		32
CAH		36		URO	AOB	ROUTINE	GPR	ADV	06/05/2016	06/05/2016	N		AC 090816 *MTNL*		CU2N		32
CAH		71		URO	AOB	ROUTINE	AE	ADV	06/05/2016	06/05/2016	N		AC 090816 *MTNL*		CU2N		32
CAH		78		URO	AOB	ROUTINE	GPR	ADV	06/05/2016	06/05/2016	N		AC 090816 *MTNL*		CU2N		32
CAH		71		URO	AOB	ROUTINE	GPR	ADV	06/05/2016	06/05/2016	N		AC 090816 *MTNL*		CU2N		32
CAH		41		URO	AOB	URGENT	GPU	ADV	06/05/2016	06/05/2016	N		AC 090816 *MTNL*		CU2NU		32
CAH		47		URO	AOB	URGENT	GPU	ADV	06/05/2016	06/05/2016	N		AC 090816 *MTNL*		CU2NU		32
CAH		64		URO	AOB	URGENT	GPU	ADV	06/05/2016	06/05/2016	N		AC 090816 *MTNL*		CU2NU		32
CAH		24		URO	GURO	ROUTINE	GPR	ADV	06/05/2016	06/05/2016	N		AC 090816 *MTNL*		EURONR		32

CAH	Personal Information redacted by the USI	18	Personal Information redacted by the USI	URO	GURO	URGENT	GPR	ADV	06/05/2016	06/05/2016	N		AC 090816 *MTNL* - 2ND LTR 251116 URGENT		EURONU		32
CAH		61		URO	AOB	ROUTINE	AE	ADV	08/05/2016	08/05/2016	N		AC 090816 *MTNL*		CU2N		32
CAH		61		URO	AOB	ROUTINE	AE	ADV	08/05/2016	08/05/2016	N		AC 090816 *MTNL*		CU2N		32
CAH		29		URO	AOB	ROUTINE	GPR	ADV	09/05/2016	09/05/2016	N		AC 090816 *MTNL*		CU2N		31
CAH		83		URO	AOB	ROUTINE	GPR	ADV	09/05/2016	09/05/2016	N		AC 090816 *MTNL*		CU2N		31
CAH		75		URO	AOB	ROUTINE	GPR	ADV	09/05/2016	09/05/2016	N		AC 090816 *MTNL* **WILLING TO TAKE CANCELLATION*		CU2N		31
CAH		49		URO	AOB	ROUTINE	GPR	ADV	09/05/2016	09/05/2016	N		AC 090816 *MTNL*		CU2N		31
CAH		18		URO	AOB	ROUTINE	GPR	ADV	09/05/2016	09/05/2016	N		AC 090816 *MTNL*		CU2N		31
CAH		84		URO	AOB	URGENT	GPU	ADV	09/05/2016	09/05/2016	N		AC 090816 *MTNL*		CU2NU		31
CAH		54		URO	AOB	URGENT	GPU	ADV	09/05/2016	09/05/2016	N		AC 090816 *MTNL*		CU2NU		31
CAH		37		URO	AOB	URGENT	GPU	ADV	09/05/2016	09/05/2016	N		AC 090816 *MTNL*		CU2NU		31
CAH		69		URO	AOB	URGENT	GPU	ADV	09/05/2016	09/05/2016	N		AC 090816 *MTNL*		CU2NU		31
CAH		42		URO	GURO	ROUTINE	GPR	ADV	09/05/2016	09/05/2016	N		AC 090816 *MTNL*		EURONR		31
CAH		47		URO	GURO	URGENT	GPU	ADV	09/05/2016	09/05/2016	N		AC 090816 *MTNL*		EURONU		31
CAH		23		URO	AOB	ROUTINE	GPR	ADV	10/05/2016	10/05/2016	N		AC 090816 *MTNL*		CU2N		31
CAH		96		URO	AOB	ROUTINE	GPR	ADV	10/05/2016	10/05/2016	N		AC 090816 *MTNL*		CU2N		31
CAH		13		URO	AOB	ROUTINE	GPR	ADV	10/05/2016	10/05/2016	N		AC 090816 *MTNL*		CU2N		31
CAH		33		URO	AOB	ROUTINE	GPR	ADV	10/05/2016	10/05/2016	N		AC 090816 *MTNL*		CU2N		31
CAH		58		URO	AOB	ROUTINE	GPR	ADV	10/05/2016	10/05/2016	N		AC 090816 *MTNL*		CU2N		31
CAH		31		URO	AOB	ROUTINE	GPR	ADV	10/05/2016	10/05/2016	N		AC 090816 *MTNL*		CU2N		31
CAH		60		URO	AOB	ROUTINE	GPR	ADV	10/05/2016	10/05/2016	N		AC 090816 *MTNL*		CU2N		31
CAH		40		URO	AOB	ROUTINE	GPR	ADV	10/05/2016	10/05/2016	N		AC 090816 *MTNL*		CU2N		31
CAH		46		URO	AOB	ROUTINE	GPR	ADV	10/05/2016	10/05/2016	N		AC 090816 *MTNL*		CU2N		31
CAH		75		URO	AOB	URGENT	GPU	ADV	10/05/2016	10/05/2016	N		AC 090816 *MTNL*		CU2NU		31
CAH		62		URO	AOB	URGENT	GPU	ADV	10/05/2016	10/05/2016	N		AC 090816 *MTNL*		CU2NU		31
CAH		48		URO	AOB	URGENT	GPU	ADV	10/05/2016	10/05/2016	N		AC 090816 *MTNL*		CU2NU		31
CAH		68		URO	GURO	ROUTINE	GPR	ADV	10/05/2016	10/05/2016	N		AC 090816 *MTNL*		EURONR		31
CAH		70		URO	AOB	ROUTINE	GPR	ADV	11/05/2016	11/05/2016	N		AC 090816 *MTNL*		CU2N		31
CAH		49		URO	AOB	ROUTINE	GPR	ADV	11/05/2016	11/05/2016	N		AC 090816 *MTNL*		CU2N		31
CAH		68		URO	AOB	ROUTINE	GPR	ADV	11/05/2016	11/05/2016	N		AC 090816 *MTNL*		CU2N		31
CAH		24		URO	AOB	ROUTINE	GPR	ADV	11/05/2016	11/05/2016	N		AC 090816 *MTNL*		CU2N		31
CAH		63		URO	AOB	ROUTINE	GPR	ADV	11/05/2016	11/05/2016	N		AC 090816 *MTNL*		CU2N		31
CAH		55		URO	AOB	URGENT	GPU	ADV	11/05/2016	11/05/2016	N		AC 090816 *MTNL*		CU2NU		31
CAH		5		URO	AOB	ROUTINE	GPR	ADV	26/05/2016	26/05/2016	N		AC 090816 *MTNL* CHILD SEE AOB		CU2N		29
CAH		39		URO	GURO	URGENT	GPU	ADV	01/06/2016	01/06/2016	N		AC 090816 *MTNL*		EURONU		28
CAH		58		URO	AOB	ROUTINE	GPR	ADV	02/06/2016	02/06/2016	N		AC 090816 *MTNL*		CU2N		28
CAH		44		URO	AOB	ROUTINE	GPR	ADV	02/06/2016	02/06/2016	N		AC 090816 *MTNL*		CU2N		28
CAH		71		URO	AOB	ROUTINE	GPR	ADV	02/06/2016	02/06/2016	N		AC 090816 *MTNL*		CU2N		28
CAH		41		URO	AOB	ROUTINE	GPR	ADV	02/06/2016	02/06/2016	N		AC 090816 *MTNL*		CU2N		28
CAH		50		URO	AOB	URGENT	AE	ADV	02/06/2016	02/06/2016	N		AC 090816 *MTNL*		CU2NU		28

CAH	Personal Information redacted by the USI	71	Personal Information redacted by the USI	URO	GURO	ROUTINE	GPR	ADV	02/06/2016	02/06/2016	N		AC 090816 *MTNL*		EURONR		28
CAH		32		URO	AOB	ROUTINE	AE	ADV	03/06/2016	03/06/2016	N		AC 090816 *MTNL*		CU2N		28
CAH		64		URO	AOB	ROUTINE	GPR	ADV	03/06/2016	03/06/2016	N		AC 090816 *MTNL*		CU2N		28
CAH		46		URO	GURO	ROUTINE	GPR	ADV	03/06/2016	03/06/2016	N		AC 090816 *MYNL*		EURONR		28
CAH		31		URO	AOB	ROUTINE	GPR	ADV	06/06/2016	06/06/2016	N		AC 090816 *MTNL*		CU2N		27
CAH		42		URO	AOB	ROUTINE	GPR	ADV	06/06/2016	06/06/2016	N		AC 090816 *MTNL*		CU2N		27
CAH		72		URO	AOB	URGENT	GPU	ADV	06/06/2016	06/06/2016	N		AC 090816 *MTNL*		CU2NU		27
CAH		54		URO	AOB	URGENT	AE	ADV	06/06/2016	06/06/2016	N		AC 090816 *MTNL*		CU2NU		27
CAH		20		URO	AOB	URGENT	GPU	ADV	06/06/2016	06/06/2016	N		AC 090816 *MTNL*		CU2NU		27
CAH		36		URO	AOB	URGENT	AE	ADV	06/06/2016	06/06/2016	N		AC 090816 *MTNL*		CU2NU		27
CAH		55		URO	AOB	URGENT	GPU	ADV	06/06/2016	06/06/2016	N		AC 090816 *MTNL*		CU2NU		27
CAH		62		URO	AOB	URGENT	GPU	ADV	06/06/2016	06/06/2016	N		AC 090816 *MTNL*		CU2NU		27
CAH		69		URO	AOB	URGENT	GPR	ADV	06/06/2016	06/06/2016	N		AC 090816 *MTNL*		CU2NU		27
CAH		84		URO	GURO	ROUTINE	GPR	ADV	06/06/2016	06/06/2016	N		AC 090816 *MTNL*		EURONR		27
CAH		42		URO	GURO	ROUTINE	GPR	ADV	06/06/2016	06/06/2016	N		AC 090816 *MTNL*		EURONR		27
CAH		80		URO	AOB	ROUTINE	GPR	ADV	07/06/2016	07/06/2016	N		AC 090816 *MTNL*		CU2N		27
CAH		76		URO	AOB	ROUTINE	GPR	ADV	07/06/2016	07/06/2016	N		AC 090816 *MTNL*		CU2N		27
CAH		43		URO	AOB	ROUTINE	GPR	ADV	07/06/2016	07/06/2016	N		AC 090816 *MTNL*		CU2N		27
CAH		91		URO	AOB	ROUTINE	GPR	ADV	07/06/2016	07/06/2016	N		AC 090816 *MTNL*		CU2N		27
CAH		28		URO	AOB	ROUTINE	GPR	ADV	07/06/2016	07/06/2016	N		AC 090816 *MTNL*		CU2N		27
CAH		27		URO	AOB	ROUTINE	GPR	ADV	07/06/2016	07/06/2016	N		AC 090816 *MTNL*		CU2N		27
CAH		56		URO	AOB	ROUTINE	GPR	ADV	07/06/2016	07/06/2016	N		AC 090816 *MTNL*		CU2N		27
CAH		29		URO	AOB	URGENT	GPU	ADV	07/06/2016	07/06/2016	N		AC 090816 *MTNL*		CU2NU		27
CAH		31		URO	AOB	URGENT	GPU	ADV	07/06/2016	07/06/2016	N		AC 090816 *MTNL*		CU2NU		27
CAH		54		URO	AOB	URGENT	GPU	ADV	07/06/2016	07/06/2016	N		AC 090816 *MTNL*		CU2NU		27
CAH		17		URO	AOB	ROUTINE	GPR	ADV	08/06/2016	08/06/2016	N		AC 090816 *MTNL*		CU2N		27
CAH		29		URO	AOB	ROUTINE	GPR	ADV	08/06/2016	08/06/2016	N		AC 090816 *MTNL*		CU2N		27
CAH		85		URO	AOB	ROUTINE	GPR	ADV	08/06/2016	08/06/2016	N		AC 090816 *MTNL*		CU2N		27
CAH		76		URO	AOB	ROUTINE	GPR	ADV	08/06/2016	08/06/2016	N		AC 090816 *MTNL*		CU2N		27
CAH		52		URO	AOB	ROUTINE	GPR	ADV	08/06/2016	08/06/2016	N		AC 090816 *MTNL*		CU2N		27
CAH		68		URO	AOB	ROUTINE	GPR	ADV	08/06/2016	08/06/2016	N		AC 090816 *MTNL*		CU2N		27
CAH		81		URO	AOB	ROUTINE	GPR	ADV	08/06/2016	08/06/2016	N		AC 090816 *MTNL*		CU2N		27
CAH		33		URO	AOB	URGENT	GPU	ADV	08/06/2016	08/06/2016	N		AC 090816 *MTNL*		CU2NU		27
CAH		49		URO	GURO	ROUTINE	GPR	ADV	08/06/2016	08/06/2016	N		AC 090816 *MTNL*		EURONR		27
CAH		68		URO	AOB	ROUTINE	OC	ADV	28/06/2016	28/06/2016	N		AC 130916 MTNL SEE AOB		CU2N		24
CAH		66		URO	GURO	URGENT	GPR	ADV	18/07/2016	18/07/2016	N		AC 300916 *MTNL*		EURONU		21
CAH		61		URO	GURO	URGENT	OH	ADV	25/07/2016	25/07/2016	N		AC 011016 *MTNL*		EURONU		20
CAH		4		URO	AOB	URGENT	GPU	ADV	26/07/2016	26/07/2016	N		AC 020816 *MTNL* *SEE AOB*		CU2NU		20
CAH		35		URO	AOB	ROUTINE	GPR	ADV	28/07/2016	28/07/2016	N		AC 300916 *MTNL*		CU2N		20
CAH		69		URO	AOB	ROUTINE	GPR	ADV	28/07/2016	28/07/2016	N		AC 300916 *MTNL*		CU2N		20

CAH	Personal Information redacted by the USI	35	Personal Information redacted by the USI	URO	AOB	ROUTINE	GPR	ADV	28/07/2016	28/07/2016	N		AC 300916 *MTNL*		CU2N		20
CAH		49		URO	AOB	ROUTINE	GPR	ADV	28/07/2016	28/07/2016	N		AC 300916 *MTNL*		CU2N		20
CAH		48		URO	AOB	ROUTINE	GPR	ADV	28/07/2016	28/07/2016	N		AC 300916 *MTNL*		CU2N		20
CAH		33		URO	AOB	URGENT	AE	ADV	28/07/2016	28/07/2016	N		AC 300916 *MTNL*		CU2NU		20
CAH		54		URO	AOB	URGENT	GPU	ADV	28/07/2016	28/07/2016	N		AC 300916 *MTNL*		CU2NU		20
CAH		45		URO	AOB	ROUTINE	GPR	ADV	29/07/2016	29/07/2016	N		AC 300916 *MTNL*		CU2N		20
CAH		67		URO	AOB	ROUTINE	GPR	ADV	29/07/2016	29/07/2016	N		AC 300916 *MTNL*		CU2N		20
CAH		50		URO	AOB	ROUTINE	GPR	ADV	29/07/2016	29/07/2016	N		AC 011016 *MTNL*		CU2N		20
CAH		87		URO	AOB	ROUTINE	GPR	ADV	29/07/2016	29/07/2016	N		AC 300916 *MTNL*		CU2N		20
CAH		60		URO	AOB	ROUTINE	GPR	ADV	29/07/2016	29/07/2016	N		AC 300916 *MTNL*		CU2N		20
CAH		32		URO	AOB	ROUTINE	GPR	ADV	29/07/2016	29/07/2016	N		AC 300916 *MTNL*		CU2N		20
CAH		32		URO	AOB	ROUTINE	GPR	ADV	29/07/2016	29/07/2016	N		AC 011016 *MTNL*		CU2N		20
CAH		31		URO	AOB	ROUTINE	AE	ADV	29/07/2016	29/07/2016	N		AC 011016 *MTNL*		CU2N		20
CAH		61		URO	AOB	ROUTINE	GPR	ADV	29/07/2016	29/07/2016	N		AC 011016 *MTNL*		CU2N		20
CAH		57		URO	AOB	URGENT	GPU	ADV	29/07/2016	29/07/2016	N		AC 011016 *MTNL*		CU2NU		20
CAH		53		URO	AOB	ROUTINE	AE	ADV	30/07/2016	30/07/2016	N		AC 011016 *MTNL*		CU2N		20
CAH		41		URO	AOB	ROUTINE	AE	ADV	31/07/2016	31/07/2016	N		AC 300916 *MTNL*		CU2N		20
CAH		88		URO	AOB	ROUTINE	GPR	ADV	01/08/2016	01/08/2016	N		AC 011016 *MTNL*		CU2N		19
CAH		31		URO	AOB	ROUTINE	GPR	ADV	01/08/2016	01/08/2016	N		AC 011016 *MTNL*		CU2N		19
CAH		16		URO	AOB	ROUTINE	GPR	ADV	01/08/2016	01/08/2016	N		AC 011016 *MTNL*		CU2N		19
CAH		77		URO	AOB	ROUTINE	OC	ADV	01/08/2016	01/08/2016	N		AC 300916 *MTNL*		CU2N		19
CAH		34		URO	AOB	ROUTINE	GPR	ADV	01/08/2016	01/08/2016	N		AC 011016 *MTNL*		CU2N		19
CAH		64		URO	AOB	URGENT	GPU	ADV	01/08/2016	01/08/2016	N		AC 011016 *MTNL*		CU2NU		19
CAH		40		URO	AOB	ROUTINE	GPR	ADV	02/08/2016	02/08/2016	N		AC 300916 *MTNL*		CU2N		19
CAH		62		URO	AOB	ROUTINE	GPR	ADV	02/08/2016	02/08/2016	N		AC 011016 *MTNL*		CU2N		19
CAH		68		URO	AOB	ROUTINE	GPR	ADV	02/08/2016	02/08/2016	N		AC 011016 *MTNL*		CU2N		19
CAH		23		URO	AOB	ROUTINE	GPR	ADV	02/08/2016	02/08/2016	N		AC 011016 *MTNL*		CU2N		19
CAH		53		URO	AOB	ROUTINE	GPR	ADV	02/08/2016	02/08/2016	N		AC 011016 *MTNL*		CU2N		19
CAH		21		URO	AOB	ROUTINE	GPR	ADV	02/08/2016	02/08/2016	N		AC 300916 *MTNL*		CU2N		19
CAH		58		URO	AOB	ROUTINE	GPR	ADV	02/08/2016	02/08/2016	N		AC 011016 *MTNL*		CU2N		19
CAH		84		URO	AOB	ROUTINE	GPR	ADV	02/08/2016	02/08/2016	N		AC 011016 *MTNL*		CU2N		19
CAH		51		URO	AOB	ROUTINE	GPR	ADV	02/08/2016	02/08/2016	N		AC 011016 *MTNL*		CU2N		19
CAH		24		URO	AOB	URGENT	GPU	ADV	02/08/2016	02/08/2016	N		AC 011016 *MTNL*		CU2NU		19
CAH		42		URO	AOB	ROUTINE	GPR	ADV	03/08/2016	03/08/2016	N		AC 300916 *MTNL*		CU2N		19
CAH		27		URO	AOB	ROUTINE	GPR	ADV	03/08/2016	03/08/2016	N		AC 300916 *MTNL*		CU2N		19
CAH		50		URO	AOB	URGENT	OC	ADV	02/09/2016	02/09/2016	N		AC 111016 *MTNL* NAMED AOB		CU2NU		15
CAH		66		URO	GURO	ROUTINE	OC	ADV	06/09/2016	06/09/2016	N		AC 201016 *MTNL*		EURONR		14
CAH		37		URO	AOB	ROUTINE	GPR	ADV	08/09/2016	08/09/2016	N		AC 201016 *MTNL*		CU2N		14
CAH		76		URO	AOB	ROUTINE	GPR	ADV	08/09/2016	08/09/2016	N		AC 201016 *MTNL*		CU2N		14
CAH		45		URO	AOB	ROUTINE	GPR	ADV	08/09/2016	08/09/2016	N		AC 201016 *MTNL*		CU2N		14

CAH	Personal Information redacted by the USI	46	Personal Information redacted by the USI	URO	AOB	ROUTINE	OC	ADV	08/09/2016	08/09/2016	N		AC 201016 *MTNL*		CU2N		14
CAH		19		URO	AOB	ROUTINE	GPR	ADV	08/09/2016	08/09/2016	N		AC 201016 *MTNL*		CU2N		14
CAH		34		URO	AOB	ROUTINE	GPR	ADV	08/09/2016	08/09/2016	N		AC 201016 *MTNL*		CU2N		14
CAH		62		URO	AOB	ROUTINE	GPR	ADV	08/09/2016	08/09/2016	N		AC 201016 *MTNL*		CU2N		14
CAH		34		URO	AOB	ROUTINE	GPR	ADV	08/09/2016	08/09/2016	N		AC 201016 *MTNL*		CU2N		14
CAH		79		URO	AOB	ROUTINE	GPR	ADV	08/09/2016	08/09/2016	N		AC 201016 *MTNL*		CU2N		14
CAH		49		URO	AOB	URGENT	GPU	ADV	08/09/2016	08/09/2016	N		AC 201016 *MTNL*		CU2NU		14
CAH		19		URO	AOB	URGENT	GPU	ADV	08/09/2016	08/09/2016	N		AC 201016 *MTNL*		CU2NU		14
CAH		53		URO	GURO	ROUTINE	GPR	ADV	08/09/2016	08/09/2016	N		AC 201016 *MTNL*		EURONR		14
CAH		65		URO	GURO	URGENT	GPU	ADV	08/09/2016	08/09/2016	N		AC 201016 *MTNL*		EURONU		14
CAH		72		URO	GURO	URGENT	GPU	ADV	08/09/2016	08/09/2016	N		AC 201016 *MTNL*		EURONU		14
CAH		44		URO	AOB	ROUTINE	GPR	ADV	09/09/2016	09/09/2016	N		AC 201016 *MTNL*		CU2N		14
CAH		46		URO	AOB	ROUTINE	GPR	ADV	09/09/2016	09/09/2016	N		AC 201016 *MTNL*		CU2N		14
CAH		76		URO	AOB	ROUTINE	GPR	ADV	09/09/2016	09/09/2016	N		AC 201016 *MTNL*		CU2N		14
CAH		53		URO	AOB	ROUTINE	GPR	ADV	09/09/2016	09/09/2016	N		AC 201016 *MTNL*		CU2N		14
CAH		55		URO	AOB	ROUTINE	GPR	ADV	09/09/2016	09/09/2016	N		AC 201016 *MTNL*		CU2N		14
CAH		34		URO	AOB	ROUTINE	GPR	ADV	09/09/2016	09/09/2016	N		AC 201016 *MTNL*		CU2N		14
CAH		62		URO	AOB	ROUTINE	GPR	ADV	09/09/2016	09/09/2016	N		AC 201016 *MTNL*		CU2N		14
CAH		51		URO	AOB	URGENT	GPU	ADV	09/09/2016	09/09/2016	N		AC 201016 *MTNL*		CU2NU		14
CAH		76		URO	AOB	URGENT	GPU	ADV	09/09/2016	09/09/2016	N		AC 201016 *MTNL*		CU2NU		14
CAH		22		URO	GURO	ROUTINE	GPR	ADV	09/09/2016	09/09/2016	N		AC 201016 *MTNL*		EURONR		14
CAH		22		URO	AOB	ROUTINE	GPR	ADV	12/09/2016	12/09/2016	N		AC 201016 MTNL		CU2N		13
CAH		63		URO	AOB	ROUTINE	GPR	ADV	12/09/2016	12/09/2016	N		AC 201016 *MTNL*		CU2N		13
CAH		24		URO	AOB	URGENT	GPU	ADV	12/09/2016	12/09/2016	N		AC 201016 *MTNL*		CU2NU		13
CAH		58		URO	AOB	URGENT	GPU	ADV	12/09/2016	12/09/2016	N		AC 201016 *MTNL*		CU2NU		13
CAH		44		URO	GURO	ROUTINE	GPR	ADV	12/09/2016	12/09/2016	N		AC 201016 MTNL		EURONR		13
CAH		58		URO	GURO	URGENT	GPU	ADV	12/09/2016	12/09/2016	N		AC 201016 *MTNL*		EURONU		13
CAH		65		URO	GURO	URGENT	GPU	ADV	12/09/2016	12/09/2016	N		AC 201016 *MTNL*		EURONU		13
CAH		47		URO	AOB	ROUTINE	GPR	ADV	13/09/2016	13/09/2016	N		AC 201016 *MTNL*		CU2N		13
CAH		66		URO	AOB	ROUTINE	GPR	ADV	13/09/2016	13/09/2016	N		AC 261016 *MTNL*		CU2N		13
CAH		19		URO	AOB	ROUTINE	GPR	ADV	13/09/2016	13/09/2016	N		AC 261016 *MTNL*		CU2N		13
CAH		36		URO	AOB	ROUTINE	GPR	ADV	13/09/2016	13/09/2016	N		AC 201016 *MTNL*		CU2N		13
CAH		29		URO	AOB	ROUTINE	GPR	ADV	13/09/2016	13/09/2016	N		AC 201016 *MTNL*		CU2N		13
CAH		86		URO	AOB	URGENT	GPU	ADV	13/09/2016	13/09/2016	N		AC 201016 *MTNL*		CU2NU		13
CAH		45		URO	AOB	URGENT	GPU	ADV	13/09/2016	13/09/2016	N		AC 261016 *MTNL*		CU2NU		13
CAH		45		URO	GURO	ROUTINE	GPR	ADV	13/09/2016	13/09/2016	N		AC 201016 *MTNL*		EURONR		13
CAH		18		URO	GURO	URGENT	GPR	ADV	13/09/2016	13/09/2016	N		AC 201016 *MTNL*		EURONU		13
CAH		56		URO	AOB	ROUTINE	GPR	ADV	05/10/2016	05/10/2016	N		AC 251016 *MTNL* SEE AOB		CU2N		10
CAH		57		URO	AOB	ROUTINE	GPR	ADV	02/08/2016	17/11/2016	N		CNA 17.11.16 - UNWELL - **MTNL**	CRJBTDU	CU2N		4

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

Southern Health and Social Care Trust

Root Cause Analysis report on the review of a Serious Adverse Incident

Organisation's Unique Case Identifier: [redacted]

Date of Incident/Event: [redacted]

HSCB Unique Case Identifier:

Service User Details:
D.O.B: [redacted] Gender: F Age: 66 yrs

Responsible Lead Officer: Connie Connolly

Designation: Lead Nurse Acute Governance

Report Author: Review Team

Date report signed off:

Date submitted to HSCB:

Southern Health and Social Care Trust

1.0 EXECUTIVE SUMMARY

Patient 10 is a 66 year old lady with a past medical history of colon cancer in 2010 and breast cancer in 2013.

While Patient 10 was under review and follow up by the Breast Surgeons in June 2014, a Computer Tomograpy Scan (CT Scan) of the abdomen and pelvis was arranged and this was performed on 24 June 2014. This CT scan reported a number of cysts in both kidneys. On the right side, there was a large upper pole cyst, a small lower pole cyst and a cyst on the anterior aspect of the right lower pole which had increased in size with increased complexity from scans completed in 2010. An Ultra Sound Scan (USS) of kidneys was recommended and this was completed on 24 July 2014. A Magnetic Resonance Image with contrast (MRI) was advised, and this was done on 26 September 2014. The MRI report did not comment on the anterior cyst about which concerns were raised, but did confirm a cyst with no abnormal enhancement.

On the basis of this incomplete MRI report, Patient 10 GP made routine referral to the Urology Team in Craigavon Area Hospital (CAH). This GP letter was received by the CAH Booking Centre on 29 October 2014. This letter was given to the Urology Surgeon of the week on 30 September 2014 to triage. There is no evidence that this GP referral letter was triaged or returned to the Booking Centre for processing. As a direct result of triage omission, Patient 10 was managed as a 'New Routine' patient, and waited until 6 January 2016 to be seen by a Consultant Urologist. A wait of 64 weeks.

Patient 10 was diagnosed with a probable cystic renal tumour. Surgery was scheduled for 25 January 2106 but this was postponed due to the recurrence of breast cancer at this same time. Right partial nephrectomy was performed on 31 October 2016.

The Review Panel agree that there are 2 main contributing factors which directly impacted Patient 10 delay in diagnoses. The first contributing factor was the content of the MRI report dated on the 29 September 2014. The wording of the report appears truncated and does not reference the main clinical focus, which was anterior cyst on the right kidney. The Reporter did not grade the cyst. As a result, the Breast Surgeon Dr 3 and the GP Dr 5 reading this report, did not appreciate there was growth in size of the right cyst. This was a significant missed opportunity for clinicians to expedite Patient 10 referral to Urology.

The second contributory factor is that Patient 10 GP referral letter was not triaged by the Urology Consultant on call. The Review Panel agree that if a Consultant Urologist would have viewed Patient 10 images at triage - Patient 10 would have been upgraded as a Red Flag referral in October 2014. As a direct result of no triage, Patient 10 waited 16 months to be assessed by the Urology Team and diagnosed with renal carcinoma.

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2.0 THE REVIEW TEAM

Mr Anthony Glackin Consultant Urologist

Dr Aaron Milligan Consultant Radiologist

Christine Rankin Acting Booking Manager

Connie Connolly Lead Nurse Acute Governance

3.0 SAI REVIEW 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 10 in Craigavon Area Hospital, from 24 June 2014 until 6 January 2016
- To carry out this review into the care provided to Patient 10 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 documented evidence and staff accounts of events
- To identify the key contributory factors which may have had an influence or contributed to Patient 10 delay in treatment.
- 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 relatives of Patient 10 and the staff associated with Patient 10 management

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4.0 REVIEW METHODOLOGY

- To carry out a review into the care provided to Patient 10 within the SHSCT from 8 April 2014 until 1 March 2016. Records electronic records available on the Patient Administration System (PAS), Northern Ireland Electronic Care Record (NIECR) the Northern Ireland Picture Archiving and Communication System (NIPACS) will be examined in conjunction with all Clinical and Nursing documentation.

- To carry out this review into the care provided to Patient 10 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 documented evidence and staff accounts of events

- To identify the key contributory factors which may have had an influence or contributed to the timing of Patient 10 clinical management.

- To ensure that recommendations are made in line with evidence based practice. Accompanying appendices to the report will provide evidence of recent researched-based management of

- 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 Patient 10 and the staff associated with Patient 10 care

This list is not exhaustive

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5.0 DESCRIPTION OF INCIDENT/CASE

Need narrative here re previous medical history

On 18 November 2010 Patient 10 had CT of Abdomen and Pelvis (CTAP) and was reported on 3 December 2010 which stated simple renal cyst particular on the right.

On 13 January 2013 CTAP reported by Dr 10. Bosniak type 1 cyst right kidney noted.

On 24 June 2014, Patient 10 had a CTAP with contrast as ordered by Dr 1. Dr 7's report in relation to the CTAP was issued on 7 July 2014 and reported multiple and bilateral simple cysts. A cyst arising from the anterior aspect of the right lower pole demonstrates subtle layering with high density in its medial aspect. The cyst appears minimally larger. A cyst in the anterior aspect of the right lower pole appears minimally larger and complex with high density in its medial aspect. Localised ultrasound was recommended to ensure no soft tissue component.

On 24 July 2014, Dr 1 ordered at ultrasound of the urinary tract. Dr 2's report on 30 July 2014 concluded a right lower pole complex renal cyst? Solid component. Advised MRI with intravenous (i/v) contrast to determine if the solid component enhances.

On 23 September 2014, Patient 10 seen by Dr 2 who ordered CT of Chest and Abdomen (CT CA).

On 26 September 2014 Patient 10 had a MRI of renal tract done. Dr 2's report on 29 September 2014 compared the previous CT 25/06/14 and USS 24/07/14. There is a large well-defined ovoid cystic mass, arising from the upper pole cortex of the right kidney. Appearances are consistent with cyst.

On 29 October 2014 Patient 10 attended for CT CA with i/v contrast. Dr 4 compared CT on 20/06/14 and on 1 November 2014 reported simple cyst seen in the upper pole. Complex cyst right kidney. On the same day, a routine GP referral was received in CAH Booking Centre from Dr 5 requesting assessment and advice in relation to the MRI findings reported on 26/09/14 re large renal cyst and recent breast cancer.

On 7 November 2014, letter sent to Patient 10 from Dr 3 informing her of unchanged findings of CT CA done on 29 October 2014, and that there would be further Surgical Outpatient review.

On 6 January 2016, Patient 10 was seen by Dr 8 in Urology Outpatients in response to GP referral on 29 October 2014. The MRI images were reviewed by Dr 8 in advance of the consultation. Dr 8 noted that the MRI report from 29/09/14 did not comment on the anterior lower pole of the right kidney. Dr 8 spoke with Dr 7 re the findings. In retrospect, Dr 7 reported the complex cyst on the right kidney had internal solid nodules with one area showing some enhancement with contrast. This raised the possibility of cystic renal cancer. Surgery arranged for 13th January 2016.

On 12th January 2016, Patient 10 was reviewed by Dr 3 with an enlarged left axillary noted on CT. A malignant node in the let axilla with invasive lobular carcinoma was confirmed.

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5.0 DESCRIPTION OF INCIDENT/CASE

15 February 2016 Patient 10 had a left axillary node clearance. Staging and further management of Patient 10 renal cyst has been postponed.

Patient 10 is recovering from a laparoscopic partial nephrectomy for confirmed papillary renal cell carcinoma which was performed on 31 October 2016.

6.0 FINDINGS

The Specialists within the Review Panel individually assessed each of Patient 10 radiological investigations in the timeframe between 24 June 2014 and 6 January 2016. The report by Dr 2 on 29 September 2014 references the findings of the USS and CT images done in June and July 2014. The Panel agree that when Dr 2 mentioned the earlier findings within the 29 September 2014 MRI report, it implied that the ovoid cystic mass noted had been seen and had been investigated. The inclusions of previous imaging findings are ambiguous. The consensus is that Dr 2's reported findings in relation to Patient 10 MRI of both kidneys were misleading and were inappropriately condensed. The Panel contribute this to human error. The Review Panel agree that the absence of a complete right kidney assessment, and the wording of the MRI report, made it extremely difficult for clinicians to detect the missing clinical detail. This provides sufficient rationale to why Patient 10 was not referred to Urology for immediate assessment by Dr 3 or the GP Dr 5.

The Review Panel forensically reviewed the GP Referral Letter management for Patient 10 in October 2014 .In summary, Dr 6 was the Consultant Urologist on-call on 30 October 2014 and was responsible for the triage of the GP letters to Urology for that week. There is hardcopy evidence that Patient 10 was one of eight letters for Triage. The booking centre provided the triage template for Dr 6. The GP letters were all photocopied prior to being sent to the Thorndale Unit for Dr 6 on 30 October 2014.

The Review Team were not able to find any of the original GP referral letters from 30 October 2014. The Triage form for 30 October 2014 was not returned to medical records for processing. After 10 working days, the booking centre e-mailed Dr 6's personal secretary seeking management advice for the 8 patients with outstanding triage. After no reply, a second email request was sent to Dr 6 via his personal secretary seeking management advice which was outstanding from 30 October 2014. At this point the informal booking centre default process for patients with no referral triage, was initiated. The informal default triage management process was introduced in May 2014 to ensure the GP's referrals were allocated to a 'waiting list' in the event of the consultant on-call failing to triage the week's referrals.This was only done once the consultant's personal secretary had been e-mailed requesting management advice. In the event of no response the request for management advice was escalated to the Specialist Service Administrator. The final level of escalation was to the Specialist Head of Service. There is e-mail evidence that the Assistant Director of Functional Services along with Assistant Director of Surgery and Elective Care were aware of ongoing triage omission by Dr 6. The default management process was then formally circulated on 6 November 2015.

The pathway for GP referrals without triage is for the medical records team to accept the GP Grading, code the patient specialty as 'General Urology' and allocate the next

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6.0 FINDINGS

available new patient appointment. The length of time until assessment is solely dependent on the Urology waiting time- which was minimum of 42 weeks in 2014. The default management process provides an explanation to why Patient 10 'Routine' referral letter was not upgraded and why Patient 10 was not seen by the Urology Team until 16 January 2016.

Patient 10 is now recovering from a laparoscopic excision of a papillary renal carcinoma which was done on 30 October 2016. This procedure was superseded by breast surgery in 2016 for breast lobular carcinoma on 14 February 2016. It had been agreed by the Oncology and Urology teams that the breast histology was priority and treatment proceeded in advance of renal surgery.

Relevant members of the Review Team completed a 'look-back' exercise in relation to the remaining 7 other GP letters to establish the patient management and outcome. The Panel can confirm that the other 7 patients have been seen by the Urology Team on or before 26 January 2016, and have not been known to have been exposed to significant harm.

7.0 CONCLUSIONS

The MRI report by Dr 2 on 29 September 2014 as previously discussed, was misleading and was inappropriately condensed. The quality of the information resulted in the evolving right renal cyst being overlooked by Drs 3 and Dr 5.

The SHSCT Radiology Team continuously review and audit the quality and accuracy of their reporting. On this occasion, the MRI report irregularities were not detected until viewed by a Urology Consultant.

All available evidence suggests that Dr 6 did not triage Patient 10 GP referral letter on the week ending 30 October 2014. The default triage management process was initiated which resulted in Patient 10 waiting 64 weeks for Urological assessment.

The Review Panel agree that in relation to Patient 10, the opportunity to upgrade the referral to red flag was lost by the omission of triage, this resulted in a 64 week delay to diagnosis of a suspicious renal mass.

While the remit of this Serious Adverse Incident (SAI) Review was to examine the factors in Patient 10 delayed management of papillary renal cancer. The Review Panel were provided evidence that a significant number of letters within Urology are not being triaged by the minority of the Team. It is clear that the default triage management process continues to be initiated secondary to the omission of Triage by individual members of the urology team and not the entire Urology Team

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8.0 LESSONS LEARNED

There will always be an element of human error in the interpretation and reporting of radiological imaging.

Triage of GP referral letters remains a key element in validating appropriate utilisation of specialist services and ensuring patient safety. Triage also serves as an opportunity for early intervention for patients at risk of malignant disease or clinical deterioration.

9.0 RECOMMENDATIONS AND ACTION PLANNING

The fundamental issue of triaging GP referral letter remains a challenge within Urology. This SAI has demonstrated that patients will be at an increased risk of harm when the opportunity for early intervention at Triage is omitted. The Review Panel recommend that the Directors, Managers and Clinicians within Acute Service's Urology amend the method of management and escalation of triage non-compliance.

The method and implementation of the process to address Triage non-compliance will need to be managed by the Urology operational and Medical Management teams as a matter of urgency. Any escalation process should include direct contact with the relevant Consultant after following an agreed pathway.

10.0 DISTRIBUTION LIST

Patient 10

HSCB

SHSCT Litigation

SHSCT Medical Director

SHSCT Director of Acute Services

AMD for Surgery and Elective Care

AMD for Integrated Maternal/Women's Health and Clinical Services

AD's for Surgery and Elective Care, Integrated Maternal/Women's Health/Clinical Services and Functional Support Services

Chair of Surgical Morbidity and Mortality

Southern Health and Social Care Trust

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

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(This checklist should be completed in full and submitted to the HSCB along with the completed SAI Review Report for all levels of SAI reviews)

Reporting Organisation SAI Ref Number:	Personal Information	**HSCB Ref Number:**	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER							
1) Please indicate if the SAI relates to a single service user, a number of service users or if the SAI relates **only** to a HSC Child Death notification *(SAI criterion 4.2.2)* **Please select as appropriate (✓)**	**Single Service User**	x	**Multiple Service Users***		**HSC Child Death Notification only**		
	Comment: ***If multiple service users involved please indicate the number involved***						
2) Was the Service User[1] / Family / Carer informed the incident was being investigated as a SAI? **Please select as appropriate (✓)**	**YES**	x	**NO**				
	If **YES**, insert **date informed**: 6 January 2016						
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being investigated as a SAI						
	a) No contact or Next of Kin details or Unable to contact						
	b) Not applicable as this SAI is not 'patient/service user' related						
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user						
	d) Case involved suspected or actual abuse by family						
	e) Case identified as a result of review exercise						
	f) Case is environmental or infrastructure related with no harm to patient/service user						
	g) Other rationale						
	If you selected c), d), e), f) or g) above please provide further details:						
For completion by HSCB/PHA Personnel Only (Please select as appropriate (✓)							
Content with rationale?	**YES**		**NO**				

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER ***(complete this section where the Service User / Family / Carer has been informed the incident was being investigated as a SAI)***				
3) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	x
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			x
	c) Report not shared but contents discussed ***(if you select this option please also complete 'I' below)***			
	d) No contact or Next of Kin or Unable to contact			
Continued overleaf	**e)** No response to correspondence			
	f) Withdrew fully from the SAI process			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being investigated as a SAI)*		
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**)				
Content with rationale?	**YES**		**NO**	

SECTION 2

INFORMING THE CORONER'S OFFICE **(under section 7 of the Coroners Act (Northern Ireland) 1959)** *(complete this section for all death related SAIs)*				
1) Was there a Statutory Duty to notify the Coroner at the time of death? **Please select as appropriate (✓)**	**YES**		**NO**	x
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
2) Following or during the review of the SAI was there a Statutory Duty to notify the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	x
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
3) If you have selected 'YES' to any of the above **'1' or '2'** has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	x
	If **YES**, insert **date report shared**:			
	If **NO**, please provide details:			

DATE CHECKLIST COMPLETED	**17 November 2016**

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Patient 10 [redacted]

Date/Time	Source	Time Line	Comments
March 2010		Invasive bowel tumour resected	
21/12/11		Review CTCAP NAD	
21/12/12		Review CTCAP	
08/04/14	PAS/SECTRA	Admitted under D1. CTAP with contrast ordered	?day procedure ? findings tbc
24/0614	X-ray Report	CTAP done on 24/06/14 Reported on 07/07/14	Report by Dr 2 concluded: no evidence of disease recurrence seen. A cyst on the anterior aspect on the right lower pole appears minimally larger and complex with high density in its medial aspect. The appearances may represent a haemorrhagic or proteinacious cyst. Localised ultrasound is recommended to ensure there is no soft tissue component
24/07/14	X-ray report	USS of urinary tract ordered by Dr 1. USS done on 27/07/14 and reported on 30/07/14	Report by Dr 2 concluded: Right lower pole complex renal cyst? Solid component. Advise MRI of kidneys with i/v contrast to determine if the solid component enhances.

Screened 15/03/16

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Patient 10 [redacted]

Date/Time	Source	Time Line	Comments
26/09/14	X-ray report	MRI of Renal both requested by Dr 1. MRI done on 26/09/14 and reported on 29/09/14	Report by Dr 2 concluded:(Comparison to previous ultrasound dated 24/07/14 and CT dated 24/06/14.) There is a large well-defined ovoid cystic mass, arising from the upper pole cortex of the right kidney, measuring 8.7 cm x 5.3cm in size. This lesion is T2 hyperintense, T1 hyponintense, and demonstrates no abnormal enhancement. The MR appearances are consistent with a cyst.
23/09/14	Outpatient letter	Patient 10 [redacted] seen by Dr 3. CT CA requested	
29/10/14	Sectra	Scan done on 29/10/14 Reported: 01/11/14	Report by Dr 4 concluded: (CT chest and abdomen performed following oral and i/v contrast. Comparison made with previous CT Scan examination fof 20/06/14) No lung mass lesion seen. There is no hilar or mediastinal lymphadenopathy. Liver shows no focal lesion. Gallbladder, spleen and pancreas appear normal. 3.6 cm exophytic complex cyst is seen in the lower pole of the left kidney anteriorly containing solid and cystic component. Simple cyst seen in the upper pole measuring 7cm. Left kidney show no focal lesion. Complex cyst right kidney

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Patient 10 [redacted]

Date/Time	Source	Time Line	Comments
29/10/14	GP referral letter	GP Routine referral sent 29/10/14 and received 29/10/14. Routine referral sent re large renal cyst 8.7cm x 5.3 cm and recent breast cancer. Previous history of bowel cancer. Had MRI scan done in relation to persistent Right renal angle pain. MRI showed a well-defined ovoid cystic mass, arising from upper pole of cortex of the right kidney. I would be grateful for you assessment and advice.	OP reg was done by Booking centre on 30/10/14 Triage indicates that Dr 6 was the consultant on the rota for triage. The triage outcome table is blank. Patient 10 [redacted] is one of the patients within the table. 'Triage details stamp' on the front of the letter is blank.
7/11/14	Letter from Dr 3 to Patient 10 [redacted]		Letter sent to Patient 10 [redacted] stating 'the recent CTAP had shown no worrying abnormality. The cyst on the right kidney was remarked upon again. You will be reviewed routinely in surgical outpatients.'
06/01/16	Letter from Dr 8 to Dr 5	The letter details that the MRI done on 26/09/14 does not cross reference findings of a cyst on the right anterior aspect of right lower pole which had increased in size from 2010. The subsequent routine GP referral was reasonable given the MRI had suggested a benign. The error in the MRI reporting in relation to the lesion of concern, has resulted in a significant time delay in Outpatient Review.	Dr 8 reviewed images prior to Patient 10 [redacted] presentation to OPD. Dr 8 spoke to Dr 7 in relation to the assessment gap relating to the the right anterior aspect of right lower pole. Dr 7 reviewed Patient 10 [redacted] images and found that the complex cyst on the right kidney had solid nodules with one area of enhancement with contrast.
15/01/16	Letter from Dr 9 to Dr 5	Recent core biopsy revealed lobular carcinoma. Renal surgery had been planned for 16/01/16. Patient 10 [redacted] to have axillary node clearance and radiotherapy	References that the index of suspicion in relation to the renal cyst is low.* update from Dr 8 pending

Screened 15/03/16

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Patient 10 [redacted]

Date/Time	Source	Time Line	Comments
10/02/16	Letter from Dr 9 to Dr 5	Chest CT clear, to proceed with breast surgery 15/02/16	

Screened 15/03/16

Summary of key points of concern – Patient 10 SAI

- Patient 10 was one of 8 patients not triaged during the week in question in Oct 2014. The team reviewed the 7 other patients to check they had been seen and were okay. 6 were found to have had an appointment and not suffered any adverse harm. The 7th patient's notes were missing but had been tracked to the consultant concerned. When asked, the secretary sent another email requesting their urgent return. The notes were returned on 28th November with dictation to be typed in relation to the patients care, requesting that they are booked for an intervention. Mr Glackin is going to review the patient's case urgently.
- As the secretarial team knew triage letters were going missing they kept a copy so that if the letter did not return with a plan, they could add the patient as routine (or as per GPs suggestion). This does seem to have been a known and accepted approach – not just something the secretaries developed themselves? They have kept a log of these cases since the middle of 2015. Between 28 July 2015 and 5th October 2016, there are 318 letters which were not triaged in this specialty.
- Trust notes were being transported via the individual consultant's car, against the Trust procedure. A number of notes seem to be tracked to the individual concerned and not returned – as per the 7th patient above. A report needs to be run to ascertain are any other notes tracked to this person and not on Trust premises.
- The check on the 7 patients above also raised a new concern into the timely dictation of letters. The 7th patient had been seen in January 2015 however the letter was not presented for typing until 11th November 2016. The Trust does monitor the number of charts needing audio-typing, but is there a process to monitor if post-consultation dictation has been completed? Is there a way of checking if this consultant has further patients in the same situation as patient 7?

email to him from Dr Wright. Esther Gishkori was on annual leave on 22nd December, the date of the Oversight Group meeting; Ronan Carroll, Assistant Director in Acute Services, deputised for her.

15(iii) The notes of the 22nd December 2016 Oversight Group meeting contained an error which was not picked up at the time, after they had been circulated. **This can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20161223 Doc attachment Notes of oversight meeting 22.12.21.** The following paragraph was included:

"Context
On 13th September 2016, a range of concerns had been identified and considered by the Oversight Committee in relation to Dr O'Brien. A formal investigation was recommended, and advice sought and received from NCAS. It was subsequently identified that a different approach was to be taken, as reported to the Oversight Committee on 12th October."

The reference to 'formal' investigation was an error; it should have read 'informal' investigation as per the notes of the 13th September 2016 Oversight Group meeting.

This error was picked up as part of the Grievance process following Mr O'Brien lodging a grievance in November 2018 after the completion of the MHPS investigation. Mrs Shirley Young, Associate of the HSC Leadership Centre and Dr Aisling Diamond, Deputy Medical Director, addressed this grievance in 2020.

15(iv) In December 2016, both Clinical Managers, Dr McAllister and Mr Weir, were [redacted]. I do not know who, clinically, Dr Wright engaged with in relation to the concerns, which were becoming known as part of the SAI Review in respect of patient Patient 10; it may have been Mr Mark Haynes who at that time was the Clinical Director – General Surgery and Trauma &

302 Q. Would the purpose of such attendance be to provide a clinical perspective on the issues that were emerging?
A. Yes, yes. Obviously, as a Urologist, that would have been helpful.
303 Q. But you didn't have any clinical perspective at the meeting except yours, perhaps?
A. That's right.
304 Q. I think you have sometimes described yourself as essentially acting in a de facto clinical management role within this? 15:10
A. Mm-hmm.
305 Q. NCAS hadn't been spoken to since September in connection with this case, albeit that there had been a review date marked down in their correspondence? 15:10
A. Mm-hmm.
306 Q. You were mandated by the Committee's decision to go speak to NCAS?
A. Yes.
307 Q. But that's after your decision had been made? 15:11
A. That is correct, although obviously had there been anything contradictory coming back from NCAS we would have had to have considered that, but, yes, that's right.
308 Q. The decision to appoint Messrs Weir and Khan to those roles, that was taken without their input or consultation with them at that stage? 15:11
A. At that stage, yes. Obviously we would have to meet with them to get their agreement to that but that's

Report of the Review of the Stage One Grievance panel decision in the case of Mr Aidan O Brien Consultant Urologist Southern Health and Social Services Trust.

Prepared in June 2021 by Professor Ronan O' Hare Assistant Medical Director Western HSC Trust and Therese Mc Kernan Associate HSC Leadership Centre.

June 2021.

Content	Page Numbers

1.0 Background and Context

1.1 Mr Aidan O' Brien Consultant Urologist Southern HSC Trust submitted a grievance in November 2018 and added additional issues in July 2020 at which time the grievance had not been heard. At the time of hearing in July and August 2020 Mr O' Brien had retired from his role.

1.2 The panel appointed to hear the grievance comprised Mrs Shirley Young Associate HSC Leadership Centre and Dr Aisling Diamond, Deputy Medical Director Southern HSC Trust. The grievance investigation was completed in October 2020, and the outcome was provided to Mr O' Brien at that time.

1.3 Mr O' Brien was advised of his right of appeal and an appeal was registered on his behalf by Mr Michael O' Brien by letter of 2nd November 2020.

1.4 The Trust was advised that despite registering his appeal against the findings of the grievance investigation, Mr O' Brien had decided not to participate in the appeal process. The Trust determined that as the appeal process requires the participation of the appellant, it could not proceed. Instead, the decision was made to appoint an independent panel to "review the original grievance panel's decision along with the submissions made and the relevant documentation".

1.5 The Trust appointed Professor Ronan O' Hare Consultant Anaesthetist and Assistant Medical Director Western Health and Social Services Trust and Miss Therese Mc Kernan, Associate HSC Leadership Centre to carry out the review.

2.0 The Terms of Reference for the Review are as Follows:

1. To undertake a full review of the issues of grievance raised in the correspondence to the Trust dated 27th November 2018 and 23 July 2020 from Mr A O' Brien.
2. To review all relevant grievance documentation provided by Mr O' Brien, the documentation gathered by the stage one grievance panel and the stage one grievance panel's decision, as part of the review.
3. To review any relevant notes, data or any other relevant information as part of the review of concerns.
4. To produce a written review outcome determining if the stage one grievance Panel's decision is fair, reasonable and sound.

2.1 The Trust provided a file containing the following information to the panel:

- Response to Stage One Grievance – report of the panel appointed to consider the grievance Mrs Shirley Young and Dr Aisling Diamond.
- Formal grievance from Mr O Brien dated 27th November 2018
- Schedule of documents Appendices 1-49
- Additional Issues raised in July 2020.
- Letter of appeal from Michael O Brien to Mrs Vivienne Toal dated 2nd November 2020.
- Terms of reference for the Review of the Stage one Grievance Panel Decision.

The panel requested additional information from the Trust as follows:

- The terms of reference for the Trust's Oversight Committee and confirmation of the membership. The response from the Trust advised that the oversight group has the role of considering concerns raised about consultants and that at the time concerned (2016) it did not have formal terms of reference. The membership of this group was the Medical Director (Dr Richard Wright) the Director of Human Resources (Mrs Vivienne Toal) and the Director of Service for the area to which the Consultant belonged (Dr Eleanor Gishkori)
- The action plan which was referenced as being developed by Drs Weir and Mc Callister. The Trust advised that there was no action plan available, and that Mr Colin Weir could be asked about this. As the stage one grievance panel referenced in its findings that the action plan was included in an email from Dr Weir the review team has drawn the conclusion that this had not been written up formally and included in the oversight groups papers.
- Mr O' Brien's appraisal documents for the years 2014 onwards. Mr O' Brien's appraisal documents for 2017 and 2018 were provided. The Trust failed to provide the 2014 and 2015 documents.

3.0 Methodology

3.1 The panel independently read and reviewed all the documentation provided by the Trust and met formally on the following dates to discuss the case and to formulate its response:

- 27th May 2021
- 17th June 2021.

4.0 Terms of Reference 1

To undertake a full review of the issues of grievance raised in the correspondence to the Trust dated 27th November 2018 and 23 July 2020 from Mr A O'Brien.

4.1 It is important at the outset to state that the review panel has undertaken to review all the information which has been provided to it with due care and attention. It is conscious that there is a crossover in the terms of reference, and it is not therefore possible to deal discreetly with one element without referencing another. We have therefore in considering Mr O' Brien's grievance issues, considered the responses which have been made by the Stage one Panel to these.

4.2 In his issues of grievance Mr O Brien has raised the acts and omissions of senior managers within the SHSCT in respect of the handling of concerns around his administrative practices, and that their actions and failures constitute a breach of Trust policies and procedures and a breach of his contract of employment.

4.3 The review team notes that the stage one grievance panel has not upheld this aspect of the grievance. While we do not accept that there is a breach of contract established and the approach taken by Mr O'Brien to attempt to argue that the approach was in breach of his contract of employment, we are concerned that no account has been taken of the failures of senior managers within the Trust in respect of discharging their responsibilities.

4.4 The grievance panel acknowledges that there was action taken by Mr Mackle and Martine Corrigan to meet with Mr O Brien in March 2016 to discuss concerns and that this was followed by a letter confirming the discussion and the need for action on the part of Mr O' Brien. The letter was sufficiently explicit in respect of an action plan being required. No response or action plan was received.

4.5 Mr O' Brien in his evidence suggests that he was responding by 1) arranging for the return of the patient notes from his home and 2) writing up letters when he was on Personal Information redacted by the USI leave months later; however, we do not accept that there was any real plan submitted in a prompt manner following receipt of the letter. He also references throughout his grievance that the Trust failed to approach this in the correct manner. While the grievance panel did not agree with this, from our perspective we are concerned that Mr O' Brien appears to focus on the perceived procedural weaknesses of the case and less on the seriousness of the issues raised.

4.6 In these matters we disagree with the conclusion of the grievance panel and do not find that there was appropriate action taken to affirm the seriousness of this situation. We do not base this purely on the lack of any follow up communication to Mr O' Brien but have noted other evidence contained within the documents. In witness statements it is indicated that the approach which Mr O Brien had to his work was known for years. It is reasonable then to conclude that if this were known for years and was his practice, that it would have taken more than the informal March meeting and the single letter to stress the seriousness with which this matter was viewed. We have noted the reference to Mr Mackle stepping down from his role in April 2016, but do not accept that this in any way explains the lack of follow up.

4.7 The matter was not referenced again until it came before the oversight committee in September 2016. At this time, the question of Mr O' Brien's practice was raised again and while there was an agreement that this needed to be addressed, an alternative approach was proposed by Dr Gishkori and was agreed by Dr Wright. The matters discussed and the action plan which was mentioned by other consultants with whom this had been discussed once again was not raised with Dr O' Brien. At the following month's oversight committee (October 2016) it was confirmed that given that he was due to go off Personal Information redacted by the USI in November and would be absent for a period thereafter no action had been taken to bring matters to his attention. The action plan which was available from the 16th September was not shared, and there is no explanation as to why this was not immediately actioned or why a further two months was lost (September to November) in making progress with the issues of concern.

4.8 While the grievance panel found that Dr Wright and the Oversight Committee had a reasonable basis for assurance in September 2016 that Dr Gishkori and her team would have actions in place on which progress could be reported at the meeting in October 2016, it also noted that this did not happen. Mr O' Brien had not been told of discussions at the Oversight Committee, some 5 months since they were first held which we find incredible particularly in the absence of any explanation. To advise that Mr O' Brien was going for Personal Information redacted by the USI in an October meeting and to propose delaying even further raises a question as to the seriousness with which these "concerns" were viewed. The senior managers who did not act to bring these matters to Mr O Brien's attention had a responsibility to do so and are accountable for their failures to act in accordance with their own professional codes.

4.9 The grievance panel indicates that 9 months had passed by the time the December 2016 meeting of the Oversight Committee was discussing the SAI and that Dr Wright and the Oversight Committee were entitled to escalate to a formal MHPS investigation in the context of:

- The absence of assurances about progress made to manage and attend to the concerns.
- The Serious Adverse Incident.
- The information provided on the quantum of the alleged performance matters.

4.10 While we accept that the Medical Director can at any time initiate an MHPS investigation on foot of concerns being identified, what is clear is that the issues were known of from January 2016 and the SAI itself was the likely prompt for the initiation of the investigation and not the other issues which are stated above. We conclude that the failures to follow up from the March meeting, the reporting and development of the action plan in September and lack of action on this and agreed deferral at the October meeting suggest that if the SAI had not arisen that the question of an MHPS investigation may have been delayed even further or not have arisen at all. The plans to work around Mr O Brien are likely to have continued as they had for years previously.

4.11 Mr O Brien also complained of the decision made by the case manager to classify the case against him as a case of misconduct.

4.12 The review panel considered this aspect of the grievance, considering the full report produced and the range of options which were open to the Case Manager. We noted that in consideration of the facts established the Case Manager had taken appropriate advice and on foot on all this there was a finding of misconduct. This in our view was correct as the report clearly identifies the failings which Mr O' Brien demonstrated some of which he acknowledged in the document entitled response to the formal investigation. It is noted also that there is a limited scope for the grievance panel to challenge the determination of the Case Manager and agree that this was not the appropriate forum for Mr O' Brien to question this.

4.13 Mr O Brien also complained of the time taken to handle his grievance.

4.14 The review panel noted the significant time that was taken to progress the grievance and while recognising that this was protracted and longer than might ever have been predicted at the outset, the matters of grievance were complex. It is evident that there was a need to engage with a range of different people throughout this process. Mr O Brien was also a contributor to the lengthy timeframe and the addition of this element of his grievance to the original grievance in July 2020 did not help matters. This too served to extend this further and it is therefore understandable that progress was delayed. It is also our view that a grievance taking from July 2018 to October 2020 to report is unacceptable.

5.0 Terms of Reference 2

To Review all relevant grievance documentation provided by Mr O'Brien, the documentation gathered by the stage one grievance panel and the stage one's grievance panel's decision, as part of the review.

5.1 The review panel has examined all of the documentation gathered by the grievance panel and the statement of grievance and appendices submitted by Mr O' Brien.

5.2 In looking at the decision of the Stage One panel there are elements of this that we feel are not justifiable. In addition to reading and assimilating the information which has been used to support the decisions we accept that the panel has interviewed individuals and will have formed opinions on that basis. Our review has not extended to meeting witnesses but has relied on the detailed information provided.

5.3 We note particularly in the summary of conclusions by the panel the following:

- 6.1 Overall we do not find Mr O Brien's grievance upheld.
- It is notable that the panel use the term "overall" which suggests that they have essentially weighed the issues identified against the evidence available but in the consideration of these there is more weight given to what is "against" than "in favour of" Mr O'Brien. The panel has determined that some of the matters of which he complains are not supported by evidence which it has gathered through documents, witness statements and interviews or that the evidence of Mr O' Brien has less merit than the actions that the Trust has taken in respect of the concerns that it had in respect of his performance as a consultant.

5.4 While we accept that there are several of the issues of grievance where we accept the finding that the Trust's actions have been reasonable and justified, we find that the conclusions reached have not addressed the failures on the part of Trust managers in addressing their concerns and responsibilities in a prompt and thorough manner. This, is given "light touch" treatment in the findings and does not appear to have been influential in the "overall" outcome. We hold the view that this is a weakness in the outcome and is fundamentally unfair.

5.5 An example of this is at paragraph 6.2 which relates to the use of the MHPS framework by the Trust. While it is acknowledging that there were issues on the part of both the Trust and Mr O' Brien which compromised the operation of the Framework in the way it was intended, as regards the setting aside of the timescales, and the failure of Mr O' Brien to actively participate in the early resolution of the issues which were brought to his attention in March 2016, the finding in this regard is unjustifiably in our view, more supportive of the Trust.

5.6 It has been evidenced that Mr O' Brien had been advised at a meeting and subsequently received a letter confirming the nature of the concerns. While this letter advised that these governance issues must be addressed and asked for a response with a commitment and immediate plan to address these, it is also established that this letter brought no response. No follow up was initiated, there appears to be no-one to whom the responsibility to do that was assigned and for months nothing happened. The inaction in relation to follow up while not excusing Mr O Brien's interpretation in this regard does in our view suggest that the seriousness of this was not as was later argued and gives more weight to his inaction.

5.7 In paragraph 6.3 of the grievance panel report the failure to follow up on the March letter to Mr O' Brien is referenced, and the fact that he was not made aware of the approach being suggested by Ms Gishkori to address the problems did not take away from the Medical Directors responsibilities to have concerns examined and the "time for informal resolution had passed". We accept that the Medical Director has the right to escalate a problem that he judges merits formal investigation, however the reference to these two sets of facts in the one paragraph seems to create a diversion to the seriousness of the failure to make Mr O' Brien aware of the outcome of the oversight committee in October, the subsequent discussions which were going on around that and of the plans to tackle the problems. The Medical Directors right to act in this way in no way excuses the inaction of all parties up to this point. We would contend that where "informal resolution" of any issue is proposed it is predicated by the parties involved being at least aware of the issues.

5.8 At 6.4 in the report of the grievance panel report the delays in progressing this grievance and progressing the MHPS investigation are referenced. We have previously commented on this. It is recognised that there was a contribution to the delay by both the Trust and Mr O' Brien. In relation to concluding the MHPS investigation, we find that this should have been concluded in a timelier manner. If this investigation were as serious as it is purported to be the investigator should have been given time out of her normal commitments to carry out the interviews necessary and have the report completed. This did not happen but is not referenced. There was no one pressing the completion of these matters irrespective of the breach of the published timeframes.

5.9 While Mr O Brien complains about the timescale of these matters, he too contributed to this and while some delays are understandable and acceptable other simply are not. The Trust has contributed to this and while one might argue that the parties are equally culpable, the Trust as the Employer has the responsibility take control of the process and the timescale for completion. It's general acceptance of the slow pace and failure to seek to have the grievance closed out at an earlier point deserves mention.

5.10 At 6.8 of the findings of the grievance panel the failure of Mr O' Brien to "engage meaningfully" at an "early point" is referenced as being a significant factor in the failure to find a resolution to the concerns. It notes that any chance of resolution and support may have avoided all that subsequently followed. We do not agree that this is a fair assessment. It relies again on the March 2016 meeting with him and subsequent letter as the evidence to support this and ignores the discussions that were held subsequently at which dialogue and discussion were held by other senior colleagues and which were not shared with him.** That the panel concluded the events which unfolded may have had some opportunity for resolution is quite disturbing. To lay the responsibility for this completely at the door of Mr O'Brien is disproportionate. There was an absence of concise and proper management of the concerns held about Mr O'Brien by Trust management which was not just an issue at the time but appears to have been known of for years.

5.11 At 6.9 of the findings the grievance panel references 3 key facts as the catalyst for the initiation of the formal investigation. These were noted as:

- The absence of a response from Mr O' Brien as requested
- The lack of active follow up within the Directorate to Ms Gishkori's alternative plan in September and October 2016
- The potential for an SAI

We note these to be different to the points which were referenced at 2.2.32 in the panel report in which it is stated were the factors in the decision by Dr Wright to proceed with the formal investigation:

- The absences of assurances about progress made to manage and attend to the concerns.
- The serious adverse incident
- The information provided on the quantum of the alleged performance matters.

5.12 At 6.10 of the grievance panel findings it concludes that in the absence of an assurance of a viable alternative and given that all earlier "intended interventions" outside of the formal MHPS had failed to deliver progress let alone closure, that his actions were reasonable. We have commented earlier that we accept the right of the Medical Director at any point to initiate a formal MHPS investigation, where he feels the circumstances merit such. On this occasion it was the "potential for an SAI" that is noted, and while initially pointing to the responsibilities of others, this is changed to the absences of assurances which is nonspecific and suggests responsibility lies wholly with Mr O Brien.

5.13 Our consideration of the grievance panel's finding in this regard, again ignores an important consideration which we feel is obvious throughout this case. There is an absence of thorough and proper management of the concerns raised in respect of Mr O'Brien and of the management of Mr O'Brien himself. In this respect and as highlighted in earlier paragraphs that we conclude that the stage one grievance panel has not judged the grievance fairly. We hold the opinion that there are several of Mr O Brien's complaints that should have been upheld or partially upheld.

We would not have judged this grievance in an "overall" context but in terms of the individual aspects of it and would we believe have succeeded in achieving a more balanced outcome.

6.0 Terms of Reference 3

To review any relevant notes, data or any other relevant information as part of the review of the concerns.

6.1 The review panel sought evidence in respect of Mr O Brien's appraisals from the Trust. The reason for this was to check to see what had been raised in the years concerned and prior to 2016 relating to workload. This was referenced at various points in the documentation as contributory factors in the inability to triage and write up clinics. The documentation which was provided related to 2017 and 2018 and not to the period prior to the events which arose in 2016. In both years, the appraisal documentation demonstrated positive appraisal.

6.2 There is a reference within the documentation to the emergency, on-call and out of hours responsibilities. One of the responsibilities is noted as triaging 150-190 urological referrals received during the week (One in six- week commitment). The 2018 appraisal document expressed the difficulties in dealing with demand/ supply issues and the challenges of this for Mr O' Brien. A reduction in the job plan was recorded. It further references that the greater part of the failure of patients to receive a safe quality service has been due to its inadequacy in all its forms. Mr O Brien also notes that he is seeking clarification of roles expected of the urologist of the week and refers to a meeting with Senior management in December 2018 being cancelled. This meeting had been set up to look at the Trust's expectations of the undertakings of the Urologist of the week.

6.3 In 2017 the Job plan does not reflect the amount of work carried out although the ongoing investigation is referenced as is the period of exclusion. These documents record the impact of the issue of concerns on Mr O Brien's health.

6.4 In the years for which we had sight of the appraisal documentation it is not perhaps surprising that Mr O Brien referenced the volume of work, the triage challenges and the failure of management to engage to resolve these matters. What we would have been keen to identify is whether these matters formed any part of the previous years' appraisal or not. We cannot determine the extent of effort Mr O Brien made to bring the problem to the attention of his employer before 2016, and what if any effort was expended by management to address the problem.

6.5 This panel was invited by the Southern Trust to review the previous Grievance panels' decisions and processes. Appraisal and revalidation are the cornerstone of medical governance and allows bilateral discussions, job planning and personal development from both parties. To furnish this panel only partially with Mr O' Brien's appraisals, leaving out the most important years 2014/2015 is concerning, despite several requests.

The decision of omission has been made by the current management team.

This fact needs highlighted to the current Chief Executive and Trust Board.

6.6 While in one of the appraisal documents there is reference to a reduction in the job plan in the grievance papers the review team could find no evidence of any connection from this to the job planning process. We could not evidence if any change to the job plan had been introduced to address the administrative weaknesses.

6.7 We fully accept that Mr O' Brien had a responsibility to review his practice, be that volume of work, triage arrangements, reporting back to GP's, to ensure that he was not compromising the treatment of any patient and that the Trust had a responsibility to question this, we acknowledge that their tardiness in so doing was wrong.

6.8 In the conclusions reached in the report of the Case manager, while finding that the failings of Mr O Brien should rightly be considered by a conduct panel and action plan there was another important finding. It is reported that there were "systemic failures by managers at all levels, both clinical and operational, within the Acute Services Directorate. The report identifies there were missed opportunities by managers to fully assess and address the deficiencies in practice of Mr O' Brien and that no one formally assessed the extent of the issues or properly identified the potential risk to patients. The review panel notes that while there is a recommendation that an independent review is undertaken of the administrative processes there was no learning identified in the processes so far undertaken, which we would have expected to be included.

7.0 Terms of Reference 4

To produce a written review outcome determining if the stage one grievance panel's decision is fair, reasonable and sound.

7.1 As a review team we acknowledge that we have not had the benefit of meeting with Mr O Brien although have had full access to his grievance submission. We have had sight of all documents which the Trust provided to the grievance panel in this matter. We requested additional information which, where it existed was provided except for the Appraisal documents as referenced earlier. Not having these documents to determine whether Mr O' Brien raised his concerns about triage/workload/ expectations of trust management we believe has not been helpful to us but is also an oversight by the grievance panel.

7.2 In the preceding sections of this report we have commented on the elements of the grievance panel's decision which give us cause for concern. Fundamentally we have accepted that there were problems with the administrative practices of Mr O' Brien which were known for years, within the Directorate and on a wider basis. While we accept that Mr O Brien's approach to this being raised was initially to ignore it, the absence of timely follow up did not affirm the seriousness with which the Trust was viewing this but supported his casual approach to it.

7.3 Mr O Brien's subsequent approach by way of raising a grievance which took some 2 years to conclude has served no-one well. While some elements in our view were appropriate to grievance processes others are not. This was commented on by the grievance panel and it is difficult to know if this was intentional. While we cannot judge intent, it had the impact of obfuscating progress.

7.4 The most troubling concern that we have in relation to this matter is that throughout this time there is little mention of patients and the degree to which the failure to triage and report and then subsequent ongoing delays in processes all served to compromise patient care. The case manager's report confirmed significant numbers of patients untriaged (783) and it was determined had this been done, 24 of these would have been to red flag status which impacted on the assessment and planning of their treatment and care. Of this 24, 5 have gone on to have a cancer diagnosis and their treatment was delayed by the failure to triage. There was an awareness even in the Medical Director's office that this was the case, yet patients continued to be compromised while this was not addressed. The Medical Director was aware of the extent Mr O Brien's misconduct in January 2016 but failed to make a practical intervention until December 2016. During this period, there was no regard to patient's wellbeing. Other doctors and nurses with managerial responsibility also failed to take action in relation to this misconduct. Indeed, these individuals also have issues in relation to their own conduct and professional obligations in relation to the safeguarding of patient's safety.

7.5. Finally, it has already been indicated that the review panel disagrees with the findings in several elements of the grievance. Their taking an "overall" approach has resulted in an outcome that is not totally fair and while acknowledging in different elements the failings of those concerned, does not appear to take this into account in the conclusion reached.

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

Importance: High

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

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Personal Information redacted by the USI

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

Morning Ronan

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

Attached is a PP letter from Mr O'Brien. This patient was seen by Mr O'Brien on 5th September privately (given the headed paper the letter is on) and placed on his NHS theatre list on weds 21st September, waiting a total of 16 days. His actual NHS waiting list has many other patients awaiting a routine TURP (which this man had) waiting significant lengths of time. I believe, if his theatre lists were scrutinised over the past year a significant number of similar patient admissions would be identified. This practice has a negative impact on our overall waiting times and is in my view totally unacceptable.

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

Mark

National Clinical Assessment Service

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

Website: www.ncas.nhs.uk

General Enquiries and Advice Line: 020 7811 2600
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Email: casesupport@ncas.nhs.uk

29 December 2016

SENT VIA EMAIL ONLY

PRIVATE AND CONFIDENTIAL

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

NCAS ref: 18665 (Please quote in all correspondence)

Dear Dr Wright

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

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

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

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

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

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

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

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

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

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

Relevant regulations/guidance:

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

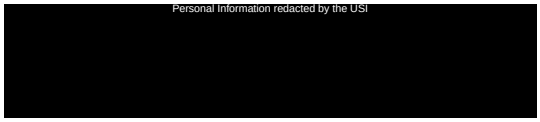
Review date:

27 January 2017

If you have any further issues to discuss, or any difficulty with these arrangements, please contact Case Support on the direct line above.

I hope the process has been helpful to you.

Yours sincerely



Grainne Lynn
NCAS Adviser

cc Case Support Team

It is the thrust of these two paragraphs, isn't it, that NCAS are consulted with before a decision to exclude has been taken?

A. That's correct.

343 Q. Then you were talking about NCAS's ability to get involved at an early stage. I think paragraph 11 might help with that. 13:49

"The first stage of the NCAS's involvement in a case is exploratory - an opportunity for local managers or practitioners to discuss the problem with an impartial outsider, to look afresh at a problem and possibly recognise the problem as being more to do with work systems than a doctor's performance, or see a wider problem needing the involvement of an outside body." 13:49

Is that what you were describing there about NCAS getting involved in an early stage?

A. Yes, that's what I would mean.

344 Q. In your opinion, does that paragraph accurately summarise the benefits of NCAS getting involved at an early stage? 13:49

A. Well, it could probably be expanded but since there -- you know, it has never been rewritten. There are a lot of problems, as you know, with the document. This wouldn't be one of the major ones, as I see it, but it definitely could benefit from some rewriting. 13:50

345 Q. If I might then turn to some of the specifics then in this case. My understanding is that your first

involvement was on 28th December 2016. There's an internal NCAS note as WIT-53523. This is, in fact, an internal NCAS note of a call from the Trust; is that correct?

A. That's right, yes. 13:50

346 Q. It says:

"Time taken: 11.30 on 28 December."

That was shared with you, I believe at 11.44. Is this 13:51
all the information you would have had prior to contacting the Trust?

A. Yes.

347 Q. It says here "RB", I assume that's refers to referring body? 13:51

A. Yeah.

348 Q. "...had a serious adverse incident investigation that flagged up a problem with this doctor's review of a patient with cancer. The patient came to some harm. Due to delay they may have come to more harm. The 13:51
review has highlighted some issues with the doctor's review system and lack of updating the system with patient notes, possibly taking the notes home and not returning."

13:51

You received this page at 11.44. You do then speak to Dr. Wright that day. Can you recall what time you spoke to Dr. Wright?

A. No, I don't recall the time.

349 Q. Whenever you spoke to Dr. Wright and before you spoke to Dr. Wright, were you aware that Dr. Fitzpatrick had looked at this case some three months?

A. I can't remember that specifically.

350 Q. If we call up your advice letters, this is at WIT-53455. I'm hoping this will assist. If you would scroll down to the first substantive paragraph. This is the following day. In this letter you refer to advice which your colleague Dr. Fitzpatrick had previously discussed with Mr. Gibson? 13:52

A. Yes, but it had then been flagged up to me that this was already a case that we had. There was a mistake, I think, with the number. I think that's on the file somewhere. So we didn't automatically match them as we would normally do. They're matched on case number when a new case comes in. So I may well have done the call without knowing that Dr. Fitzpatrick had -- but it's not something I recall. I know by the time I did the letter, obviously, which would have been fairly soon afterwards, I would have thought, that I did know but I can't be sure whether I knew or didn't know. 13:53

351 Q. Your letter goes out the following day. So, clearly you gave this some urgent attention. Just so I'm clear, you're saying that normally, in normal circumstances if a case comes back to NCAS the system in some way links it? 13:53

A. It links it, yeah.

352 Q. And in that scenario would you have the ability to easily and quickly pull up previous advice?

A. Yes. Yes.
353 Q. You're saying there may have been an issue with linkage, if I can use that term this case?
A. Yeah, that's right. If you don't have the right number the case won't be linked. And we do link cases that come from the same employer. It goes back to the same number. If it's a new employer we would get a new number linked to the case. 13:53
354 Q. So, this time you can't say whether or not you'd seen Dr. Fitzpatrick's advice? 13:53
A. I don't know, really.
355 Q. In a perfect world would you --
A. Obviously, yes, in a perfect world I definitely would.
356 Q. On that note then, Dr. Fitzpatrick obviously had dealt with this in September or at least taken the call. You outlined in your witness statement that you believe Dr. Fitzpatrick wasn't available as he works part time. Would it have been preferable had this been kept with Dr. Fitzpatrick do you think? 13:54
A. Well, we do try to make keep cases with the same adviser. It makes for continuity of care. But it wouldn't be uncommon for an adviser not to be available an then it to be allocated to somebody else and then it would be a judgement call about who keeps it. 13:54
357 Q. I don't particularly want to labour the point. If we go to AOB-01049, please. This is a copy of Dr. Fizpatrick's initial advice. I fully accept what you're saying, that you may not have seen this at the time. Having reviewed this since, do you consider that 13:54

there's perhaps quite a lot of useful information which you could have used going into that phone call?

A. Yes.

358 Q. If we look at the very bottom of that page, there's reference to as well as perhaps a series of issues there's also reference to delayed referral to oncology. What you're told about the SAI subsequently is perhaps the outworkings of such a process; would you agree? 13:55

A. It could have been, yes.

359 Q. If we go over the page, Dr. Fitzpatrick offers a series of advices or suggestions about how to deal with the problem. He suggests that removal of charts could be dealt with via disciplinary action. That there could be a audit of what's described as poor note-keeping or note-taking. Then he says: 13:55 13:56

"The problems with the review patients and the triage can best be addressed by meeting with the doctor and agreeing a way forward.

We discussed the possibility of relieving him of theatre duties in order to allow him the time to clear his backlog. Such a significant backlog will be difficult to clear." 13:56 13:56

At the time you speak to Dr. Wright, so far as you can recall are you aware of these recommendations or advises from Dr. Fitzpatrick?

A. I don't recall.

Hainey, Lynne

From: Hainey, Lynne
Sent: 29 December 2016 09:04
To: Hynds, Siobhan
Subject: AGENDA - Fri 30.12.16
Attachments: AGENDA - Fri 30.12.16.docx

Hi Siobhan
This appears to have been issued yesterday to Mr O'Brien via e-mail from Dr Wright's office. Think it sounds misleading ie to discuss the date of your planned return to work, whenever a decision has been made to exclude. I will have a look at Terms of Ref and letter drafted by Simon this morning

Any queries just give me a shout
Thanks

Lynne

Meeting with Dr Richard Wright (Medical Director),

Mr Aidan O'Brien (Consultant Urologist)

& Lynne Hainey (Senior Human Resources Advisor)

10am on Friday 30th December 2016

in Dr Wright's office, 1st Floor, Trust HQ

A G E N D A

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

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

3. To clarify Trust expectations regarding the return of patient notes that have been tracked out to you.

You are welcome to bring a friend or representative to the meeting for support if you wish.

30 December 2016

FILE REFERENCE: 1

MEETING 30 DECEMBER 2016

DR RICHARD WRIGHT

MR AIDAN O'BRIEN
~~(DR WRIGHT)~~accompanied by Mrs Personal Information redacted by **O'Brien**

MS. LYNNE HAINEY (Employee Relations)

Audio Transcription Prepared by:

Angela Harte
Personal Information redacted by the USI

DR WRIGHT: I gather you have been off, Aidan.

MR O'BRIEN: Yeah.

DR WRIGHT: And I know you've not been that well. It's good to see you back on your feet and working and so on. So that's -- you know, I am not aware of the details of why you have been off.

MR O'BRIEN: [redacted]

DR WRIGHT: Well, I am glad you are through [redacted] obviously (inaudible) watch this with interest.

MRS O'BRIEN: It might happen to you all at some time.

DR WRIGHT: (Inaudible).

MRS O'BRIEN: Yes, indeed.

DR WRIGHT: Thank you for coming up today. We wanted to talk to you very quickly. There have been a number of things that have come to light that we need to take action on and rather than send letters and so on it is much better to speak to the individual.

So, essentially, we have been -- the Trust has been investigating a SAI investigation into this particular case -- the SAI is not complete yet -- in relation to a patient may have come to some harm through a delay in treatment. But during an investigation it has come to light that were other issues that were linked to this and were brought to my attention.

I don't know (inaudible) also taking in the fact that some of these issues were raised with you by letter in March of this year as you will be familiar and are mostly around administration matters, patient notes.

~~FEMALE SPEAKER 1~~Ms HAINEY: We can go into the specifics if you wish.

DR WRIGHT: (Inaudible).

MR O'BRIEN: Okay.

~~FEMALE SPEAKER 1~~Ms HAINEY: Certainly the issues that ~~we~~were raised relate to the lengthy period of time to undertake triage of GP referrals and currently we have a number of 318 untriaged presently. The suggestion is that this may have a led to a poor clinical outcome as Dr Wright has indicated for one patient and unnecessary delay of treatment for a second patient. And this has come out as I understand as part of the SAI.

There is also the concern that has been raised previously informally about taking patient notes home and that these have not been returned and the concern from the Trust perspective then is that the clinical management plans for those patients remains unclear. And there is a concern obviously that the treatment may be delayed in that respect.

The third concern is that there is back log of over 60 undictated clinics going back approximately 18 months. So we have a situation where there is approximately 600 patients may not have had their clinical outcomes dictated. So the Trust are unclear again about what the clinical plan is for those individual patients.

Certainly, the concern, obviously, as Dr Wright has mentioned, is provided by the SAI, is that those administrative practices have the potential to lead to harm for patients and that is concern that --

MRS O'BRIEN: SAI stands for?

~~FEMALE SPEAKER 1~~Ms HAINEY: Sorry, serious adverse incident or investigation. And that is the concerns that have been raised with Dr Wright.

MR O'BRIEN: I am not aware of the case at all or ~~may be (inaudible).~~maybe you're not at liberty…….

DR WRIGHT: I don't know it. We can certainly furnish you with the details of it. The investigation into that is not complete yet, so I haven't seen the final report on it but certainly the issues that --

MRS O'BRIEN: When did it arise?

DR WRIGHT: It arose the last ~~couple~~number of months.

MRS O'BRIEN: A number of months, so before -- and it is a patient of Aidan's?

DR WRIGHT: Yes.

MRS O'BRIEN: Right.

DR WRIGHT: We can certainly share that with you. ~~And now~~Now, we met as an oversight committee, which is the structure within the Trust to consider these matters and the director of HR and the service director, or their representative, and myself. And given that we have got some evidence of patient harm in one case and potential for harm in others, to be honest I really have no choice but to formally investigate this. This is why we are letting you know we are going to do that and it is to outline the procedure for that and the consequences of that.

MRS O'BRIEN: Is it normal procedure to keep the case, the serious incident, is that normal procedure to not involve the ~~—~~……..

~~DR WRIGHT~~ MRS O'BRIEN: That would be part of the SAI process which is separate (inaudible) investigation. It would be ~~(inaudible)~~normal that ~~you~~your involved in that but

that has not completed yet.

MRS O'BRIEN: But normal procedure that you wouldn't be part of the very -- from the very start? It seems very secretive to me that you investigate something and then, you know~~.~~……

DR WRIGHT: I haven't been involved in the SAI investigation. There is a process. And I am sure the clinician concerned will be involved at the appropriate opportunity. But so -- but it is a bit unusual. It may be that because you have been off that this has happened at this time but I haven't been involved in that process.

MRS O'BRIEN: It is just that when there is always problems with (inaudible) the complaint nearly goes to you first to make a report on it.

DR WRIGHT: That would the usual (inaudible). I don't know the answer to that but, nevertheless, this has come to light and it was highlighting issues that had already been highlighted to yourself, Aidan, in March and similar issues. So I am having -- so we are going to have an investigation under what is known as the maintaining higher professional standards framework, which is the agreed framework with the BMA and the Department Of health. We can give you a copy of that and we will send you a copy.

~~FEMALE SPEAKER 1~~Ms HAINEY: I have copies here today I can share with you along with associated local guidance, Mr O'Brien, to determine how those (inaudible) are actually in terms of (inaudible).

DR WRIGHT: To do that we appoint what we call a case manager and a case investigator. I don't know if you are familiar with this process? So the case manager is a person who I delegate to run this investigation on my behalf. So we have asked one of our senior clinicians who has no involvement in the service delivery (inaudible) and Mr ~~Amit~~Ahmed Khan, who is the ~~associate medical director~~Associate Medical Director for paediatrics and child health. So he will act as the case manager. We have asked Mr Colin Weir to be the case investigator as the CD, the ~~clinical director.~~Clinical Director. So that would be the team if you like and we do~~—~~…. I suppose the question is I know you know Colin. Do you have any difficulty with him being the investigator?

MR O'BRIEN: No.

DR WRIGHT: Usually it would be the CD of the area and he would be well placed to understand the issues (inaudible) a surgeon who knows the (inaudible) and complexities of triage and (inaudible) all the difficulties that that brings.

~~FEMALE SPEAKER 1~~Ms HAINEY: The investigating officer is normally assisted in the investigation by a representative from HR and that person is to be appointed as yet but I will be able to confirm that with you as soon as possible.

DR WRIGHT: So that will be team. There will also be a non-executive director of the Trust (inaudible) to oversee the process. That would be someone that you could go to if you felt in any way the process was not being run properly or you were unfairly treated. That person has not yet been -- usually the chair will nominate someone and we'll let you know who that is. (inaudible) involved in process and (inaudible) ensure there has been, you know, (inaudible).

Now during the process, Aidan, I am not sure what your plans were for coming back to work. (inaudible) but I am not sure.

MR O'BRIEN: I had planned to come back to work next Tuesday, though, frankly, I don't know whether I am fit to come back next Tuesday.

DR WRIGHT: I think that's fair.

MR O'BRIEN: [redacted]

DR WRIGHT: I am sure there is. (Inaudible).

MR O'BRIEN: I don't know what is your view about that because the—…….I mean, some of the context of this though is the enormous pressure to operate. The complaints and the enquiries that I deal with every day are, ~~when~~'When am I having my operation done?~~-~~' People's clinical outcomes are being compromised all of the time, day in day out, because of not only the lack of capacity as a whole but, in addition, the inequity within departments.

For example, in performance data -- I think it's ironic that it's called performance data because it is not the performance, it is not what you do, it is what has to be done. In October, I had 288 people on my waiting list for in-patient admission and one of my colleagues has 29. And I have implored that that situation would be addressed. What was driving ~~me~~my back was, you know, the demands for operating. In fact when I went off I circulated a list of the ten most urgent people to be done and the two who are waiting the shortest period of time have been done by one colleague and none of the rest.

I— …… just to give you, Richard, a context. It is very, very important to appreciate, you know, the totality of the work that we do. I have said when we had a

meeting to deal with triage, I triaged the red flag referrals, that you don't have the time to triage. This thing of triaging non-red flag referrals it is a historical hangover from a time when we as a department, and particularly if I may, in the view of Michael Young, there wasn't enough to do when you are call so we need to have something to fill in the time in order to justify the new system. And if you are a person who tries to operate on the acute admissions as they come in -- like the last week I was on call I did 21 additional operations that week, whereas others, and particularly the person who recently left you know, and I always followed him on the week on call and then this past year more --

MRS O'BRIEN: You supervised him.

MR O'BRIEN: -- I have been supervising him and backing him up. As Martina Corrigan used to say, now you are starting your week on call after having the other week in call.

DR WRIGHT: Yes.

MR O'BRIEN: And then you picked up, you know, everything that had been up long-fingered and deferred, and when you are operating and you have already worked 12, you don't have the time to sit down and triage.

DR WRIGHT: One of the things that I said in this, in my experience (inaudible) whilst sometimes (inaudible) criticisms of individuals, there is almost inevitably a detailed look back at the Trust systems. (Inaudible) and they are often a contributor, so I don't doubt that that will be an issue that will be looked at.

MRS O'BRIEN: I would back up this. Aidan is now going into his 25th year as a consultant here. I can say with hand on my heart he has worked between 70 and 90 hours a week in those 25 years and that's Saturdays, Sundays, everything.

DR WRIGHT: I understand.

MRS O'BRIEN: I mean, he goes in here at 8.30 in the morning. He comes home about 8.30 at night. He has something to eat and he -will go.. and he'll be doing work again, preparing operating lists, ringing patients. Because his waiting list is so long, if he is picking patients from his ~~longest~~long list waiting list, and ~~there~~they are three years on a wait listing, their circumstances have changed so much. So he takes the time. He rings the patient, he checks all their biochemistry.

MR O'BRIEN: It takes me session and then I have been doing extended operating ~~days~~lists. I know there's a context (inaudible) but I just actually—….. I have done 19 additional theatre sessions in the ten months of this year, my being off the last six weeks, 15 extra oncology clinics, 14 extra urodynamic sessions and all under pressure to do so and expectation to do so.

———And you wrote to us all about the highly recompensed consultant in the earlier part of

the year, do you remember, additional sessions and all of that, I am not here to discuss money, but all of that completely un—.....

DR WRIGHT: I do realise that (inaudible). I am well aware of the amount of work that you put in on our behalf. So all the more reason that (inaudible) structure around that is right and that we are not actually -- and the Trust is not asking you to do too much or so this will all give you the opportunity to explain all of that. (inaudible).

MRS O'BRIEN: And the other thing I would have said, you're talking about referrals. Now, I have health service background myself. Now I was a nurse, what would be like a nurse practitioner as they are now, nursing sister in orthopaedics, and this was nearly 40 years ago. Any referral that came in to orthopaedics to the consultant that I worked with, the two consultants I ~~work~~worked with, I got the referrals, I decided. I have always looked at Aidan and said, this is not something a consultant should be sitting down~~,~~ looking at, like someone who is getting a few times up at night passing urine. Why does a consultant have to process that? A well-qualified—.....I did that. I would have ascertained what were the urgent ones. I would have ascertained, ordered the X-rays, got them on to the clinic as soon as possible. That's 40 years ago. The system is—.....there is too much.

MR O'BRIEN: I have been (inaudible) a meeting to discuss this two years ago, it must be two years ago, that I didn't have the capacity to do it and I wouldn't be doing it and I agreed that red flags certainly yes, particularly if you are doing advanced triage. I mean, and there are various ways of doing triage. But if you are going to sit down, you ring the patient, you get the CT scan done, and all of that rather than just ticking a box.

DR WRIGHT: (Inaudible) I know that. (Inaudible) it may well be that (inaudible).

MRS O'BRIEN: That is way I am bringing it up. It is to emphasise the amount of work that goes on and hence you get delays in things because of the workload.

DR WRIGHT: That, I have no doubt, will come out and you will have an opportunity to make that case and I would hope ~~(inaudible)~~ there will be learning from the organisation as a result of this. I am aware of the ~~(inaudible).~~ hours you put in.

~~FEMALE SPEAKER 1~~Ms HAINEY: As Dr Wright says, any investigation process will give you the opportunity to respond in full. All the information that you put out will be taken into consideration. You know, whenever there is an investigation that does not necessarily mean that there is a negative outcome for the individual at the end. It all depends on the information (inaudible).

MRS O'BRIEN: I would hope there will be no negative..... because after 2 5 years of service beyond the call of duty, beyond the call of duty, it makes me very angry. I am telling you.

DR WRIGHT: Can I be honest with you, I don't get much pleasure in calling this meeting but

all I can say is things have been brought to my attention that I do need to act on. But I can assure you that ~~(inaudible)~~we will make the process as fairly and as smoothly as can.

MR O'BRIEN: I am concerned about -- who is the person? I don't know who the person is?

DR WRIGHT: (Inaudible) information if you have not already been told.

MRS O'BRIEN: He hasn't been told.

MR O'BRIEN: That's the first I know of it.

DR WRIGHT: There are a couple of practical things. One of the things we do need you to do, and this this is an absolute must, we do have a large number of ~~(inaudible)~~unaccountable patient notes being tracked down to you and we need any that you know of their whereabouts or ~~(inaudible)~~if there in your house or wherever, we need those returned immediately.

MR O'BRIEN: Can I just say something about that, Richard? I can't return them without processing them if you know what I mean.

DR WRIGHT: No. I want to be very clear about this. We need them returned by Tuesday at 11 o'clock in the morning and I would like them returned to Martina Corrigan's office. And you can give us whatever information you are able to but we have to them returned. I am going to be asked to account for these patient notes at a very high level and I need to know exactly where they are so we can deal with the issues and do a follow-up subsequent to that. But I want to be very specific, Aidan. I need those notes back by 11 o'clock on Tuesday morning. ~~There is a (inaudible)~~Because if we have notes missing. We have ~~(inaudible).~~a very major problem.

MRS O'BRIEN: If you have a what?

DR WRIGHT: If there are notes unaccounted for that we can't track, then I have a major ~~problem (inaudible) to~~problem to deal with, so I need to know exactly.

MRS O'BRIEN: Did you not already say they are tracked?

DR WRIGHT: But they are not available to me. They need to be back in the Trust. I need to see them on Tuesday. (Inaudible) we have notes that have been unavailable to other clinics. Patients have been turning up and not being able to be seen with their notes because they have been tracked out to yourself, Aidan, and unavailable to~~—~~…….

MRS O'BRIEN: They mustn't have been requested. You have always made the notes available.

DR WRIGHT: On this point I am being very specific. We need the notes back at 11 o'clock on Tuesday morning. ~~(inaudible)~~We need to take a stock-take of where they all are and what we have and what we don't have. So it may be not a problem. If they are all there, that's grand. But if we do have notes that are unaccounted for, that would be a different

issue.

MR O'BRIEN: What do you mean?

DR WRIGHT: Well, there are potentially data protection issues if notes are missing and we don't know where they are. If they are unavailable we will have to disclose to patients that we don't have them. So if you have—…….do you know where they are?

MR O'BRIEN: I mean,…….. I have notes at home certainly. The difficulty is what happens when -- if I just bring them in and they haven't been processed? Do you know what I mean?

MRS O'BRIEN: That's going to lead to a worse problem.

MR O'BRIEN: Yes.

DR WRIGHT: That is a separate issue the Trust will have to deal with. But, at the minute, we don't have any evidence that they are being processed, so I would like to see them on Tuesday morning (inaudible), the ones you to have. So I am being quite direct about that.

MR O'BRIEN: There is no possibility of making a deferment for a two weeks or something of that nature—……

DR WRIGHT: No.

MR O'BRIEN: —…….. so that I could process all of them?

DR WRIGHT: No. I am going to have to account for these so I need to know where they are. (Inaudible) sayNow we may well decide what we do with them when we get them, but I am being very direct about this. So now the result of that (inaudible) number of other actions.

— They are asking for an occupational health referral, Aidan, as would normally be the case before your return back to work. It may be that (inaudible)by the sounds of it you are not quite ready for coming back in any case but it simply is a matter of checking where you are with your recovery. So you will be getting asked to attend an occupational health (inaudible).

MR O'BRIEN: When would that happen?

DR WRIGHT: Sometime in the next few weeks I would think (inaudible).

MR O'BRIEN: So what do I do about work on Tuesday?

DR WRIGHT: I am about to come to that. Okay. In order for this investigation to carry on and in order for us to scope the terms of reference of it, because we have not quite determined the extent of the investigation, we would like you to remain off week for the next four weeks. Okay. So that -- and this is to protect you and to protect the Trust -- and allow the investigation scope to be determined.

FEMALE SPEAKER 1Ms HAINEY: That will be line with the maintaining the higher

professional standards framework, Mr O'Brien, which refers to a decision and situations like this to exclude a practitioner from the work place for a period of time, as Dr Wright says, to do a preliminary exercise and scope out the terms of reference for the formal investigation. And during that period of time we would hope to be able to meet with you and give you an opportunity to provide any representations that you wish to make to the Trust. But certainly what we will is we will confirm all of this in writing to you after today.

…….. silence ……..

I appreciate it is a lot to take in and certainly we would want to look to provide you with as much support as possible during this time. As Dr Wright says we can certainly link with other occupational health and get an urgent referral for you. We also have what is known as care call. It is a (inaudible) staff to avail of in such circumstances if they felt they needed that additional support.

…….. .silence …….

MR O'BRIEN: So what you are saying is the charts are to be returned by Tuesday morning.

…….silence ……..

And what about all of the things that are organised?

What happens to clinics and the operating list?

DR WRIGHT: We will be discussing that with your clinical lead and your clinical director to follow up with that but it doesn't sound from what you are telling me this morning, even from a physical point of view, that you would necessarily be in a position to action those in any case but we will have to put other arrangements in place for those patients.

~~FEMALE SPEAKER 1~~Ms HAINEY: Just to be clear, any exclusion is obviously on full pay and it is (inaudible) precautionary measure. It is not a sanction in itself. And (inaudible) period.

…….. silence…….

MR O'BRIEN: I'm Shell-shocked. ~~(Pause)~~

…… silence……

DR WRIGHT: I appreciate that *……*

MRS O'BRIEN: I think there is no better person, you know, to process the thing than yourself. Nobody is going to be able to process what you need to do.

DR WRIGHT: And that (inaudible). We will have to see the extent. I am hoping that when we get the notes back this is a much smaller problem than it potentially could be. But currently I have up to 300 notes that are tracked out to you that can't account for. So I -- this could be quite a big problem or it could be a very small problem. I am hoping it

will be the latter, in which case we will review the situation.

MR O'BRIEN: You see, as Personal Information redacted by says, I would have been best able to -- there -- they're just people who need to be contacted or referred.

MRS O'BRIEN: Aidan always -- you always hate putting the -- in case the person you are thinking of has been forgotten about. If it goes away, out of his sight, he will never get it back and it is impossible to keep track of patients who he's -- and what wants to do with.

DR WRIGHT: We will have to put something in place to deal with that. That may well in a very short time mean getting you back into action and dealing with these. But at the minute I need to the scope the extent of the problem. I realise this is distressing for you. It is not ~~(inaudible).~~..... But faced with what is on my desk at the minute in terms of the potential problem, it is unlikely you are going to be either fit enough or in a position to deliver this in the timeframe (inaudible).

MR O'BRIEN: Is what—..... when you say that, what do you mean by that?

DR WRIGHT: Well, it would appear there's quite a large number of these patients. So no one person is going to be able to sort this out within a few weeks (inaudible) measures.

MR O'BRIEN: But I could have. I could have. I could do some of that at home.

DR WRIGHT: But, Aidan, we wrote to you in March outlining these issues. We have no evidence yet that that has been addressed.

MR O'BRIEN: It has been addressed, even though -- like, the greater emphasis I placed was on operating. I didn't take any holidays at all you know~~.~~ .....

DR WRIGHT: However, the issues were raised with you in March and they're still here now. So, you know, we haven't got on top of them by leaving them with you (inaudible) different.

MR O'BRIEN: If I were -- can I just ask, please, this? If I were not to return to work under these circumstances for the period that you have outlined, and I mean if I had the first two weeks of that, I mean I could have all of that not only returned to you, totally, but resolved. I could have them organised.

MRS O'BRIEN: I think you may be just adding to your problems.

MR O'BRIEN: I would just plead with you—.....

MRS O'BRIEN: It is not a covering up process. It is just a process.

DR WRIGHT: I will be very direct here. One of the other reasons for getting you to return them very rapidly is that there will no further allegations that there might be any sort of covering up process. So this as much about protecting you and protecting me. If we start an investigation now and then we leave you with all this for a fortnight or two to three weeks before we see what the sense of the problem is, there could be all sorts of potential

allegations (inaudible) changed (inaudible) allegations. Okay.

A

So I hear what you're saying. I can see your logic in saying that but the oversight committee have considered this at a very senior level in the Trust and that was their decision. So we are requiring you to bring the notes back on Tuesday.

~~FEMALE SPEAKER 1~~Ms HAINEY: Are you able to comply with that request, Mr O'Brien?

B

MR O'BRIEN: Yes, I am just very concerned about it.

MRS O'BRIEN: Will they be kept -- you would be so concerned about the processing of them. You wouldn't want them sort of filed into their place and then you've forgotten all the names. Unless you take a note of the names and the hospital numbers so that then you can deal with this.

C

DR WRIGHT: ~~(Inaudible)~~You can bring them back to Martina Corrigan directly. Not anywhere else. Directly to her office and she will (inaudible) keep an inventory.

MRS O'BRIEN: So it is a matter of, like, she is checking them off against the ones that are tracked out. Is that it? It is just correlating the numbers and the --

D

DR WRIGHT: They are also issues raised about what has been dictated and what has not been dictated, so will have to review what is in those notes. ~~(Inaudible)~~Some of that may be simple. So I suppose the problem is I don't know precisely the issues at this moment in time but there are quite a lot of notes so it is going to take a little bit of time~~.~~……..

silence…….

E

I mean being very direct. One of the questions I will be asked with chief medical officer, probably could ask me on Tuesday, how many notes are missing (inaudible). So I need to (inaudible).

MR O'BRIEN: Well, yes, but there are no notes missing at all.

F

DR WRIGHT: You know that but I don't know that.

MRS O'BRIEN: No. Not missing. It is just they are not processed.

DR WRIGHT: That is why I am hoping you are going to be able to --

MR O'BRIEN: But my concern is dealing with them, you know.

DR WRIGHT: But you can't deal with them on your own (inaudible) anyway so a (inaudible) couple of months.

G

MRS O'BRIEN: He does deal with them. You know he can. You ring the patients, you review them. He has been dictating. he has been doing ~~—~~……

~~FEMALE SPEAKER 1~~Ms HAINEY: What you are saying -- I can I understand what you are saying, but Dr Wright is clearly saying is that they need to be returned. The decision has been made to undertake a formal investigation and also that during that period of time that immediate exclusion should be put in place. So during that period of time you should not

H

be undertaking any work that is associated with your job in the Trust. You know. It is in your interest obviously and everybody's interest to provide the information as requested to Dr Wright. And Dr Wright can then look at the measures that have been put in place to manage those patients.

…….silence ……

DR WRIGHT: So what happens next, Aidan, is we will write to you with a summary of ~~the (inaudible)~~ what ~~you~~was said today and to outline the process and give you the ~~(inaudible)~~various copies of the frameworks that apply. And (inaudible) in touch with during the next week or two. I am sure Colin will want to ~~(inaudible)~~set up an interview with you very rapidly.

~~FEMALE SPEAKER 1~~Ms HAINEY: Obviously we would encourage you as part of that --

MRS O'BRIEN: When this letter was sent in March~~,~~ …….I was unaware of that, I mean, what did the letter say in March? Do you have a copy of it? I mean, was there a time on it or ~~no~~?

DR WRIGHT: I think it used the words as soon as possible.

MRS O'BRIEN: All right.

DR WRIGHT: (Inaudible).

MR O'BRIEN: I wish I had ignored all of the other things. I just wish I ~~had. (**Pause**)~~ hadn't

…….silence…….

DR WRIGHT: Well, we are where we are with it. I think once we scope the size of the issue, which it may not be as bad as we initially think if what you are saying is right. Get the terms of reference agreed and let's get the whole thing done as quickly as we can (inaudible). I am sure there is going to be --

MRS O'BRIEN: I would have a problem with this person. I think he has -- I don't think he shares much -- what's the right word to say, he has caused Aidan problems in the past. That does not surprise me that that name is there. I have an issue with that. Do you have an issue with that?

MR O'BRIEN: He is no longer in that role anyhow.

MRS O'BRIEN: ~~He~~It doesn't matter~~.~~ ….. I am very much aware of this gentleman~~.~~ ~~(**Pause**)~~……. silence……..

~~FEMALE SPEAKER 1~~Ms HAINEY: It is a lot to take in certainly (inaudible) occupational health.

MRS O'BRIEN: It is horrible beyond words. ……. *distressed* ……

~~FEMALE SPEAKER 1~~Ms HAINEY: Would you like a glass of water, a cup of tea or coffee?

MRS O'BRIEN: No~~.~~…… I just think it is~~—~~ …….. I just think the health service, as it is

being run at the moment, I mean, I view it as an outsider and I can quite honestly say that things like this are -- this seems to be like the sticking plasters that the organisation puts in place to cope with problems without really coping with the problem itself. It's layers of bureaucracy, layers of investigation. And that doesn't solve the problems. It is only a way of —……

MR O'BRIEN: The contextual problem in all of this is, …do you ~~know~~….. whilst on leave, Richard, I spent four good days there in mid-December doing my appraisal documents because I had spent all of my SPA time either operating or reviewing cancer patients. …… *silence* …… And, you know, I do know that there are people who to the letter of the law will not do that and there are people who can -- I work with people who never regard the suffering of patients as their ~~(inaudible).~~personal responsibility…….. It is a Trust issue.~~-~~ That's a Trust problem.

—— Like, I have been pleading for this past two or three years that I shouldn't even see any more new patients and adding people to my waiting lists all the time. The immorality of not being able to undertake what you have pledged to do and then you spend every additional operating ~~session~~second that's vacated, when other people go on holiday, to operate on them. And as a consequence other things get neglected.

MRS O'BRIEN: Where is the fairness to a patient who— …… it's like a lottery. If they draw the straw that they are a new patient going to Mr O'Brien, they are immediately going to wait three years longer than someone else.

DR WRIGHT: That may well be one of the things (inaudible). I don't know. (Inaudible) it that may be well something that has to change as a result of this. (inaudible) investigation. …… It is a difficult issue. It has come ~~(inaudible)~~….. I'd prefer not to be having this conversation. The evidence is going to be presented to us. We have to investigate. That's what it is, an investigation. (Inaudible).

MR O'BRIEN: But there is— …… by definition ……. there is fault because you— …….. there's just not enough hours in the day to be faultless and ~~I~~I've tried it. I tried it without sleeping. I tried it without food. And that's the reality. You try to hopefully allocate the fault or the inadequacy to that area that's least likely to have consequences for patients. …… *silence*……..

—— I am devastated, Richard. …..... …*silence* …….. Absolutely devastated.

DR WRIGHT: It's probably a lot (inaudible) consolation but there would be at any one time quite a few of these investigations going on in the Trust, which to be fair (inaudible) majority of (inaudible) for yourself but it is not that unusual. (Inaudible). The process it's

one that (inaudible) so we have to follow (inaudible). But what I will undertake is to make sure that the timetable is ramped up as quickly as possible. (Inaudible). It may well be that it turns out that the work we are asking you to do is far too much. Your job plan is unrealistic.

MRS O'BRIEN: No, Aidan's job plan is realistic. It is just the job plan -- he can't stay to his job plan because things that are allocate to SPA, or whatever they are --

DR WRIGHT: Then may be the job plan is not realistic. It is on (inaudible) what is on written down on paper and what actually happens in practice.

MR O'BRIEN: My job plan --

DR WRIGHT: The job plan doesn't (inaudible).

MRS O'BRIEN: No, (inaudible), because when he got his first, when they come on to the new consultant contract, Aidan's first job plan was for 15.5. Then now it is down to 12. But when he was doing the 15, when it was ascertained, it was really 18 but that was unrealistic.

DR WRIGHT: But the real answer is to find other ways to get that work done. Get other people as opposed to (inaudible)

MR O'BRIEN: You can't. You can't.

MRS O'BRIEN: You would need ten consultants then. That's what it needs.

DR WRIGHT: Then that is what we do.

MRS O'BRIEN: I am telling you now, from myself and my children, what we have had to sacrifice as a family because of his job. It is unbelievable. This is the most hurtful thing that all those years of such work and hours should be reduced to this moment ~~(inaudible). It's just grossly unfair.~~

It's just grossly unfair. ……. *distressed* ……..

DR WRIGHT: It seems what we are saying this is an investigation. It is not -- we haven't got an outcome. I have no doubt the Trust is going to be criticised as a result (inaudible).

MRS O'BRIEN: I certainly hope that that is the conclusion. It is the Trust that will be criticised.

DR WRIGHT: (Inaudible) but this -- I suppose this report has been put in front of me (inaudible) and I have to investigate this.

MRS O'BRIEN: You know, as a lay person even, you know, I mean, you just see it all the time. The innocent person hung out to dry for other problems.

That's the way I see it ~~-~~…….. *distressed* ……..

And don't try and cover it over because that's what happens all the time. In the media you

hear big organisations, one person has to take the blame. It is ridiculous~~.~~…… *distressed …….*

MR O'BRIEN: I am concerned for the patients that need the most operating on. -……. silence ……I am concerned about so much really. The charts, I have some charts as well actually that I have for private patients that I need to review. But I can bring back, if it is necessary, the hospital charts pertaining to those people. I also have accompanying private charts.

DR WRIGHT: ~~(Inaudible)~~It is the hospital charts.

~~FEMALE SPEAKER 1~~Ms HAINEY: We can get you a copy of these documents. Do you (inaudible) certainly (inaudible) the detail outlines exactly what to expect as part of the investigation process, what your rights are under the process, the detail of what to expect on a full investigation. I can either give you them today or I can post them out to you.

MR O'BRIEN: (inaudible). Is that it?

~~FEMALE SPEAKER 1~~Ms HAINEY: Yes, do you want me to get a (inaudible) for you?

MR O'BRIEN: No.

~~FEMALE SPEAKER 1~~Ms HAINEY: That's about the department (inaudible) document and the associated (inaudible) he has to conduct an investigation.

MRS O'BRIEN: You could photocopy that one.

~~FEMALE SPEAKER 1~~Ms HAINEY: As Dr Wright says, we will write out to you informing you what our discussion has been today and the (inaudible) investigation and the decision to exclude for a period of time whilst the investigation is ongoing. I would draw to your attention a paragraph in that particular document. I can highlight it for, Mr O'Brien. It talks about exclusion (inaudible) period of exclusion. It's just a guide to (inaudible). You shouldn't undertake any work for other organisations, whether paid or voluntary, during the time for which you are being paid by the HPS employer. And I will just highlight that for just to ensure you keep yourself right in that respect.

MR O'BRIEN: Can I review my private patients during that time?

~~FEMALE SPEAKER 1~~Ms HAINEY: You would need to think about the guidance on that, Dr Wright (inaudible).

DR WRIGHT: The normal expectation would be that you wouldn't be undertaking private work but that's not something I can be (inaudible). At the end of the day, I think you need to read what's in there and it is a decision you can make yourself but if the private patients are linked or are trust patients it could cause some problems. So I would normally recommend that you don't. But clearly if there are within those bounds, people who are urgent ~~(inaudible).~~clinically.

MRS O'BRIEN: Well, Aidan just does reviews. He doesn't operate on them or anything.

DR WRIGHT: (Inaudible). It is clear if you don't but (inaudible). If you could avoid that for a period of time of time it would be better.

MRS O'BRIEN: It is just for four weeks anyway.

MR O'BRIEN: (Inaudible) that's not necessary if possible. I am thinking of one person who had a ~~MRI~~MR scan done last week and a re-evaluation of his prostate cancer so I haven't been seen the result yet so I was hoping to review him.

DR WRIGHT: Another way of doing it would be to ask a colleague to review him or a (inaudible). I think it is -- read the guidance and you need to make a call on that one. But what I would say is that obviously ~~(inaudible)~~patients at risk first and foremost but I would be discouraging it in general obviously.

MRS O'BRIEN: I don't think ~~new~~any patients are at risk.

MR O'BRIEN: I am so sorry, Richard~~.~~ ..... *silence* .....

DR WRIGHT: I appreciate (inaudible) for you as I say.

MR O'BRIEN: Does Michael know about this?

DR WRIGHT: I have not spoken personally to Michael yet but I would (inaudible). I am not sure if Colin ~~(inaudible)~~has said anything yet, so we haven't ~~(inaudible).~~ ..... we wanted to speak to you first.

~~FEMALE SPEAKER 1~~.....*silence* .....

Ms HAINEY: I do want to re-emphasise there are support mechanisms available within the Trust and you will get an urgent occupational health referral otherwise. There is support for you. (inaudible) Dr Wright in terms of any additional support that you feel you require during this time.

MRS O'BRIEN: Right.

DR WRIGHT: So I think (inaudible) the best outcome (inaudible) in a few weeks.

Hainey, Lynne

From: Hainey, Lynne
Sent: 03 January 2017 17:38
To: Hynds, Siobhan
Subject: Re: Management of PP's / non chronological listing

No Siobhan, not as yet because it was not agreed upon by the oversight committee and we agreed that any other concerns can be added as required

Sent from my BlackBerry 10 smartphone.

From: Hynds, Siobhan
Sent: Monday, 2 January 2017 17:07
To: Hainey, Lynne
Subject: RE: Management of PP's / non chronological listing

Lynne

Did you include this? Sorry for all the questions!

S

From: Hainey, Lynne
Sent: 28 December 2016 16:10
To: Hynds, Siobhan
Subject: FW: Management of PP's / non chronological listing
Importance: High

Hi Siobhan
This is the issue in relation to private patients – should we be advising Mr O'Brien on Friday that this is to be included in investigation

L

From: Gibson, Simon
Sent: 28 December 2016 15:34
To: Hainey, Lynne; Wright, Richard
Subject: FW: Management of PP's / non chronological listing
Importance: High

Dear both

In relation to previous e-mail.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust

Update 10 January 2017

Mr O' Brien returned all the notes that he had in his on Monday 2 January 2017 to his own office on 2nd floor main block CAH. These have all been casenote tracked by Martina Corrigan to her own tracking code with the comment in AMD office, Admin Floor. There were a total of 307 charts returned from his home this included 94 Southern Trust notes that Mr O'Brien had seen privately put had written his private notes in these charts. Martina then checked his office and has casenote tracked all the charts from here again to her own tracking code with comment in Mr O'Brien's office, CAH and the number on the Pigeon Hole, there were 88 notes in his office. Martina then ran another report from PAS and found that there are still 27 tracked as follows and attached to Mr O'Brien

CU2 – AOB (clinic code) = 8 dating back for quite a period of time
CAOBO – Mr O'Brien's office = 17
CAOBA – Audio Typist Mr O'Brien x 2 charts dating to 2014

Action: is to check with Health Records and Secretary that these have not been returned to them at a time and not updated on PAS – this should be completed by end of this week and Martina will advise.

Issue three

Ronan Carroll reported that there was a backlog of over 60 undictated clinics going back over 18 months. Approximately 600 patients may not have had their clinic outcomes dictated, so the Trust is unclear what the clinical management plan is for these patients. This also brings with it an issue of contemporaneous dictation, in relation to any clinics which have not been dictated.

Action

A written action plan to address this issue, with a clear timeline will be submitted to the Oversight Committee on 10th January 2017
Lead: Ronan Carroll/Colin Weir

Update 10 January 2017

Martina ran a report of all the undictated clinics from Business Objects and found that this related to 668 patients and dating back to November 2014. Martina spoke to Mr O'Brien and he advised her that he had an outcome on every patient from these clinics, albeit they were not dictated on nor where they all recorded on PAS. He has advised her that some of the patients have been seen again or have had their surgery since they had attended the clinic. Mr O'Brien met with Martina on Monday 9 January 2017 and hand-delivered the outcome sheets for which there are 272 handwritten outcomes for SWAH patients and 299 for other clinics, which leaves a shortfall of 97 patients.

Plan

1. is to check with the lists of undictated clinics and identify these 97 patients and then the consultants will do a casenote review to see if they can from these notes determine what the outcome should have been.

A. No.

44 Q. The Panel's note of the transcript is at AOB-56018 to AOB-56032. There doesn't appear to be a mention of numbers or an indication of that sort of figure. But just to give that context, do you recall? 10:29

A. What I recall is Mr. O'Brien gave me outcome sheets of all the patients that had -- obviously, there was the issue from his secretary advising that there were 60 plus clinics not dictated on. Mr. O'Brien gave me all the outcome sheets and it totalled up to 668. But, to 10:30 be fair, and an amendment to that would be that whenever he discussed it with me, albeit there was 60 plus clinics, some of them did have a dictation. But we still had to go through all 668 patients to double-check that they did definitely have a dictation 10:30 and an outcome.

45 Q. So, the majority of those had already had letters dictated?

A. I can't recall the figure. But whenever I went back to go into it, the 668 matched up with the 60 plus clinics 10:30 that we were told there was no dictation on. But then what Mr. O'Brien had said was, when he was discussing with me, he had outcome sheets and he said, no, we'd have a line through a patient's name to say "I have sorted that patient out because they've been brought 10:31 back for a procedure." But they still all had to be checked. So I suppose I'm splitting hairs here, but there were 668 patients that we had to check was there a dictation on. I can't recall how many of them

Letters waiting to be triaged from Mr O'Brien's office – 9 January 2017

Month of Letters	Amount	Comments
June 2015	70	All sorted except for one, this was without letters being triaged Note 3 patients deceased before having been sent for.
August 2015	20	The urgents in this have had appt but the routine have not had appointments yet but are due to be selected for end of January/February 2017
September 2015	32	
October 2015	77	
November 2015	66	
February 2015	65	
March 2016	59	
May 2016	111	
June 2016	75	
July 2016	31	
August 2016	45	
September 2016	70	
October 2016	62	
Total	**783**	

Update as of 10 January 2017

Mr O'Brien had advised Martina Corrigan that these letters were in a filing cabinet in his office. Martina collected these on Monday 9 January and there are actually 783 letters that had never been triaged. See attached table: the longest were June 2015 and Martina has checked and these have all been dealt with apart from one who is the partial booking cycle for a Jan/Feb appointment. Therefore the longest on the untriaged waiting list has been waiting since August 2015 but these may be appointed soon due to the fact that they are nearly at the top of the waiting lists.

Plan – firstly to carry out an admin exercise with the rest of the letters and ensure that these patients have not already attended and then the remaining letters will be triaged by the four consultants who have advised that they willing to do this. After some discussion it was agreed that in keeping with their normal triage pathway that these letters will need advanced triaged which will take quite a bit of time because of the volumes. Therefore this will need to be done over and above core time and we have been asked firstly can these letters as an exceptional case be done off site (consultant home) and also as the four have already committed to additional Waiting List initiative work for next three months this will put them over their hours and also be in breach of the terms of the WLI so they would like to know how best that this will be addressed.

If there are any patients that need seen as Urgent and are waiting longer than other patients then the Consultants are willing to do additional clinics to see these patients again outside of Core time and after the above about payment has been agreed. It is very difficult for the consultants to quantify the time that it will take to do this and the volumes that may need to be seen at an additional clinic but once agreed they will via Martina keep you updated.

Also to note when Martina met with Mr O'Brien on Monday 9 January to collect the outcomes he also gave her a copy of four patient letters that were sent direct to him and have not been recorded on PAS. One was a medical inpatient discharge asking for a follow-up appointment in Urology – discharged on 10 February 2015, one was consultant referral from Dr Adams (Obs/Gynae) dated 24/03/15 and 2 were GP letters from GP's one dated 15 May 2015 and the other 19 May 2015. These will be included in Triage but I will get one of the Team to look at these urgently as they are longer than the others and they have not been recorded and if they need an appt I will get these appointed to the next available clinic

Issue two

An issue has been identified that there are notes directly tracked to Dr O'Brien on PAS, and a proportion of these notes may be at his home address. There is a concern that some of the patients seen in SWAH by Dr O'Brien may have had their notes taken by Dr O'Brien back to his home. There is a concern that the clinical management plan for these patients is unclear, and may be delayed.

Action

Casenote tracking needs to be undertaken to quantify the volume of notes tracked to Dr O'Brien, and whether these are located in his office. This will be reported back on 10th January 2017

Lead: Ronan Carroll

Hainey, Lynne

From: Carroll, Ronan
Sent: 30 December 2016 12:44
To: Gibson, Simon; Corrigan, Martina
Cc: Gishkori, Esther; Hainey, Lynne; Wright, Richard; Boyce, Tracey; Weir, Colin
Subject: RE: Confidential - AOB

Importance: High

Simon,
Tks – we will now speak with Mr Young (clinical lead) re the plan & then informing the remaining consultants urologist Tuesday am with Mr Weir as CD
Ronan

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

From: Gibson, Simon
Sent: 30 December 2016 11:44
To: Corrigan, Martina
Cc: Carroll, Ronan; Gishkori, Esther; Hainey, Lynne; Wright, Richard; Boyce, Tracey
Subject: Confidential - AOB

Dear Martina

The meeting with Mr O'Brien has just concluded. There are a number of operational issues as a consequence:

1. Have discussed a script should anyone ask with Lynne Hainey and we have agreed the following: "Mr O'Brien remains absent from work and this will be kept under review. Staff will be updated when this situation changes"

2. Mr O'Brien is aware that an OH referral is now being made.

3. Mr O'Brien will be delivering charts to your office at 11am on Tuesday. Should you need space, you could use the AMD's office – I will make sure it is clear today.

Ronan – Mr O'Brien was informed that he was being "Immediately excluded" to allow the Trust time to scope the scale of the issues which have been identified in terms of:

- Notes at home
- Untriaged referrals
- Undictated clinics
- Conclusion of SAI
- Any other areas which are identified

As part of your plan, there will need to be a clinical note review of all charts/referral letters returned by Mr O'Brien to assess whether patients have a clinical management plan or require a clinical review with a Urologist. The follow-up meeting with Mr O'Brien will take place in four weeks, so potentially Friday 27th January to discuss the outcome of this scoping exercise, of which the outcome of the clinical note review will be a critical factor. Dr Wright is willing to approve any additional costs incurred for this review to be completed within this timescale.

Happy to discuss if you require any further clarity.

Hainey, Lynne

From: Gishkori, Esther [redacted]
Sent: 03 January 2017 15:17
To: Carroll, Ronan; Gibson, Simon; Corrigan, Martina
Cc: Hainey, Lynne; Wright, Richard; Boyce, Tracey; Weir, Colin
Subject: RE: Confidential - AOB

Ronan,
I'm sure Simon will be able to answer the queries below but I just wanted to comment on point 4. Mr O'Brien is at liberty to do what he wants off ST premises but he cannot use the services of the Trust in the carrying out of his own private work. Not unless
the secretarial staff do the work outside core hours and don't use any facilities of the Trust.
Thanks
Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office [redacted] **Mobile** [redacted]
[redacted]

From: Carroll, Ronan
Sent: 03 January 2017 14:49
To: Gibson, Simon; Corrigan, Martina
Cc: Gishkori, Esther; Hainey, Lynne; Wright, Richard; Boyce, Tracey; Weir, Colin
Subject: RE: Confidential - AOB
Importance: High

Richard/Simon/Esther
Colin & Martina & I met with the urology consultants this am, at which we shared with them all the events that had been taking place and the decisions that had been taken.
From this meeting we need to answer a few questions

1- What are the ToR for the investigation/review
2- How long would you expect the review to last?
3- What was Mr O Brien advised re the undictated outpatient clinics i.e. can he dictate or has he to cease having anything to do with the outstanding backlog
4- What is the Trust's position on Mr O Brien undertaking private work and in particular using Trust secretarial staff to type private patient work whilst off?
5- What is the Trust position in regard to notes being transported in staff's private car to and from SWAH? Clinics run twice mthly (2nd & 4th wks)

Mr O Brien contacted Martina and advised that the notes which were not on Trust's premises have been left in his office. Martina has checked and this is confirmed, these notes will be transferred to the med exe office asap to be tracked to Martina on PAS and then a refreshed report will be ran to see if there are any more outstanding.

The Team are going to think/discuss and come back to Colin & I on thurs with how they proposed to complete the actions required associated with review.

Ronan

Southern Health & Social Care Trust

Case Conference
26th January 2017

Present:
Vivienne Toal, Director of HROD, (Chair)
Dr Richard Wright, Medical Director
Anne McVey, Assistant Director of Acute Services (on behalf of Esther Gishkori)

Apologies
Esther Gishkori, Director of Acute Services

In attendance:
Dr Ahmed Khan, Case Manager
Simon Gibson, Assistant Director, Medical Director's Office
Colin Weir, Case Investigator
Siobhan Hynds, Head of Employee Relations

Dr A O'Brien

Context
Vivienne Toal outlined the purpose of the meeting, which was to consider the preliminary investigation into issues identified with Mr O'Brien and obtain agreement on next steps following his period of immediate exclusion, which concludes on 27th January.

Preliminary investigation
As Case Investigator, Colin Weir summarised the investigation to date, including updating the Case Manager and Oversight Committee on the meeting held with Mr O'Brien on 24th January, and comments made by Mr O'Brien in relation to issues raised.

Firstly, it was noted that 783 GP referrals had not been triaged by Mr O'Brien in line with the agreed / known process for such referrals. This backlog was currently being triaged by the Urology team, and was anticipated to be completed by the end of January. There would appear to be a number of patients who have had their referral upgraded. Mr Weir reported that at the meeting on 24th January, Mr O'Brien stated that as Urologist of the Week he didn't have the time to undertake triage as the workload was too heavy to undertake this duty in combination with other duties.

Secondly, it was noted that there were 668 patients who have no outcomes formally dictated from Mr O'Brien's outpatient clinics over a period of at least 18 months. A review

of this backlog is still on-going. Mr Weir reported that Mr O'Brien indicated that he often waited until the full outcome of the patient's whole outpatient journey to communicate to GPs. Mr Weir noted this was not a satisfactory explanation. Members of the Case Conference agreed, that this would not be in line with GMCs guidance on Good Medical Practice, which highlighted the need for timely communication and contemporaneous note keeping.

Thirdly, there were 307 sets of patients notes returned from Mr O'Briens home, and 13 sets of notes tracked out to Mr O'Brien were still missing. Mr Weir reported that the 13 sets of notes have been documented to Mr O'Brien for comment on the whereabouts of the notes. Mr Weir reported that Mr O'Brien was sure that he no longer had these notes; all patients had been discharged from his care, therefore he felt he had no reason to keep these notes. Mr Weir felt that there was a potential of failure to record when notes were being tracked back into health records, although it was noted that an extensive search of the health records library had failed to locate these 13 charts. Members of the Case Conference agreed further searches were required taking into consideration Mr O'Brien's comments.

Historical attempts to address issues of concern.
It was noted that Mr O'Brien had been written to on 23rd March 2016 in relation to these issues, but that no written response had been received. There had been a subsequent meeting with the AMD for Surgery and Head of Service for Urology to address this issue. Mr Weir noted that Mr O'Brien had advised that at this meeting, Mr O'Brien asked Mr Mackle what actions he wanted him to undertake. Mr O'Brien stated Mr Mackle made no comment and rolled his eyes, and no action was proposed.

It was noted that Mr O'Brien had successfully revalidated in May 2014, and that he had also completed satisfactory annual appraisals. Dr Khan reflected a concern that the appraisal process did not address concerns which were clearly known to the organisation. It was agreed that there may be merit in considering his last appraisal.

Discussion
In terms of advocacy, in his role as Clinical Director, Mr Weir reflected that he felt that Mr O'Brien was a good, precise and caring surgeon.

At the meeting on 24th January, Mr O'Brien expressed a strong desire to return to work. Mr O'Brien accepted that he had let a number of his administrative processes drift, but gave an assurance that this would not happen again if he returned to work. Mr O'Brien gave an assurance to the Investigating Team that he would be open to monitoring of his activities, he would not impede or hinder any investigation and he would willingly work within any framework established by the Trust.

Dr Khan asked whether there was any historical health issues in relation to Mr O'Brien, or any significant changes in his job role that made him unable to perform the full duties of Urologist of the Week. There was none identified, but it was felt that it would be useful to consider this.

Decision
As Case Manager, Dr Khan considered whether there was a case to answer following the preliminary investigation. It was felt that based upon the evidence presented, there was a case to answer, as there was significant deviation from GMC Good Medical Practice, the agreed processes within the Trust and the working practices of his peers.

This decision was agreed by the members of the Case Conference, and therefore a formal investigation would now commence, with formal Terms of Reference now required.
Action: Mr Weir

Formal investigation
There was a discussion in relation to whether formal exclusion was appropriate during the formal investigation, in the context of:

- Protecting patients
- Protecting the integrity of the investigation
- Protecting Mr O'Brien

Mr Weir reflected that there had been no concerns identified in relation to the clinical practice of Mr O'Brien.

The members discussed whether Mr O'Brien could be brought back with either restrictive duties or robust monitoring arrangements which could provide satisfactory safeguards. Mr Weir outlined that he was of the view that Mr O'Brien could come back and be closely monitored, with supporting mechanisms, doing the full range of duties. The members considered what would this monitoring would look like, to ensure the protection of the patient.

The case conference members noted the detail of what this monitoring would look like was not available for the meeting, but this would be needed. It was agreed that the operational team would provide this detail to the case investigator, case manager and members of the Oversight Committee.
Action: Esther Gishkori / Ronan Carroll

It was agreed that, should the monitoring processes identify any further concerns, then an Oversight Committee would be convened to consider formal exclusion.

It was noted that Mr O'Brien had identified workload pressures as one of the reasons he had not completed all administrative duties - there was consideration about whether there was a process for him highlighting unsustainable workload. It was agreed that an urgent review of Mr O'Brien's job plan was required.
Action: Mr Weir

It was agreed by the case conference members that any review would need to ensure that there was comparable workload activity within job plan sessions between Mr O'Brien and his peers.
Action: Esther Gishkori/Ronan Carroll

Following consideration of the discussions summarised above, as Case Manager Dr Khan decided that Mr O'Brien should be allowed to return to work.

This decision was agreed by the Medical Director, Director of HR and deputy for Director of Acute Services.

It was agreed that Dr Khan would inform Mr O'Brien of this decision by telephone, and follow this up with a meeting next week to discuss the conditions of his return to work, which would be:

- Strict compliance with Trust procedures and policies in relation to:
    - Triaging of referrals
    - Contemporaneous note keeping
    - Storage of medical records
    - Private practice
- Agreement to read and comply with GMCs "Good Medical Practice" (April 2013)
- Agreement to an urgent job plan review
- Agreement to comply with any monitoring mechanisms put in place to assess his administrative processes

Action: Dr Khan

It was noted that Mr O'Brien was still off Personal information redacted by the USI and that an Occupational Health appointment was scheduled for 9th February, following which an occupational health report would be provided. This may affect the timetable of Dr O'Brien's return to work.

It was agreed to update NCAS in relation to this case.
Action: Dr Wright

a. After a meeting to advise him of his exclusion on 30 December 2016, Mr O'Brien contacted me to advise me of his intention to return the patient notes that he had at home and that these would be left in his office on the 2nd floor of the main hospital over the weekend. I retrieved these notes and I can confirm that there were a total of 307 charts returned from his home; this included 94 Southern Trust notes that Mr O'Brien had seen privately but where he had written his private notes in these charts. I also checked his office and I can confirm that there were an additional set of 88 notes in his office.

b. On 9 January 2017, Mr O'Brien contacted and met with me (in the carpark at the hospital) to inform me that he had letters in the drawer of his filing cabinet and that I had permission to retrieve these. On 9 January 2017 I collected these letters and discovered that there were 783 letters not triaged with the longest going back to June 2015 (although it should be noted that this patient had been seen as they had been picked off chronologically even though they had not been triaged, so the longest waiting was in fact August 2015). I, as Head of Service, worked with the other consultants on getting these letters triaged and it was from this exercise that the 5 SAIs were identified as being patients who had come to harm as they had not been upgraded. Mr O'Brien also gave me four letters that had been sent direct to him and that had not been recorded on any system anywhere and I included them in with the other letters for triage.

c. At this meeting Mr O'Brien also provided me with copies of all the outcome sheets from the patients (571) that he had seen at clinic but had not dictated on and, on checking, there were a further 97 who had no outcome at all. I carried out an admin review on these patients to check whether they were on the right waiting lists, had they their tests ordered if appropriate, and then organised for the consultants to go through the notes and ensure that no patients needed to be seen face to face.

System to be checked to see if the patients were on a waiting list (outpatient and/or elective), if they had tests requested and, if they had, had the result been actioned and, if they hadn't had tests requested but required same, then these needed to be requested.

c. Once I had done the admin on all charts, I worked with Mr Glackin and Mr Young to go through all of the charts and identified patients who needed to have further actions. I updated in June 2017 that I had been through all of the patient charts and all the outcomes were being completed by Mrs Robinson's team in the Booking Centre;

(i) There were 110 patients who were added to a Review OP waiting lists.

(ii) There were 35 patients who were added to a routine theatre waiting lists.

(iii) There were 3 patients whom the consultants had concerns on and I had arranged urgent appointments for them. All three were seen and I can confirm that there were no further concerns.

(iv) The remaining patients did not require any further action.

Documents namely;
20161223 - Email about backlog report- Attachment 57
20161223 - Email about backlog report att1- Attachment 58
20170113 - a further 6 pts with no outcome- Attachment 59
20170113 - a further 6 pts with no outcome att1- Attachment 60
and can be located in folder - Martina Corrigan - no 40 of 2022 – attachments

Documents namely;
20170505 update on chart review
20170607-email SH re undictated clinics
20170607-email SH re undictated clinics attachment - OC 1
20170607-email SH re undictated clinics attachment - OC 2

A. That's correct.
190 Q. That was a process that was not completed. It started in January but not completed until June 2017. That was due to the number of patients involved. Was that something that was passed on to other consultants on top of their own workload to look at, or what way was that organised? 12:06
A. Dr. Wright agreed that they would get a waiting list initiative payment to do them outside of working hours. Obviously we couldn't displace clinical activity because Urology, as we know, their demand capacity is through the roof. But that was outside of hours, so evenings, weekends. 12:06
191 Q. Although that wasn't completed until June 2017, Mr. O'Brien came back to work in the February. 12:06
A. That's correct.
192 Q. In your witness statement, for the Panel's note at WIT-26315, you expressed a view that you don't think that Mr. O'Brien should have been allowed back to work so soon and you called that a mistake. Can you give a bit of context to why you have that view? 12:06
A. It's just back to what I had said previously. This is in hindsight, I didn't say this at the time, but it is a reflection when I was doing my Section 21, I think the investigation should have been a wee bit further. At that stage it hadn't even really started. I think there needed to be more of a -- you know, to extend it to talk to the likes of the people I'm saying there to say what other areas do we need to look at. It was 12:07

Toal, Vivienne

From: Toal, Vivienne [redacted]
Sent: 06 January 2017 18:20
To: Gibson, Simon
Subject: Fw: letter to aob
Attachments: letter to aob 30 Dec.docx

Simon,
Richard signed letter to Mr O'Brien and it has gone in post tray this pm.
Just a wee reminder to speak to Tracey re involving AOB in SAI now that he is back from [redacted] leave.
Thanks
Vivienne

Sent from my BlackBerry 10 smartphone.

From: Toal, Vivienne [redacted] >
Sent: Friday, 6 January 2017 16:27
To: 'heather.mallagh-cassells[redacted]
Subject: letter to aob

Heather

Can you please print for Richard to sign?

He will come up to me shortly.
Thanks
Vivienne

Southern Health and Social Care Trust

6th January 2016

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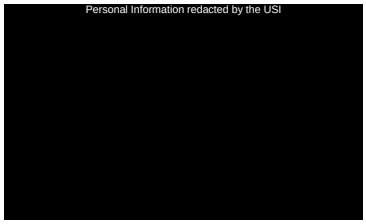
Mr Aidan O'Brien



Dear Mr O'Brien

Formal notification of immediate exclusion and investigation under Maintaining High Professional Standards Framework (MHPS)

Thank you for meeting with Ms Lynne Hainey, Acting HR Manager and myself on 30th December 2016, at which you were accompanied by your wife.

The reason for meeting was to inform you of concerns that have been brought to my attention as part of a Serious Adverse Incident (SAI) Investigation. As discussed, these concerns relate to your administrative practices, and the possibility that patients may have come to harm as a result of those administrative practices. You will recall that we had previously attempted to address some of the issues regarding these administrative practices informally, however this has been unsuccessful (the enclosed letter of 23rd March refers).

As discussed, the initial concerns raised are as follows:-

1. The lengthy period of time taken to undertake the triage of GP referrals (with currently 318 un-triaged cases).

   The ongoing SAI investigation is in relation to a Urology patient who may have a poor clinical outcome due to the lengthy period of time taken by you to undertake triage of GP referrals. Part of this SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason.

   You indicated that you have had no involvement in the SAI process and therefore I undertook to raise this with the SAI Team. I am advised that the

SAI commenced in October 2016, and therefore has coincided with your period of sick leave. The SAI is ongoing, and you will be contacted as part of this process.

2. That there is a backlog of over 60 undictated clinics going back over 18 months and therefore there are approximately 600 patients who may not have had their clinic outcomes dictated, so the Trust is unclear what the clinical management plan is for these patients.

3. That some of the patients seen by you may have had their notes taken back to your home, and are not available within the hospital. There is a concern that the clinical management plan for these patients is unclear, and may be delayed.

Given the serious nature of the concerns, we met with you to discuss the matter and the process for managing the complaint.

It was confirmed that the concerns identified will be managed in line with the '*Maintaining High Professional Standards in the Modern HPSS*' Framework (MHPS) and the associated *'Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance' (*copies of both documents were provided to you for your information).

In line with the Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance, an Oversight Committee within the Trust has been appointed. It has been agreed that given the serious nature of the concerns a formal investigation will be undertaken.

As discussed, Dr Ahmed Khan, AMD (Paediatrics) has been appointed as the Case Manager for this investigation. Mr Colin Weir, Clinical Director is the Case Investigator and will be assisted by a representative from the Trust's HR Department (HR Representative to be confirmed).

It was explained to you at our meeting that, in accordance with MHPS, a decision has been made to immediately exclude you from the workplace effective from 30th December 2016, with full pay. This is a pre-cautionary measure and is to protect you from any further concerns being raised, to protect the interests of patients, and to assist the investigative process. Please note that NCAS had been informed of this, in advance of the meeting.

This exclusion will be up to but no more than 4 weeks and will allow for further preliminary information to be collated to decide the scope of the investigation, and therefore the Terms of Reference for investigation. The Case Manager will make

contact with you as soon as possible in relation to the progression of the formal investigation process, and to provide you with a copy of the Terms of Reference for same. In the meantime, contact will be made with you to arrange a meeting during the 4 week period of immediate exclusion to allow you to state your case, and propose alternatives to exclusion. You are entitled to be accompanied to all meetings during the course of the investigation as per Section 1 Paragraph 30 of the MHPS Framework.

This 4 week exclusion period should allow sufficient time to determine a clear course of action, including the need for formal exclusion. Any decisions made will, of course, be communicated to you. I would refer you to the MHPS Framework document, Section 1, Paragraphs 18 – 27 and Section II, Page 13 – 20 regarding exclusion.

It was made clear to you that you are required to return any case notes / dictation that you have in your possession. You were requested to return these to Martina Corrigan, Head of Service for Urology by 11.00 am on 3rd January 2017, and I understand that you have now done this. Now that these charts have been returned, they will be recorded and their location tracked on PAS either back to filing, your office or your secretary's office, in line with Trust procedures. A review will be undertaken by the Trust of any actions required for each patient.

I recognise that this will be a stressful time for you and I would therefore reiterate that the services of the Trust's Occupational Health Department or the staff counselling service, Care-call are available to you. An appointment was arranged for you to attend the Trust's Occupational Health Department on Thursday 5th January 2017, and your manager now awaits the report from Occupational Health. Please note that Care-Call services are also available and they can be contacted on 0808 800 0002.

In the meantime, should you have any queries in relation to the content of this letter, please do not hesitate to contact me.

Yours sincerely

_____

Dr Richard Wright
Medical Director

Buckley, LauraC

From: Gibson, Simon [redacted]
Sent: 17 January 2017 11:49
To: Carroll, Ronan; Hynds, Siobhan; Khan, Ahmed
Cc: Weir, Colin
Subject: RE: A O'B

Dear Siobhan

In terms of keeping the process clear and correct, can I ask that you respond to these queries as the HR advisor on this investigation.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
[redacted]

From: Carroll, Ronan
Sent: 17 January 2017 11:40
To: Gibson, Simon; Hynds, Siobhan; Khan, Ahmed
Cc: Weir, Colin
Subject: FW: A O'B
Importance: High

Siobhan/Simon
Maybe you could help Colin with queries below.
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]

From: Weir, Colin
Sent: 17 January 2017 09:42
To: Hynds, Siobhan; Khan, Ahmed; Carroll, Ronan
Subject: A O'B
Importance: High

Dear all

In the interests of openness I need to tell you that Mr O'Brien phoned me last night. We had a conversation that he was happy for me to relay to you and that the conversation was only about process.

He expressed surprise at the timescale. I too understood from MHPS that the exclusion was only to be 4 weeks except in exceptional circumstance. The doctor could return to work while investigations continue. I have never done this before and seek your advice

He also has not been told who the non-executive director is, to whom he can make contact about the process. His exclusion has a clear end date.

He was told by me that I would write this email in the interests of progressing the process under MHPS and the Trust's implementation of this.

I think it is causing unnecessary stress by prolonging the timescale and a lack of communication on this.

Can you help please. I have made it clear as investigator I await my instructions to investigate and report back in a timely fashion

Colin

Colin Weir FRCSEd, FRCSEng, FFSTEd
Consultant Surgeon | Honorary Lecturer in Surgery | AMD Education and Training |Clinical Director SEC
Southern Health and Social Care Trust

Changed my number Personal Information redacted by the USI

Secretary Jennifer Personal Information redacted by the USI

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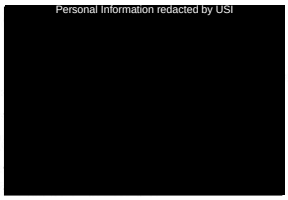

17 January 2017.

Dr. Richard Wright,
Medical Director,
Southern Health & Social Care Trust,
Southern Trust Headquarters,
Craigavon Area Hospital,
68 Lurgan Road,
Portadown,
BT63 5QQ.

Dear Dr. Wright,

I write to you in relation to my immediate exclusion and the formal investigation of which I was advised when I met with you and Ms. Hainey on Friday 30 December 2016, when I was accompanied by my wife, and of which you formally notified me in your letter of 6th January 2016 (sic) and which I received on 11 January 2017.

Your letter formally notified me of my immediate exclusion, pursuant to Maintaining High Professional Standards in the Modern HPSS (MHPS) and the associated Southern Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance (Trust Guidelines), and which was effective from 30th December 2016 when we met with you and Ms. Hainey.

I write to you at this time as I have become increasingly concerned regarding the procedural conduct of the investigation to date.

When we met with you and Ms. Hainey, you advised that a non-executive member of the Southern Health & Social Care Trust Board (the Board) would be appointed and that I would be advised of the identity of this person. I note that the appointment of a non-executive member of the Board is a requirement of MHPS (Section 1: Paragraphs 8 and 28) and of the Trust Guidelines (Paragraph 2.10 and Appendix 2). Both MHPS and the Trust Guidelines stipulate that the role of the non-executive member is to oversee the case to ensure that momentum is maintained, to ensure that the investigation is completed in a fair and transparent way, and to consider any representations from the practitioner about his or her exclusion, or any representations about the investigation.

To date, I have received no written notification of the name of the non-executive member of the Board, or of his or her contact details. Your letter of formal notification did not include any reference to the appointment of a non-executive member. It is for this reason that I am left with the only option of writing to you directly to address my concerns. In this regard, I should be grateful if you would advise me, as a matter of urgency, of the identity of the non-executive member, the date of appointment or designation, and the member's contact details.

Secondly, I have yet to receive the minutes of the meeting of the 30th December 2016. Pursuant to Section 1: Paragraph 24 of MPHS and pursuant to Appendices 2 and 5 of the Trust Guidelines, I should be grateful if you would provide me with a copy of all minutes, records and documentation relating to the meeting of Friday 30 December 2016.

Thirdly, I have become increasingly concerned with regard to the slow pace of proceedings. Despite the distress of our meeting with you and Ms. Hainey, I did take some comfort from your reassurance that you hoped that all would be completed within two or three weeks. I note from Appendix 2 of the Trust Guidelines that the investigation **must** be completed within four weeks.

In particular, I have been concerned not to have received any communication from the Case Investigator, or notification of a meeting with the Case Investigator, to provide me with the opportunity to state my case and to propose alternatives to exclusion, pursuant to Section 1: Paragraph 23 of MHPS and Appendix 5 of the Trust Guidelines, within the four weeks allowed.

For this reason, I took the initiative of contacting Mr. Weir, the Case Investigator, by telephone last evening to enquire of the date of a meeting, and with the expectation that the meeting would be scheduled for later this week. I was reassured that Mr. Weir was cognisant of the significance of my having a meeting with him within the four week period, but alarmed to learn that a meeting has been scheduled for him to meet the HR representative on Thursday 26 January 2017, and that no meeting with me has been scheduled to take place until after that meeting. I therefore should be grateful if you can provide me with details of when I can be provided with the opportunity to meet with the Case Investigator and with the HR representative.

You will be aware that it is the clear guidance from both the MPHS (Section 2: Paragraph 4 – 6) and the Trust Guidelines (Appendix 5) that exclusion is only to be used in the most exceptional circumstances. In advance of the meeting to discuss alternatives to exclusion, I believe that I should be informed in more detail of the reasons and justifications for exclusion, so that I may be able to adequately respond to them, and to consider proposals for alternatives. I note that this is a requirement of Section 1: Paragraph 22 of MHPS.

Whilst I will strenuously and robustly address the concerns enumerated in your letter of formal notification, when provided with the opportunity to do so, I must make clear at this stage that I do not accept, as stated in your letter, that the Trust attempted to address the issues regarding administrative practices, informally or at all. I was invited to meet with Mr. Eamon Mackle and with Mrs. Martina Corrigan on, or after, 23 March 2016 when I was advised of the Trust's concerns, and provided with the letter dated 23 March 2016. There was no enquiry made as to the causes of the concerns. There was no offer of a discussion of how the concerns could be resolved, or of any assistance in doing so. When I asked what I should do to address and resolve the concerns, my request was met with silence and a shrug of the shoulders. There was no follow up to the meeting, or to the letter of 23rd March 2016.

I am anxious to return to work. I am particularly concerned for the welfare of those patients awaiting excessively long periods for admission for surgery, and whose outcomes are being further jeopardised by further delay, and for those patients whose review has been further delayed during this period of exclusion.

You will appreciate that this whole process has been profoundly traumatic, stressful and distressing for me and for my family. The fact that the only communication that I have received from the Trust to date has been your letter of formal notification, has only further exacerbated that stress. It is also inevitable that this is causing me reputational and financial loss and damage, particularly as you advised me to desist from private practice whilst the investigation is conducted. Moreover, the welfare of patients is causing me further concern. Accordingly, I trust that you will address the issues raised in this letter as a matter of urgency.

Yours sincerely,

Personal information redacted by the USI

Aidan O'Brien.

Note of Meeting with Mr Aidan O'Brien, Consultant Urologist – Tuesday 24 January 2017

Present:
Mr O'Brien (accompanied by his son, Personal Information redacted by the USI
Dr Colin Weir, Case Investigator
Mrs Siobhan Hynds, Head of Employee Relations

Introductions were made and Mr O'Brien was thanked for attending the meeting. Mr Weir explained his role as case investigator and that he would be assisted in the investigation by Mrs Hynds.

It was explained that the purpose of the meeting today was to discuss the next steps in the MHPS process following a decision to place Mr O'Brien on a period of immediate exclusion on 30 December 2016. Mr Weir outlined that we had asked to meet with Mr O'Brien to provide him with an opportunity to discuss the next steps in the process, to state his case at this point of the process should he wish to and to provide an opportunity to hear from Mr O'Brien his proposals for alternatives to formal exclusion.

Mr Weir outlined that following the meeting today (24 January) a case conference would be convened on 26 January 2017 with the case manager, Dr Khan and other appropriate members to determine the next steps.

It was noted that at the meeting on 30 December 2016, Mr O'Brien was advised of a decision by the Trust to place him on immediate exclusion and was advised of concerns which had been raised with the Trust's Medical Director, Dr Richard Wright, following a Serious Adverse Incident (SAI) Investigation. The concern related to Mr O'Brien's administrative practices which had the potential to have caused harm to patient/s and / or which had actually caused harm.

It was noted that Mr O'Brien was notified at the meeting on 30 December that an initial scoping of Mr O'Brien's administrative practices identified:

- that, from June 2015, 318 GP referrals had not been triaged in line with the agreed / known process for such referrals. Further tracking and review was required to ascertain the status of all referrals.
- that there was a backlog of 60+ undictated clinics dating back over 18 months amounting to approximately 600 patients, who may not have had their clinic outcomes dictated. It was unclear what the clinical management plan is for these patients.

- that some of the patients seen by Mr O'Brien may have had their notes taken back to his home, and are not available within the hospital. The clinical management plan for these patients is unclear, and may be delayed.

Mr Weir advised Mr O'Brien that the initial 4 week period following immediate exclusion of Mr O'Brien, allowed for scoping to continue within the Acute Services Directorate to determine the scale of the concerns regarding Mr O'Brien's administrative practices, to inform the scope of the investigation under MHPS Framework and the Terms of Reference for the investigation. Mr O'Brien was updated in respect of the initial 3 concerns notified to him on 30 December and was notified of a fourth issue of concern identified during the preliminary investigation.

The update position as at 24 January is:

- that, from June 2015, 783 GP referrals had not been triaged in line with the agreed / known process for such referrals. All referrals require to be tracked and reviewed to ascertain the status of these patients in relation to the condition for which they were referred. This work is being undertaken by 4 Trust Consultants and the review is not yet complete.
- that 668 patients have no outcomes formally dictated from Mr O'Briens outpatient clinics over a period of at least 18 months. Again this review is still on-going.
- That, 307 sets of patient notes were returned by Mr O'Brien from his home, 88 sets of notes located within Mr O'Brien's office, 13 sets of notes, tracked to Mr O'Brien, are still missing. Work is continuing to validate this list of missing notes.

The fourth issue of concern identified during the initial scoping exercise relates to Mr O'Brien's private patients. A review of Mr O'Brien's TURP patients identified 9 patients who had been seen privately as outpatients, then had their procedure within the NHS. The waiting times for these patients are significantly less than for other patients. Further investigations are on-going.

Mr O'Brien referred to the issue of the triage referrals and advised that since the issue was brought to him in March 2016, he was undertaking his own validation of referrals to him. He advised that prior to this the workload volume made it impossible to do so.

Mr O'Brien discussed the issue of the 13 sets of notes which are tracked to him but are missing. He advised that he wished it noted that he had not returned 307 sets of notes from his home. That some of the notes were in his office and which he left with the notes returned from home. Mr O'Brien further noted that he has a very good memory of his patients and was shocked by a number of patients on the list as he was very sure the notes

had been returned. This included [redacted] He stated he recalls [redacted] as her chart was not available to him and he stated he had returned [redacted] notes on Tuesday 3 January. He commented that he had never lost a set of notes in his career, that he has complied with every request to return charts and on occasion has delivered charts back to Wards himself when requested to do so.

Mr [redacted] queried the decision to place Mr O'Brien on immediate exclusion in December 2016 when Mr O'Brien's practice was known to the Trust for a long period of time. [redacted] queried why the matter escalated to immediate exclusion. He stated that the letter in March 2016 didn't constitute an informal or formal process and when Mr Mackle had spoken to him about the concerns, Mr O'Brien asked what he was supposed to do and Mr O'Brien reported that Mr Mackle didn't respond but rolled his eyes.

Mr O'Brien also reported that he had spoken about his concerns about his workload with a number of Clinical Director's over the years with no change. He reported there is an inequity in lists and workloads which hasn't been addressed.

In respect of the issues of concern, Mr O'Brien stated that he was surprised by the number of undictated clinics in SWAH i.e. 272. Mr O'Brien stated he thought this number was about 110. He commented that he didn't know what the other 289 clinics related to. Mr O'Brien stated that in terms of percentage of clinics dictated it was approximately 62%.

In respect of the fourth concern regarding private patients, Mr O'Brien stated that he was concerned about the inference here and stated that he was concerned about reputational damage.

Mr O'Brien advised that he will make a written submission as part of the investigation in due course. [redacted] raised concern about the likely timescale of the investigation. It was confirmed to Mr O'Brien that given the scale of the scoping exercise which is not yet complete, the investigation process would not conclude within a 4 week timeframe. It was noted that it was important the investigation is done properly. Assurances were provided that the investigation process will be as expeditious as possible.

In stating his case, Mr O'Brien noted that he will provide a comprehensive written account in due course. He noted that significant workload pressures and additional operating sessions completed by him over the requirement within his job plan had impacted. Mr O'Brien noted that he had worked a high number of hours each week over and above his job plan, had undertaken Chair of the MDM meetings, had spent a significant number of hours reviewing cases in preparation for these meetings, sometimes into the early hours of the

morning and had used his SPA time to undertake operations or reviews of patients in an attempt to keep on top of his workload.

Proposals for alternatives to exclusion

Mr O'Brien was provided with an opportunity at the meeting on 24 January 2017 to propose alternatives to his exclusion for consideration by the Case Manager.

- Mr O'Brien outlined that at present his main priority was to return to work. He stated that if the investigation is going to take longer than 4 weeks to complete he is concerned at the potential for reputational damage.
- Mr O'Brien reported that the immediate exclusion and the investigation was a very stressful situation for him which has resulted in 10lbs weight loss. He stated that both mentally and physically it is important to him to be able to get back to work.
- Mr O'Brien outlined that there are various aspects of his work that have never been in question and he is of the view that he could continue to operate, he could undertake urologist of the week, undertake on call duties and triage referrals.
- Mr O'Brien noted he was accepting of and entirely happy to return to work within a defined framework to circumvent the concerns under investigation. He further outlined that he has no desire to impede or interfere with the investigation. He outlined that in due course he will provide a 'good contextual reason as to why this has happened'.
- Mr O'Brien would be accepting of working within normal time constraints for both operating lists and clinics. He agreed that any clinics would have outcomes recorded and dictation done by the end of that clinic. He was entirely open to regular review and monitoring of this.
- Mr O'Brien stated, if he had been advised in March that the concerns could lead to this i.e. immediate exclusion and formal investigation, he would have taken time out to clear the backlog and wouldn't be in this situation.
- Mr O'Brien reported that he had undertaken work not included in his job plan and for which he was not remunerated. He stated that the period of immediate exclusion was psychologically, mentally and physically draining and went on to advise that he 'feared' for himself if he was not able to return to work.
- He concluded by stating he was happy to work with a defined framework set by the Trust, to comply with hospital policies/procedures, to work to pre-determined defined timescales and he gave an assurance that no patient files would be removed from the Trust. He reiterated he had no desire to impede or interfere in the investigation in anyway. Mr O'Brien stated that the concerns centred around his

administrative practices and he believes the concerns can be managed with a framework in place.

- Mr O'Brien further stated that when the issues were raised with him in March 2016, there was no plan as to how he was to address the matters. He stated he began to deal with some of the outstanding cases whenever he had time to do so during his working week.

Mr O'Brien noted that he has learned the consequences of over work and he noted that if he is able to return to work he will not be doing the hours he was previously doing and he will work to his job plan. Mr O'Brien noted that he has previously raised the issue of new patients and feels at his age he shouldn't be seeing any more new patients.

Mr O'Brien was asked about his appraisal and he advised his last appraisal was signed off by Michael Young. He advised he had raised the issue regarding inequity of waiting lists in his appraisal.

Mr O'Brien commented that he was not diminishing the gravity of the issues from the point of view of the Trust but he belives he can return to work to elements where there are no issues of concern. He commented he was happy to work to any other safeguards the Trust deem appropriate. He stated the last 6 months have been difficult for him health wise and he should perhaps have had his procedure done at an earlier point.

The meeting concluded and Mr O'Brien and Personal Information redacted by the USI were thanked for attending the meeting. Mr O'Brien was advised that the decision of the case conference on Thursday 26 January 2017 would be notified to him as quickly as possible after the meeting.

Update as of 24 January 2017

From 783 letters collected from Mr O'Brien's office there were 90 patients (June 2015 – 70 letters and August 2015 – 20 letters) who already had appointments. This was due to them being added to the waiting list as per the GP grading and these have been selected chronologically without being triaged by a consultant and seen at clinics. It should be noted that it has agreed by the Urology Consultants that these 90 patient's should have their outcomes followed up to ensure that there were none that had come to any harm due to delay in triage.

As of Friday 20 January the Consultants had returned 330 of the letters triaged – the longest dating back to September 2015. From this:

9 patients have been upgraded to Red Flag and all these patients have been given appointments (1 x last week and the rest this week) and we need to await the outcomes from their appointments and tests.
28 patients have been upgraded from Routine to Urgent – these are currently being added to clinics as per consultants as extras.
7 patients whilst having been seen, met the Red Flag Criteria but because they were not triaged they remained on an urgent list and have now been seen but it has been requested that all of these patients have their outcomes checked.
3 Patients need urgent follow-up as the letters received were in respect to outcome of results or needing a review but currently in the review back-log, these are being added as extra to clinics.
1 patient had urgent letter received and should have been upgraded to RF which was done 5 months later by another consultant on the receipt of a second GP referral letter. Patient then followed Red Flag pathway and has now been diagnosed as palliative. Team have discussed and this now needs to be screened for SEA/SAI.

The Consultants have the remainder of these letters for triage (363) and plan to have this completed by end of January 2017. But all of the patients identified above need outcomes etc followed up and this will be updated when complete.

Issue two

An issue has been identified that there are notes directly tracked to Dr O'Brien on PAS, and a proportion of these notes may be at his home address. There is a concern that some of the patients seen in SWAH by Dr O'Brien may have had their notes taken by Dr O'Brien back to his home. There is a concern that the clinical management plan for these patients is unclear, and may be delayed.

Action

Casenote tracking needs to be undertaken to quantify the volume of notes tracked to Dr O'Brien, and whether these are located in his office. This will be reported back on 10th January 2017
Lead: Ronan Carroll

Update 24 January 2017

After thorough checking there still remains 13 sets of notes tracked to Mr O'Brien that we have not been able to locate.

Issue three

Ronan Carroll reported that there was a backlog of over 60 undictated clinics going back over 18 months. Approximately 600 patients may not have had their clinic outcomes dictated, so the Trust is unclear what the clinical management plan is for these patients. This also brings with it an issue of contemporaneous dictation, in relation to any clinics which have not been dictated.

Action

A written action plan to address this issue, with a clear timeline will be submitted to the Oversight Committee on 10th January 2017

Lead: Ronan Carroll/Colin Weir

Update 24 January 2017

Due to concentrating on the untriaged letters the Team have not had an opportunity to look at these clinics in detail. However, one of the consultants had a look at one clinic and compared against outcome sheets provided. Two of the patients had nothing written in notes but outcome advised of follow-up appointments. 4 oncology patients were overdue an oncology review appointment (being arranged now) and there were 4 patients who should have been added for diagnostic/procedures that hadn't had this actioned. As there are another 65 clinics that still need to be gone through this will take some time.

Another concern in respect to this which has been raised by the team was out of these undictated clinics there is no way of knowing how many patients have had tests/diagnostics requested and if these patients have had tests carried out and if the results have been seen/followed up on. This is an unknown quantity. The other consultants use the DARO (discharge awaiting results function on PAS) to keep track of their results and then get this list and chase up on outstanding ones, we have no way of tracking Mr O'Brien's as these clinics have not been dictated on and therefore we do not know what has been requested/seen/followed up on until all of these charts are gone through.

Private Patients

Update 24 January 2017

On request we have been provided with Mr O'Brien's admissions (electively and emergency) for 1 January 2016 until 31 December 2016. There are 853 patients on this list and due to time limitation we have not had the opportunity to go through this in any detail. However there is a concerning factor in that there are a number of patients who have been listed as being on Suspect Cancer pathway but have been waiting quite a bit of time outside of the 31 and 62 day pathway. For example, 762, 417, 329, 292, 138 days and all of these patients will need notes pulled to assess were they on the suspect cancer pathway and what their outcomes were.

We did do a snapshot on patients who had a TURP procedure, as there was one patient previously highlighted that they had been seen privately by Mr O'Brien and were brought in for their TURP operation quite quickly and as TURP patients are currently waiting up to 150 weeks (1050 days), we were asked to look into this. Please see table below which are patients having been identified as having seen Mr O'Brien privately. This is only a snapshot and as stated more work needs to be done on, e.g. look at these patients outcomes etc. as required.

Casenote	Date on Waiting List	Date Operation	Days Between Added to WL and Operation Date
CAH01427	07/09/2015	06/07/2016	**303**
CAHB07288	13/10/2015	16/03/2016	**155**
CAHB46605	25/04/2016	04/05/2016	**9**
CAHB46605	05/05/2016	15/06/2016	**41**
CAHB56444	30/10/2015	17/08/2016	**292**
CAHE239682	18/01/2016	27/01/2016	**9**
CAHE295314	27/05/2016	29/06/2016	**33**
CAHE295314	29/06/2016	27/07/2016	**28**

It was agreed to consider any previous IR1's and complaints to identify whether there were any historical concerns raised.

Action: Tracey Boyce

Consideration of the Oversight Committee

In light of the above, combined with the issues previously identified to the Oversight Committee in September, it was agreed by the Oversight Committee that Dr O'Briens administrative practices have led to the strong possibility that patients may have come to harm. Should Dr O'Brien return to work, the potential that his continuing administrative practices could continue to harm patients would still exist. Therefore, it was agreed to exclude Dr O'Brien for the duration of a formal investigation under the MHPS guidelines using an NCAS approach.

It was agreed for Dr Wright to make contact with NCAS to seek confirmation of this approach and aim to meet Dr O'Brien on Friday 30th December to inform him of this decision, and follow this decision up in writing.

Action: Dr Wright/Simon Gibson

The following was agreed:

Case Investigator – Colin Weir

Case Manager – Ahmed Khan

you sufficient detail to enable you to determine, firstly, if there's a case to answer, and also to enable you to decide on the next appropriate steps, including whether formal exclusion is required or whether there are alternatives to exclusion pending conclusion of the investigation. 12:18

"It is also a requirement to consult with NCAS where a formal exclusion is being considered", and you are provided with a phone number for Dr. Lynn. 12:18

Have you any recollection of when this meeting took place?

A. So, this email is important because I was doing clinic in Daisy Hill; I was with a complex patient. This email arrived in my inbox, which I didn't get to see until I finished the clinic at 1.30. I had to be in Craigavon, driving, and the meeting was at two o'clock. So I did indicate that I'm not going to be able to see the investigation report before the meeting and I will discuss it at the time. 12:18 12:19

That's what was happening in my life at that moment in time. I was seeing a patient, I had no time outside of clinic activity to see the report which is going to happen in a couple of hours' time, and then I had to reach that meeting. So the first time I saw that preliminary report was in that case conference. 12:19

64 Q. The Panel is familiar with the report and I suspect

we don't need to open it.

Plainly, as this email suggests and as the process we looked at earlier this morning suggests, plainly this meeting is focused on a number of potentially pivotal decisions: (A) is there a case to answer and, if there is a case to answer, then a range of possibilities including a formal MHPS investigation. And, secondly, again I think you'll agree with me, a pivotal decision in relation to whether exclusion is necessary. You agree with that, do you? 12:20 12:20

A. I do. I do.

65 Q. I suspect you would also agree, from what you've just said earlier, that receiving this report when you're in clinic an hour and a half or so, or two and a half hours prior to the start of the meeting, was far from ideal? 12:20

A. Yes.

66 Q. The suggestion that you might contact NCAS, was that something you thought you should do prior to the meeting? 12:21

A. I don't think so. I saw that email actually in practical terms until I reached to the venue of the meeting. My focus obviously was, first of all, to attend that important meeting which was happening. The two key elements of those meetings, I see that meeting was an important point in time, which was to decide two important elements. First of all, is a formal investigation under the MHPS Framework going to happen. 12:21

investigatoe 26 jan 17 - final located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD] He referred, *inter alia*, to workload pressures, additional operating sessions, inequitable workload compared to his colleagues, and high numbers of hours worked.

30. The documented typed notes written by Siobhan Hynds from the meeting *[20170126 - E Preliminary report from case investigatoe 26 jan 17 - final located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]* recorded that Mr. O'Brien stated the exclusion was stressful, was keen to return to work, and would be accepting of working with acceptable time frames for clinics, operating lists, and dictation to be complete at the end of every clinic. He was open to our suggestion of regular monitoring of the above. He stated that being excluded from work was stressful.

31. On 26.1.2017 I was present at an Oversight Committee meeting in relation to Mr. O'Brien which was Chaired by Dr Wright, Medical Director, with HR representatives, Assistant Director, Simon Gibson, Dr Khan, Case Manager, Siobhan Hynds, HR representative and me as Case investigator *[20170126 - E Preliminary report from case investigatoe 26 jan 17 - final located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD].*

32. During this meeting we noted the position (as per para 26 above). There was discussion in which I advocated for Mr. O'Brien in my role as clinical director. From personal knowledge of working with Mr. O'Brien, seeing him operate and operate with him in the elective and emergency situation and having his assistance for me at short notice, I felt as a surgeon he was “good, precise and caring”. I knew from referrals to me from Mr. O'Brien that he had deep knowledge of his patients and his letters were very detailed. The committee asked my view on Mr. O'Brien’s return to work. Based on the above, I proposed and advocated for a return to work with either restricted duties or robust monitoring of Mr. O'Brien’s practice. The committee decided that the operational team would undertake this process. The committee agreed with the

time that we need to act on that role. But I can see from Mr. Weir's point of view that he was giving his view or his opinion in that way. On reflection, perhaps maybe it would have been, you know, better if the advocacy role wasn't introduced at that point in time. I can only say on hindsight and on reflection, I must say I did not question, or I did not challenge at that point in time. Neither anyone else. 12:33

72 Q. Thank you. If we scroll down just to see the decision that you make on the next page. You have said that you're a person who likes to take advice, you took advice at this meeting, but the decision that there was a case to answer was yours. Now, you've also said in your witness statement that -- I'll just read it out to you. If you need to bring it up, we can. You say: 12:33 12:34

"As this was my first experience of being involved in an MHPS investigation, it wasn't very clear to me at the beginning what my role as Case Manager would involve. The Oversight Committee was comprised of the Medical Director, Director of HR, and Director of Acute Services. This committee was already involved and made some decisions for this case, so this blurred roles and responsibilities for me". 12:34

In terms of your autonomy and authority at this meeting to take a decision that there was a case to answer and a formal investigation should ensue, was that in your mind a decision that had already been taken by

Oversight in December, so that you were influenced by that? Or was this an entirely independent and different stage of the process where you were simply informed by what Mr. Weir was reporting and the advice that you were taking around the table? 12:35

A. I think there's a lot of information come to my knowledge since. At that point in time when I went to the case conference and I made that decision on the basis of information and evidence provided to me, in addition to the advice I received on at that point in 12:35 time. I still believe that that was my decision as a Case Manager for exclusion, with the advice from the Oversight Committee which was present there. I was aware of some indication/discussion with Dr. Wright that this was potential or likely - I don't exactly 12:36 remember the term - but there was some discussion already has happened, and this is a potential or likely case for formal MHPS investigation, for various reasons which we have already discussed. But I still believe that was my decision at that point in time in the case. 12:36

73 Q. Help us if you can with this. The notion that there was a case to answer is legalistic language. The Framework document and the Guideline document produced by the Trust isn't very helpful in allowing the reader to take a grip of what is meant by that phrase. What 12:37 was the task, as you understood it, and what factors did you take into account? Was there, in your own mind, an alternative to an MHPS investigation in all of the circumstances, even if there were concerns about

Mr. O'Brien's practice?

A. I think the first point I would like to make is the MHPS Framework document is not easy to navigate, it is not easy to understand. You have to go through several times to understand the terms and the analogy and pathways on that. I did go through several times to understand various things. But at that point in time when I went into the case conference, that was the framework in front of us; it was the MHPS Framework we were working from. So that point in time there was no -- I must say there was no alternative framework or the policy. The Trust Guideline 2010 for managing performance and doctors and dentists was alongside with MHPS, but we were on the MHPS Framework document and we were keep referring back to that in that discussion as well. 12:38 12:38 12:39

74 Q. I can maybe push on this. What test did you think you were applying? What did those words, "case to answer", mean to you?

A. "Case to answer" meant to me at that point in time we need to do a further investigation, a formal investigation, to understand; to allow for the doctor as well to make their comments, case, statements, representation. But also we need to look at in a formal investigation way by approaching, by gathering information, by taking the statements, by doing the interviews. That was my understanding a case to answer means in MHPS terms. 12:39 12:39

75 Q. Having taken a view at that point that there was a case

a. I was contacted by the Medical Director at end of December 2016, who wished to nominate me as Case Manager of an MHPS investigation. In the discussion, he explained some emerging concerns about a Urology Consultant.

b. I met with the Medical Director at the beginning of January 2017 (6/1/2017) to discuss this in more detail. He gave me a summary of this case. He also indicated that a lookback exercise was ongoing.

c. I attended the oversight committee Case Conference on 26th January 2017. A preliminary report of the lookback exercise was provided by the then case investigator (Mr Colin Weir). I must emphasise that I wasn't aware of the extent & severity of the concerns until this report was presented at the case conference.

d. After considering all evidence presented & with the advice from the oversight committee, I made the decision to conduct formal investigations under the MHPS Framework.

e. After consultation and consideration of all the information provided to me, I also made the decision to lift the immediate exclusion of Mr O'Brien. However, there would be a return to work action plan with monitoring arrangements by the Acute Directorate team. An assurance report would also be provided on regular intervals to me as Case Manager.

f. As this was my first experience of being involved in an MHPS investigation, it wasn't very clear to me at the beginning what my role as Case Manager would involve. The Oversight Committee was comprised of The Medical Director, Director of HR, and Director of Acute Services. This committee was already involved and had made some decisions for this case, so this blurred roles and responsibilities for me. I did have the benefit of the MHPS Framework and the Trust Guidelines but my MHPS training was not until March 2017, which was few months into the investigations.

II. If different, also state when you became aware that there would be an investigation into matters concerning the performance of Mr. O'Brien?

9.2 See my answer at 9.1 above.

III. Who communicated these matters to you and in what terms?

9.3 The Medical Director (Dr Richard Wright) communicated to me some information about some of these concerns in December 2016 and then he provided a summary of concerns in January 2017.

10.4 I also considered all concerns raised from a recent SAI in December 2016 and the NCAS advice (sought on 28th December 2016 by the Medical Director) which was shared by the Medical Director.

10.5 I reviewed General Medical Council (GMC), Good Medical Practice guidelines

II. Outline any advice received by you in relation to that decision, whether or not you accepted or applied that advice, and identify the person(s) or bodies who provided that advice to you;

10.6 I received advice from the Oversight Committee members in the oversight committee case conference on 26th Jan 2017. In that meeting Mrs Vivienne Toal, Director of HROD, Dr Richard Wright, Medical Director, and Ms Anne McVey, Assistant Director of Acute Services (on behalf of Esther Gishkori as she had an apology) were present. After considering the report from the lookback exercise, all advised in favour of a formal investigation under the MHPS framework.

10.7 I also considered the recent advice from NCAS (sought in December 2016 by the Medical Director) and shared at the case conference. **NCAS advise letter - Dec 2016 attached. This can be located at Relevant to HR/Reference no 1/updated 2016 Exclusion Mr O'Brien - 25 Nov 2021/20161229 - 11.28 e-mail from SG enc NCAS letter.pdf**

III. Specify the information you took into account when reaching that decision, and identify the person(s) who provided that information to you, or the sources of that information;

10.8 I took account of:

a. The preliminary report of the lookback exercise from the Case Investigator for consideration by the Case Manager / Case Conference, presented by Mr Colin Weir (Case investigator);
b. I also considered concerns raised from a recent SAI in December 2016;
c. The recent advice from the Practitioner Performance Advice (formerly NCAS) which had already been sought in December 2016 by the Medical Director and shared at the case conference;
d. The MHPS Framework and Trust Guidelines documents.
e. The General Medical Council (GMC) Good Medical Practice guidelines.

Hainey, Lynne

From: White, Laura
Sent: 30 December 2016 12:37
To: McBride, Michael [redacted]
Cc: Wright, Richard; Gibson, Simon; Gishkori, Esther; Toal, Vivienne; Hainey, Lynne
Subject: Ltr to Dr Michael McBride
Attachments: file.pdf

Dear Mr McBride

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

Regards, Laura

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

Direct Line: [redacted]

-----Original Message-----
From: laura.white [redacted]
Sent: 30 December 2016 12:32
To: White, Laura
Subject: Scan from YSoft SafeQ

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

Southern Health and Social Care Trust

30th December 2016

Dr Michael McBride
Chief Medical Officer
DHSSPS
C5.15 Castle Buildings,
Stormont Estate,
Belfast,
BT4 3SQ

Dear Dr McBride

Notification of immediate exclusion of Mr Aidan O'Brien GMC No: [redacted]
Consultant Urological Surgeon, Southern Health & Social Care Trust

I am writing to inform you that, under the terms of Maintaining High Professional Standards (MHPS), the Southern Trust has today excluded the above doctor.

The reason for the exclusion, taken following advice from NCAS, was to allow a four week period to scope out the scale of potential problems in relation to Mr O'Briens administrative practices, which may have led to patients coming to harm, and form the Terms of Reference of a formal investigation.

The scoping exercise will be considering:

1. Potential delays in triaging GP referral letters
2. Potential delays in recording the clinical outcome of outpatient clinics
3. Potential adverse impact of patients notes being kept at home for unreasonable periods of time

The decision was taken by the Southern Trust's Oversight Committee on the basis that, if Mr O'Brien's administrative practices have potentially led to patients coming to harm, should he return to work, the potential that his administrative practices could continue to harm patients would still exist.

In line with MHPS guidance, this scoping exercise will be completed within four weeks, and I will update you upon its conclusion. If the exercise identifies significant concerns during its progress, I will of course alert you earlier.

Yours sincerely

[redacted]

Dr Richard Wright
Medical Director

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: [redacted] Email: [redacted]

Hynds, Siobhan

From: Khan, Ahmed [redacted]
Sent: 26 January 2017 13:18
To: Hynds, Siobhan
Subject: RE: Quick Discussion

Siobhan, I have tried to contact Dr Grainne Lynn, the NCAS advisor but couldn't get through. Is there any direct number we can try? I am now leaving for CAH , if reached before meeting then we can try from Trust HQ. see you soon.
Thanks
Ahmed

From: Hynds, Siobhan
Sent: 26 January 2017 11:36
To: Khan, Ahmed
Subject: RE: Quick Discussion

Thanks

From: Khan, Ahmed
Sent: 26 January 2017 11:36
To: Hynds, Siobhan
Subject: RE: Quick Discussion

Siobhan, I am doing clinic this morning. Will ring you by 12.30.
Thanks
Dr khan

From: Hynds, Siobhan
Sent: 26 January 2017 11:29
To: Khan, Ahmed
Subject: Quick Discussion
Importance: High

Hi Dr Khan

Can you give me a quick call this morning – [redacted]

Many thanks

Siobhan

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

[redacted]

additional matters may have been discussed but all relevant information is captured in the letter.

12. In advising NHS bodies on how they should deal with concerns about performance of individual practitioners, reference is made to the procedures set out in Maintaining High Professional Standards in the Modern NHS (MHPS) in England or Maintaining High Professional Standards in the Modern HPSS in N. Ireland. These documents set out the procedures for handling concerns about practitioners relating to conduct capability and health. It also contains specific guidance on how NHS bodies should investigate concerns, and the procedures they should follow when considering the exclusion of a practitioner.

The role and involvement of NCAS/the Advice Service

13. The first contact from Southern HSC Trust was on 7 September 2016. I was not involved at that stage and the case was assigned to my colleague Dr Fitzpatrick. My first involvement with the case was in December 2016 when I was asked to call Dr Richard Wright (the then Medical Director) about a serious adverse event investigation that had flagged up a problem with Dr O'Brien's review of a patient with cancer. The patient had allegedly come to some harm, and there were concerns about Dr O Brien's review system, including allegations that he was not updating the system appropriately and, possibly taking notes to his home and not returning them.

14. I dealt with the matter instead of Dr Fitzpatrick as he works part time and was unavailable.

15. A summary of my discussions with Dr Wright on 28 December 2016 appears in my advice letter dated 29 December 2016 which I now produce as **GL1**. I explained that any formal investigation would need to be conducted under MHPS, and that given the information to date it was likely a more formal process was now warranted. It was noted that at the time Dr O'Brien was unwell and further steps were being taken to see if he was fit to work and possibly fit to participate in an investigative process. We did discuss at the time the criteria for possible formal exclusion.

16. I left it that given the possible exclusion I would review the case with Trust in about a month's time. I then sent follow up emails in January, March and May 2017 and in August 2017 our file was closed as there was no response to my emails. This is in line with our standard practice. We do not have a proactive role in these matters and

52. The 23 March 2016 letter I remember well. It was on a Thursday, may have been a day or so after the 23rd I got it. I was asked by Martina Corrigan to meet Mr Mackle. I was concerned because of a previous complaint I had about him, I had lodged a grievance about him. But I went along and it was very courteous. He said he appreciated my hard work and preferred to give me the letter personally rather than send it by post. He raised issues, which were in the letter and I asked 'What do you want me to do?' he shrugged. Martina Corrigan was there in place of Heather. They left and I concerned myself with people suffering poor clinical outcomes. There was no particular action plan put in place.

53. After I got the letter I just worked harder. I looked at the review backlog and did entire clinics. I find it distressing to look back over those 9 months. There were times Personal information redacted by the USI when I was in so much pain but I worked when I was ill.

54. I did additional review lists and sacrificed my admin time. I wish it was otherwise, but it was for the good of the patients. It was better to have relieved discomfort of a patient.

55. I have spent time operating from 9am to 8pm for years when it was not part of my job plan. Michael Young has also done it. All the additionalities that have been done were additional to my job plan activity which was in place of SPA time, admin time and my own time. I had to do this activity when I was recovering from my surgery. Management did not offer any support.

56. Dr Chada enquired if I work differently from my colleagues. I advised that yes I do, we all work differently. Some ways can be irritating. Some colleagues refused to provide clinical summaries for MDM as is required, they would just have sent the cancer tracking letter. It all led to me believing I had enough and stepping down from a management role.

57. I know triage is an issue for people but they are doing it. Other activities are suffering as a consequence. It is a tick box. You can do it if you don't do a 3 hour ward round and know every detail about each patient. Some colleagues get their registrar to do the ward round.

58. Since I have returned to work with the action plan in place, I come on a Thursday and have to have everything returned by 4pm the next Friday so I take an annual leave day and spend all night doing all what is needed. As I sit here, I still don't know what is expected of me in respect of triage. This month on the 18th I'm at a wedding, so I will tick the boxes and complete triage.

59. Dr Chada advised that I am required to review the referral information only and make a decision about the appropriate category. Dr Chada stated that she appreciated there was not enough time to do enhanced triage and that would be a good way of doing it, but it was not what was being expected I advised that this is the first time I have ever had it clarified in terms of what is expected of me. I confirmed that I am doing enhanced triage on current referrals. Last week on

Gibson, Simon

From: Gibson, Simon
Sent: 28 December 2016 15:34
To: Hainey, Lynne; Wright, Richard
Subject: Investigation - AOBrien
Attachments: Letter to AOB - 1st draft 30-12-16.docx; Terms of Reference - SHSCT investigation into Dr A O'Brien - as at 28th December 2016.doc; Appendix 3 - Copy of Backlog Report - no clinic outcomes as per 15.12.16.xlsx; Ltr as requested

Dear Lynne

I was drafting correspondence for Richard to pass to Dr O'Brien on Friday. However, having just met Richard, he briefed me on advice from NCAS and that the discussion with Dr O'Brien may be purely verbal, with the information attached used by yourselves only as an aide memoire, pending fuller scoping of the facts.

I have attached all the information, which you may find useful when you do formally communicate with Dr O'Brien – feel free to amend at will.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by the USI

Southern Health & Social Care Trust
Investigation into Dr Aidan O'Brien

TERMS OF REFERENCE

During the completion of a Serious Adverse Incident investigation, a number of concerns were raised with the Medical Director. The Medical Director, under delegated authority from the Chief Executive, authorised a range of preliminary enquiries to seek to verify the substance and accuracy of issues raised by staff.

Following completion of the Trust's preliminary enquiries, information was presented to an Oversight Group consisting of the Medical Director, the Assistant Director of Acute Services, (acting on behalf of the Acute Services Director) and Director of Human Resources and Organisational Development. This preliminary information led the Oversight Group to agree that a formal investigation under Maintaining High Professional Standards was justified to consider the following issues:

1. **To determine whether there has been unreasonable delays in the triaging of outpatient letters by Dr O'Brien, and whether patients may have come to harm as a result of these delays**

2. **To determine whether patients notes have been stored at home by Dr O'Brien, whether these have been at home for significant periods of time and whether this has affected the clinical management plans for these patients either within Urology or within other clinical specialties**

3. **To determine whether there has been an unreasonable delay by Dr O'Brien in dictating outpatient clinics, and whether there may have been delays in clinical management plans for these patients**

4. **To determine whether Dr O'Brien offered an advantage to NHS patients awaiting a procedure who had previously attended him in a private outpatient capacity, to the disadvantage of other patients awaiting a procedure, by not listing patients in chronological order**

Further to these Terms of Reference, The Oversight Group directed that a Case Manager, Case Investigator and Senior HR advisor should now be appointed, and that Dr O'Brien should be met with to inform him of:

- A formal investigation commencing, and the Terms of Reference
- The membership of the investigating team
- The process of investigation under the Maintaining High Professional Standards Framework
- The initial 4 issues of concern under consideration
- The immediate restrictions being placed upon Dr O'Brien
- A timetable for the progression of the investigation

Hynds, Siobhan

From: Hainey, Lynne [redacted]
Sent: 29 December 2016 14:04
To: Hynds, Siobhan
Subject: Terms of Reference for Investigation December 2016
Attachments: Terms of Reference for Investigation December 2016.docx

Sorry Siobhan, got caught up in something else there – attached is the draft Terms of Reference, however I have received a letter from Simon from NCAS which is likely to impact on the attached. Sorry to pester you with this. Any queries, just give me a shout

Thanks

Lynne

Southern Health and Social Care Trust

Quality Care - for you, with you

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TERMS OF REFERENCE FOR INVESTIGATION

December 2016

A formal investigation has been commissioned into concerns relating to Dr Aidan O'Brien, Consultant Urologist. These concerns arose following the conclusion of a Serious Adverse Incident Investigation, are concerns which are repetitive in nature and highlight Dr O'Brien's failure to comply with remedial action requirements, previously agreed.

The concerns relate to Dr O'Brien's administrative practices, and the possibility that patients may have come to harm as a result of those administrative practices. The under noted terms of reference set out the scope of the investigation.

Grade:	Consultant, Urology
Base Hospital:	Southern Health & Social Care Trust Craigavon Area Hospital
The matters to be investigated:	***The below outlines the issues of concern to be investigated, this does not preclude investigation of any further issue of concern which may arise during the course of the investigation.*** ***Matters to be investigated:*** **1. To determine whether there have been unreasonable delays in the triaging of outpatient/GP letters by Dr O'Brien, and whether patients may have come to harm, or had un-necessary delays in treatment, as a result** **2. To determine whether patients notes have been stored at home by Dr O'Brien, whether these have been at home for significant periods of time and whether this has affected the clinical management plans for these patients either within Urology or within other clinical specialties** **3. To determine whether there has been an unreasonable delay by Dr O'Brien in dictating outpatient clinics, and whether there may have been delays in clinical management plans for these patients as a result**
Case Investigator:	**Mr Colin Weir, Clinical Director** supported by an HR Representative (to be confirmed)
Case Manager: Designated	**Dr Ahmed Khan, Associate Medical Director (Peadiatrics)**
Board Member	To be appointed in the New Year

Gibson, Simon

From: Gibson, Simon
Sent: 19 January 2017 10:46
To: Hynds, Siobhan; Toal, Vivienne; Wright, Richard; Gishkori, Esther
Subject: RE: Terms of Reference for Investigation
Attachments: Terms of Reference for Investigation January 2017 DRAFT FINAL (2).docx

Dear all

I have considered this draft in the context of NCAS advice, and amended to try and make TOR as specific, focussed and quantitative as possible, by adding in the information presented by Ronan at the 10th January meeting.

In particular, the learning from another case in relation to non-chronological scheduling of patients is that this element in particular is better if very specific

Would welcome comments.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office

Personal Information redacted by the USI

From: Hynds, Siobhan
Sent: 18 January 2017 13:53
To: Toal, Vivienne; Wright, Richard; Gishkori, Esther
Cc: Gibson, Simon
Subject: Terms of Reference for Investigation
Importance: High

Dear All

Please find attached draft terms of reference for Mr A O'Brien investigation for your comment / approval.

Many thanks

Siobhan

Vivienne

Mrs Siobhan Hynds
Head of Employee Relations
Human Resources Department

Hill Building, St Luke's Hospital Site
Armagh, BT61 7NQ

Personal Information redacted by the USI

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TERMS OF REFERENCE FOR INVESTIGATION

December 2016

A formal investigation has been initiated into concerns relating to Dr Aidan O'Brien, Consultant Urologist. These concerns arose following the conclusion of a Serious Adverse Incident Investigation, are concerns which are repetitive in nature and highlight Dr O'Brien's failure to comply with remedial action requirements, previously agreed.

The concerns relate to Dr O'Brien's administrative practices, and the potential for patients to have come to harm as a result of those administrative practices. The under noted terms of reference set out the scope of the investigation.

Grade:	Consultant, Urology
Base Hospital:	Southern Health & Social Care Trust Craigavon Area Hospital
The matters to be investigated:	***The below outlines the issues of concern to be investigated, this does not preclude investigation of any further issue of concern which may arise during the course of the investigation.*** **1. To determine whether there have been unacceptable and/or unreasonable delays in the care relating to 783 referral letters untriaged by Mr O'Brien during the period June 2015 to October 2016 and whether patients have come to harm, or had unnecessary delays in treatment, as a result.** **2. To determine whether the length of time the 307 sets of patient notes were stored at home by Dr O'Brien has affected the clinical management plans for these patients either within Urology or within other clinical specialties.** **3. To determine whether there has been an unreasonable delay by Dr O'Brien in dictating clinic outcomes from 668 outpatient consultations, and whether there may have been delays in clinical management plans for these patients as a result.** **4. With an initial focus on patients undergoing an endoscopic resection of their prostate in 2016, to determine whether Dr O'Brien has seen private patients as outpatients and then scheduled the private patients for their procedure on the NHS in non-chronological order, contrary to Trust policies and procedures**

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TERMS OF REFERENCE FOR INVESTIGATION

Case Investigator:	**Mr Colin Weir, Clinical Director** [redacted] supported Mrs Siobhan Hynds, Head of Employee Relations [redacted]
Case Manager: Designated	**Dr Ahmed Khan, Associate Medical Director, Daisy Hill Hospital** [redacted]
Board Member	Mr John Wilkinson, Non-Executive Director Contactable via the Chair's Office [redacted]

Hynds, Siobhan

From: Hynds, Siobhan [redacted]
Sent: 15 March 2017 00:01
To: Khan, Ahmed
Cc: Chada, Neta
Subject: Terms of Reference for Investigation FINAL
Attachments: Terms of Reference for Investigation FINAL.docx; Witness List - MHPS AO'B.xlsx

Importance: High

Dr Khan

Please find attached final draft of TOR for the AO'B investigation. Please also find the proposed witness list to date although it is likely Dr Chada will need to speak to others. Once we have others determine we will update Mr O'Brien.

If you are in agreement with the drafted TOR can you please share with Mr O'Brien. Dr Chada and I are beginning the first of our meetings with witnesses this week.

Thanks

Siobhan

Mrs Siobhan Hynds
Head of Employee Relations
Human Resources & Organisational Development Directorate
Hill Building, St Luke's Hospital Site
Armagh, BT61 7NQ
Tel: [redacted] Mobile: [redacted] Fax: [redacted]

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TERMS OF REFERENCE FOR INVESTIGATION

A formal investigation has been initiated into concerns relating to Mr Aidan O'Brien, Consultant Urologist. The concerns relate to Mr O'Brien's administrative practices, and the potential for patients to have come to harm as a result of those administrative practices. The under noted terms of reference set out the scope of the investigation.

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Base Hospital:	Southern Health & Social Care Trust Craigavon Area Hospital
The matters to be investigated:	***The below outlines the issues of concern to be investigated, this does not preclude investigation of any further issue of concern which may arise during the course of the investigation.*** ***Matters to be investigated:*** **1. (a) To determine if there have been any patient referrals to Mr A O'Brien which were un-triaged in 2015 or 2016 as was required in line with established practice / process.** **(b) To determine if any un-triaged patient referrals in 2015 or 2016 had the potential for patients to have been harmed or resulted in unnecessary delay in treatment as a result.** **(c) To determine if any un-triaged referrals or triaging delays are outside acceptable practice in a similar clinical setting by similar consultants irrespective of harm or delays in treatment.** **(d) To determine if any un-triaged patient referrals or delayed triages in 2015 or 2016 resulted in patients being harmed as a result.** **2. (a) To determine if all patient notes for Mr O'Brien's patients are tracked and stored within the Trust.** **(b) To determine if any patient notes have been stored at home by Mr O'Brien for an unacceptable period of time and whether this has affected the clinical management plans for these patients either within Urology or within other clinical specialties.** **(c) To determine if any patient notes tracked to Mr O'Brien are missing.** **3. (a) To determine if there are any undictated patient outcomes from patient contacts at outpatient clinics by Mr O'Brien in 2015 or 2016.** **(b) To determine if there has been unreasonable delay or a delay outside of acceptable practice by Mr O'Brien in dictating outpatient**

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TERMS OF REFERENCE FOR INVESTIGATION

	clinics. **(c) To determine if there have been delays in clinical management plans for these patients as a result.** **4. To determine if Mr O'Brien has seen private patients which were then scheduled with greater priority or sooner outside their own clinical priority in 2015 or 2016.** **5. To determine if any of the above matters were known to line managers within the Trust prior to December 2016 and if so, to determine what actions were taken to manage the concerns.**
Case Investigator:	**Dr Neta Chada, Associate Medical Director** supported Mrs Siobhan Hynds, Head of Employee Relations [redacted]
Case Manager: Designated	**Dr Ahmed Khan, Associate Medical Director (Paediatrics), Daisy Hill Hospital** [redacted]
Board Member	Mr John Wilkinson, Non-Executive Director (contactable via the Chair's Office)

we are content that we continue with the formal MHPS process...."

We have 7th February letter and meeting. We know from your statement that legal advice was sought and you're content to proceed with the MHPS process having lifted immediate exclusion. You said here:

"Given Colin Weir's role as his Clinical Director at the time this broke there is a potential conflict of interest even though from our perspective he was doing a great job. We need to reappoint a different case investigator who is not involved with AOB."

Does that make sense to you? 15:04

A. I remember having the discussion with our legal adviser from --

173 Q. Let me just frame the question. It says we are taking the Clinical Director out of the case investigator role. It seems to me that that's typically a role for a Clinical Director, but you're taking him out because, notwithstanding he is doing a great job, we need to find somebody who is not involved with AOB. The particular circumstances of this clinical director and his relationship with Mr. O'Brien. Isn't that the problem? 15:04 15:05

A. There were so many issues that were proving difficult to respond to without making a significant change to the process. We discussed it with our legal team who felt that the CD's role was a conflict of interest,

even though it has been something that we have done many times in the past.

174 Q. That's what I'm asking you. Please explain the conflict?

A. They had been involved as his CD for some time whenever some of these issues arose and, therefore, may have been involved in the administration of some of the systemic issues that may be relevant. 15:06

175 Q. He had only been appointed in June 2016.

A. Yes. But that was the view, I think, of the legal advisers at the time. They were very adamant that we had potentially a conflict of interest here. 15:06

176 Q. Did you see any evidence of the conflict in terms of how Mr. Weir was conducting himself?

A. No, not personally. 15:06

177 Q. I don't wish to ask you about what instructions you gave your lawyers but they appear to have, on the basis of your evidence, told you that this was the appropriate course. Leaving aside what you may or may not have told your lawyers, did you form a view that there was a conflict? 15:07

A. I think Mr. Weir was indicating this was proving to be a very difficult task for him, both personally and professionally. He had also had some periods of ill-health over that time. He was indicating it was an uphill struggle to conduct this investigation. 15:07

I wouldn't have said it was a direct conflict but it was apparent that it was becoming a problem for him and may have become a bigger problem down the line as the

investigation went on.

178 Q. You can't help us to understand what the conflict was?

A. I think the role of managing him going forward in terms of the implementing the package of measures to ensure that he was complying was proving to take a fair bit of their time and it was an onerous role. To do that as well as conduct an investigation into the same time when there may have been potential breaches of the measures in place, which the CD was responsible for implementing could have been a conflict at that point. The CD was responsible, on the one hand, for ensuring Mr. O'Brien complied with these various measures, but he was investigating, at the same time, that process. I think it was along those lines that that could have been problematic, where there were breaches of the measures put in place, because he would eventually then be investigate himself. 15:08 15:08 15:09

179 Q. Could I ask you whether the answer you have just given is speculative or conjectural on your part?

A. I'm trying to recall the conversation and I think it was along those lines, so I think it is more than speculation, but I can't remember the details of it. 15:09

180 Q. Very well. Where this appears to have started in one of the answers I brought you to was Mr. O'Brien was raising issues or concerns. Can you better help us with that? 15:09

A. I'm struggling, to be honest, to give you a clear answer to this. I think possibly he might have mentioned -- with Mr. Wilkinson I don't know, I'm not

Hynds, Siobhan

From: Hynds, Siobhan [redacted]
Sent: 21 February 2017 13:47
To: Khan, Ahmed; Wright, Richard
Subject: RE: Confidential

Yes - I'll get something arranged asap.

Siobhan

-----Original Message-----
From: Khan, Ahmed
Sent: 21 February 2017 12:52
To: Wright, Richard
Cc: Hynds, Siobhan
Subject: RE: Confidential

Richard, Thanks. I am content with this arrangement. From our last meeting with Mr O'Brien, An urgent job planning meeting is required within first week or so of his return . I am sure Dr Weir would be able to facilitate this.

Siobhan, I am sure you will update Neeta for this case and her role as investigator. Can a short meeting be arranged in next couple of weeks for 3 of us.
Regards,
Ahmed

-----Original Message-----
From: Wright, Richard
Sent: 21 February 2017 11:40
To: Khan, Ahmed
Cc: Hynds, Siobhan
Subject: Confidential

Hi Ahmed
Thanks for your help so far with the AOB investigation. On Friday last Vivienne and I [redacted] after AOB approached John Wilkinson (NED) In short we are content that we continue with formal MHPS process and have lifted the immediate exclusion.
However [redacted] given Colin Weir's role as his CD at the time this broke there is a potential conflict of interest even though from our perspective he was doing a great job. [redacted] we need to reappoint a different case investigator who is not involved with AOB.
To that end I have asked Neta Chada to take over as case investigator and she has agreed. If you are content with this can you arrange to meet her to discuss. Siobhan is drafting a letter to AOB on your behalf. I would be happy to let Colin Weir know, if your are content with this approach.
Apologies for the inconvenience.
regards
Richard

Sent from my iPad

Case Manager was advised of this, and we agreed to keep him updated on at least a monthly basis.

1.18 If issues were raised by witnesses which we felt pertained to the service and needed to be addressed even before the Investigation was completed, we raised these with Dr Khan. An example of this is when one of the witnesses indicated Mr O'Brien was not assigning clinical priorities to his theatre list, making it difficult to know how to sort the lists if theatre sessions to be cancelled to adjusted for some other reasons. I was advised this clinical prioritization was routine with the rest of the Surgeons. (Paragraphs 1.15-1.17 are covered in an email dated 12 April from Mrs Hynds to Dr Khan *located in Relevant document can be located at Relevant to PIT/ Evidence Added or Renamed 19 01 2022/ Evidence no 77/ No 77 – Dr Neta Chada/ 20170412 – E MPHS Case Update).* I understand Dr Khan, as Case Manager, asked for updates on Mr O'Brien's compliance with the action plan which had been put to him by the Trust. Oversight of this part of the process was not in my remit as the Case Investigator as outlined in MHPS.

1.19 In parallel to the witness interviews, I was also given regular updates on the progress of the gathering of the information in relation to each of the Terms of Reference, as this assisted in some of the questions I had for witnesses and was needed to understand the extent of the concerns. I was also copied into updates to Dr Khan from managers on whether any further charts had been removed/clinics not dictated etc.

1.20 When I took over as Case Investigator, I believe I was advised of four Terms of Reference, as outlined in the Trust's discovery documents. However, as the information was being gathered it became clear to me that a further Term of Reference needed to be considered. ToR 5 was to determine to what extent any of the above matters were known to managers within the Trust prior to December 2016, when the outcome of the SAI was shared with the Medical Director, and to determinate what actions were taken to manage any concerns. I believe I added this ToR by mid-March 2017.

1.21 Some witnesses wanted details of the agenda of the meetings and were sent the Terms of Reference when they were invited to the interview.

a widening of the terms. Such requests should be decided on promptly so that the investigation is not delayed", et cetera.

I want to ask you about the process by which ToR5 was added. Is it fair to say that it started with you? 12:08

A. That's my memory of it. I believe it went through the information that I was provided with and felt that for fairness and for an understanding of what had happened to date, that a review or some information from people about what had happened prior to this, should be considered. 12:09

82 Q. We will come on to the rationale in a moment. I just want to look at some e-mails in this context. TRU-283121. Highlight the bottom, please. I will check the reference. So, if we just go back a page, please, and TRU-283121. This is the 3rd March, shortly after your appointment. Siobhán Hynds is sending to Dr. Khan, the Case Manager, copying you into draft: 12:09

"Terms of Reference for your agreement. These need to be issued to Mr. O'Brien when agreed". 12:11

The last line is irrelevant for present purposes. If we go to the next page, please, 283122, and so we can see there are four matters to be investigated. Term of reference 1 concerns the issue of triage. ToR 2 concerns the issue of patient notes being stored at Mr. O'Brien's home. 3 is in relation to delay in 12:11

something that you embraced as being a valuable thing to explore during this investigation?

A. At the time of the case conference I was surprised by the fact that this issue was known to the organisation for a period of time, at least for 2016. I was also a little surprised about the appraisal and revalidation and all other things as well. So, yes, in my mind I don't think at that point in time I was thinking of admin or admin review or looking at this as a terms of reference, but there was something in my mind around that issue of organisational awareness of the issue for a period of time. When this final terms of reference came to me, I was satisfied. I agreed to that and I was satisfied this was part of the investigation now. 14:56 14:56

119 Q. Is this part of, I suppose, the inherent flexibility of the MHPS process in that issues like this - number 5 - not directly focused on the clinician's actions or conduct but forming part of the context in which he is working, including his relationships with management and their knowledge, is this part of the advantage of the MHPS process, that this kind of thing can be looked at alongside the actions of the clinician? 14:57 14:57

A. I'm afraid I'm not able to answer that because I don't have much of expertise. This was the only MHPS I was involved in in terms of looking at. In that instance, I felt it was useful to include that terms of reference. 14:57

120 Q. Yes. Because self-evidently, perhaps, it is important that if the clinician is struggling to perform to the

Hynds, Siobhan

From: Hynds, Siobhan [redacted]
Sent: 16 March 2017 16:53
To: O'Brien, Aidan
Cc: Khan, Ahmed
Subject: Strictly Private and Confidential
Attachments: Witness List - MHPS AO'B.xlsx; Terms of Reference for Investigation FINAL.docx

Importance: High

Dear Mr O'Brien

Dr Khan has asked me to forward you the terms of reference for the MHPS investigation and the witness list to date. There will be others to be added to the witness list and I will confirm with you an updated list in due course.

Regards,

Siobhan

Mrs Siobhan Hynds
Head of Employee Relations
Human Resources & Organisational Development Directorate
Hill Building, St Luke's Hospital Site
Armagh, BT61 7NQ
[redacted]

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Investigation under Maintaining High Professional Standards Framework

Witness List

NAME	DATE	TIME	VENUE
Ms Martina Corrigan	Wednesday 15 March 2017	12 noon	Admin Floor, Craigavon Area Hospital
Mr Michael Young	Thursday 23 March 2017	11:00 AM	
Mrs Claire Graham	Monday 3 April 2017	2.00 PM	
Mr Ronan Carroll	Thursday 6 April 2017	11.30 AM	
Mr Eamon Mackle	Date to be confirmed		
Mr Colin Weir	Date to be confirmed		
Ms Heather Throuton	Date to be confirmed		

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TERMS OF REFERENCE FOR INVESTIGATION

A formal investigation has been initiated into concerns relating to Mr Aidan O'Brien, Consultant Urologist. The concerns relate to Mr O'Brien's administrative practices, and the potential for patients to have come to harm as a result of those administrative practices. The under noted terms of reference set out the scope of the investigation.

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Case Investigator:	**Dr Neta Chada, Associate Medical Director** supported Mrs Siobhan Hynds, Head of Employee Relations Personal Information redacted by the USI
Case Manager: Designated	**Dr Ahmed Khan, Associate Medical Director (Paediatrics), Daisy Hill Hospital** Personal Information redacted by the USI
Board Member	Mr John Wilkinson, Non-Executive Director (contactable via the Chair's Office)

was in his remit to agree that, then it was up to him to agree it. I mean I asked for permission to add it and that's what I felt my role was.

85 Q. The e-mail was asking for his agreement, whereas, in fact, the advice seems to suggest that it's within the remit of the Trust decision-making group, which, in local parlance, would have been the Oversight group. 12:16

Did you have an understanding that an Oversight group had been in command of this case and that that's where the issue of the terms of reference should have gone? 12:16

A. I knew that there was an Oversight group in command, in charge in overseeing this, and that there had been a scoping exercise done and that the terms of reference had been set by that decision-making group. I suppose I didn't consider whether the Oversight Group should specifically have agreed this term of reference. I suppose my view was my chain of command, if you like. My line of communication was with Dr. Khan rather than anybody outside of that, and therefore I shared with Dr. Khan. 12:17 12:17

86 Q. In terms of the communication with Dr. Khan, did you discuss this with him or did you get a green light back from him?

A. I believe that -- I believe that there was a green light back because the term of reference was adopted and shared with Mr. O'Brien, as far as I'm aware. I don't formally -- I don't remember specifically being told yes or no. I think the e-mail was sent with, 12:17

g. During January and February: Mr O'Brien met with the Medical Director (Dr Wright) and Mr John Wilkinson, the Designated Non-Executive Director. This was discussed at oversight committee meetings. In consideration of representations made by Mr O'Brien the decision was made to replace Mr Colin Weir as Case investigator with Dr Neta Chada. I then informed Mr O'Brien of this in a letter. (**Evidence: Letter from Case Manager to Mr A O'B 24 February 2017). This can be located at Attachment folder S21 31 of 2022- Attachment 4.**

During March 2017:

h. The MHPS investigation Terms of Reference (TOR) were drafted and approved by oversight committee members. This was then shared with me and, after considering all concerns previously presented to me, I agreed with these TOR. There were 5 points in the TOR shared with me. (**Evidence: 20170119 Emails Re: Terms of Reference for Investigation) These can be located at Attachment folder S21 31 of 2022- Attachment 5a and 5b.**

i. MHPS investigation Terms of Reference (TOR) were shared with Mr O'Brien along with an initial Witness List.

During April 2017:

j. I requested a Return to Work Action Plan assurance report from the Director of Acute Services. The assurance was provided by Mr Ronan Carroll, Assistant Director Acute Services. (**Evidence: 20170414 Email MHPS case update) This can be located at Attachment folder S21 31 of 2022- Attachment 6.**

k. I sent an MHPS investigation update report to Mr John Wilkinson, Designated Non-Executive Director. **(Evidence: my email on 13/4/17 to Mr Wilkinson) This can be located at Attachment folder S21 31 of 2022- Attachment 7.**

During May 2017:

l. I requested a Return to Work Action Plan assurance report from the Acute Directorate. This is provided by Mr Ronan Carroll, Assistant Director, Acute Services.

11. Confirm that you were the person responsible for formulating the Terms of Reference for the formal investigation to be conducted under the MHPS Framework and Trust Guidelines. If so, address the following matters:

11.1 Terms of Reference were already formulated and approved by the Oversight Committee. I received these in January 2017 for review and agreement. I am not aware of any changes in the number of TOR. When I received them for agreement, I believe that there were already 5 Terms. I agreed to these. (See email communication from Dr Wright to Siobhan Hynds attached). **This can be located at Attachment folder S21 31 of 2022- Attachment 54 and also located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20170119 - Email - Re Terms of Reference for investigation 2.pdf**
Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20170119 - Attachment - Terms of Reference for Investigation January 2017 DRAFT FINAL.pdf

A) Outline all of the steps you took in order to formulate the Terms of Reference;

11.2 After receiving these Terms of Reference, I carefully considered each one of them against the preliminary findings to ensure the Terms of Reference covered all the concerns identified. However, we also had the option to extend MHPS investigations if anything new came to light.

11.3 I reviewed the MHPS Framework document and the related Trust Guidelines of 23 September 2010. I also reviewed General Medical Council (GMC) Good Medical Practice guidelines.

B) Outline any advice received by you in relation to the formulation of the Terms of Reference, whether or not you accepted or applied that advice, and identify the person(s) or bodies who provided that advice to you;

11.4 I received advice from the Oversight Committee including the Medical Director and Director of HR. All oversight committee members, after considering findings report from lookback exercise, suggested a formal investigation under the MHPS framework.

11.5 I also considered recent advice from Practitioner Performance Advicer which had already been sought in December 2016 by the Medical Director and shared at the case

"Please find attached final draft of terms of reference of Aidan O'Brien investigation. Please also find the proposed witness list to date although it is likely Dr. Chada will need to speak to others. Once we have others determined, we will update Mr. O'Brien.

If you are in agreement with the draft terms of reference, can you please share with Mr. O'Brien Dr. Chada and I are beginning the first of our meetings with witnesses this week". 14:51 14:52

So if we scroll down, please, and just take a look at the terms of reference. Just scroll on down, number 5. This number 5 is the addition. You were obviously asked to express your contendness or otherwise with that addition. Did you discuss this proposal for addition with Dr. Chada? 14:52

A. I don't think so. I can't recall talking to Dr. Chada about this specific term of reference. I do remember that there was some discussion. I think it was between -- not discussion as specifically for this term of reference but around the terms of reference discussion with Siobhán Hynds, saying this is known to -- this issue is known to the organisation before and Dr. Chada is also aware of that. 14:53 14:53

I was aware this issue in the background -- awareness of this issue in the background by Dr. Chada and

Siobhán Hynds. I must say I don't recall discussing this with any of the Oversight Group or Oversight Committee.

117 Q. You say you had an awareness of it being discussed in the background. Have you any understanding of whether the Oversight Group approved this element of the terms of reference or do you think that stage in the process was missed? 14:54

A. My understanding from the beginning of this process of terms of reference was that they were coming to me after the approval of Oversight Group, or the same time at least. So every time I was getting -- I got about two or three communication emails from Siobhán Hynds about this, and every time initially it was asking Oversight Group -- initially, actually, it was saying the Oversight Group to approve or comment. Then it came to me has a final version of that terms of reference. I am not aware that it was or it wasn't, but my understanding at that point in time was it was looked at and approved by the Oversight Group. 14:54 14:55

118 Q. We don't need to bring it up on the screen but we have at TRU-285787 you saying back to Siobhán, "I am happy with the attached terms of reference, can this be shared with Mr. O'Brien". So you expressed the view that you were content. 14:55

If Dr. Chada hadn't come up with this, is this something you might have come up with anyway? To put it another way or a slightly different way, is this

3. Managing the investigation

The investigation starts once its terms of reference are finalised and when a case manager and investigator(s) have been appointed. Once the decision is taken to hold an investigation there should normally be discussion with the practitioner to secure as much engagement as possible. The practitioner should be made aware of the terms of reference and who the proposed case manager and investigator(s) are so that any objections can be raised.

The organisation can then:

- **finalise terms of reference;**
- **appoint a case manager;**
- **appoint case investigator(s).**

The investigator(s) will:

- **collect evidence;**
- **interview the practitioner;**
- **weigh the evidence and identify the facts of the case.**

3.1 Finalise terms of reference

These will have been agreed in outline at the time a decision was made to carry out the investigation, but some final drafting may be needed. The terms of reference as finally drafted should be agreed by the organisation's relevant decision-maker(s). The case manager and investigator(s) appointed to manage and carry out the investigation (see next sections) would not normally be involved in this process.

Terms of reference should be tight enough to prevent an unfocused general investigation of everything concerning the practitioner. It may be appropriate to specify areas not to be investigated as well as the areas where evidence and commentary are expected. Box 4 suggests a format.

Box 4 – Terms of reference for an investigation

An investigation is commissioned into the performance of [practitioner's name], working as a [practitioner's job title] for [organisation's name], at [workplace address].

The matters to be investigated are [ ].

The following matters are excluded from the investigation [ ].

It is expected that the investigation will be completed by [date] and that a report will be submitted to [named manager] by [date].

The report should detail the investigation's findings of fact and include a commentary on how the performance of [practitioner's name] compares with that expected from a practitioner working in similar circumstances.

As a minimum, terms of reference should set out:

- the issues to be investigated;
- the period under investigation;
- the timescale for completion.

It may be that as the investigation progresses the terms of reference are found to be too narrow or that new issues emerge that warrant further investigation. In such cases, the investigator(s) should inform the case manager who should seek the agreement of the responsible manager or DMG to a widening of the terms. Such requests should be decided on promptly so that the investigation is not delayed. The practitioner must be informed of any changes to the terms of reference unless, exceptionally, he is kept unaware of the investigation at all.

3.2 Appoint a case manager

A case manager is normally appointed by the DMG (in primary care) or the responsible manager (in the H&C sector). Usual practice is for a case manager to be a senior member of the organisation's staff, with a role to:

- ensure that the investigation is conducted efficiently;
- ensure that confidentiality is maintained where appropriate;
- act as the coordinator between investigators, the practitioner and anyone who the investigators need to interview;
- obtain any documentation required;
- ensure that the process is properly documented;
- receive the investigator's report;
- make recommendations to the responsible manager or the DMG on what action might follow, having regard to the contents of the investigator's report.

To be seen to be objective, case managers need to be able to demonstrate that they:

- understand the general nature of the concerns raised and the clinical and work contexts in which they occurred;
- are sufficiently senior within the organisation to secure the cooperation of other staff members;
- are familiar with the local policy for investigating concerns and related procedures;
- have, preferably, some training and experience in undertaking performance investigations;
- have access to relevant advice and expertise from colleagues within the organisation;
- have access to relevant external experts and authority to instruct them;
- have the necessary protected time to support the investigation.

The case manager should have no real or perceived conflict of interest in relation to any aspect of the investigation. Given the structure of the NHS and the small size of some organisations, minor conflicts of interest are difficult to avoid. Any reservations about the choice of a case manager ought to be reported to the DMG or responsible officer at the outset so that a decision can be made about their significance. The practitioner's views should also be taken into account.

In England, MHPS requires that the medical director should act as case manager for cases involving clinical directors and consultants.