that you can address it, your report does, of course, go on to say that the failure to address matters after March was a missed opportunity. I will just find the reference. If we go to TRU-00703, you say at the top of the page: 12:40

"The above issues" - and that was dictation and triage - "were raised in the correspondence in March 2016. However, there appears to have been no management plan put in place at that time and Mr. O'Brien seems to have been expected to sort this out himself with no arrangements for monitoring or changes to practice were being made and sustained." 12:41

But is it fair to say it's no more than that; you don't identify the managers concerned with this shortcoming. You feel you didn't need to go to the NCAS advice or ask questions around what was happening in September and October, even if you didn't know directly about the NCAS advice? 12:41

A. I mean, as you have indicated, Mr. Wolfe, I do later in the conclusions indicate that management could have taken action at an earlier stage. The investigation was in relation to Mr. O'Brien rather than specifically about the managers. I added that term of reference because I felt that it was a fair, equitable, reasonable thing to do. But NCAS advice and Maintaining High Professional Standards advices around doctors as opposed to, you know, shortcomings or 12:42

failings of other people, so I felt that it was important that I highlighted this and then it would be up to somebody else to have a look to see, you know, what else needed to be done.

12:42

I still -- I mean, I accept everything you have said and I still don't think I would have done it differently. I still think I was looking for what assistance was given to Mr. O'Brien after March, you know; who did what in relation to that, and even prior to that. That's what I was interested in and that's the area that I covered.

12:42

104 Q. But it's about more than being equitable and fair to Mr. O'Brien, isn't it? This term of reference was formulated by you, assumedly with the approval of Dr. Khan, in order to get to grips with whether things could have been done better by Trust management in light of the concerns that were identified?

12:43

A. Yes. And I think my report does highlight that things could have been done better and there were missed opportunities. I believe I concluded that.

12:43

105 Q. Although you have said I am looking back from December 2016, you, in fact, only looked back so far?

A. Yes. I mean, in effect - and I say that and I do absolutely accept, I have said December '16 - I really only looked back from -- anything that happened from the autumn time to my view was part of this, and I only looked back from before that. Absolutely.

12:43

106 Q. In terms of setting terms of reference, can I broaden

standard expected of him by his or her employer, it's necessary, isn't it, to understand that in its fullest context, including, amongst other things perhaps, whether adequate support is provided or has been provided, whether the job plan is perhaps too heavy, whether the expectations are too much. Would you agree with that? 14:58

A. I think it's a joint responsibility for the organisation and the doctor or the healthcare worker in the situation that both brings their responsibility together. Without one or the other taking their own responsibility, there are high risks of failure and, as a result, potential or severe harm. So in my view, both parties, organisation and the staff or the employee or the healthcare worker, need to take their responsibility. That's why I felt, when I was happy with the terms of reference, I agreed with that, that this part is in the terms of reference. 14:59 14:59

121 Q. We'll look a little later, perhaps, at whether you were satisfied that this element of the terms of the terms of reference was exploited, if you like, to its fullest potential during the investigation and the conclusions that emerged from it. 14:59

Just one other aspect of the terms of reference, and I quite take your point that you're not expert in this and not particularly experienced in this. An element of what the Inquiry is seeking to grapple with is whether the terms of reference were sufficiently broad 15:00

Can you help us, Dr. Khan, in terms of where was the action plan developed and who developed it, and was it in fact brought to a meeting of the several people mentioned here to discuss its robustness? 10:07

A. The action plan was developed after the case conference. At the case conference, one of the actions were to develop an action plan by the Director of Acute Services and her team. Ms. Esther Gishkori and Ronan Carroll, or her team, was to develop an action 10:08 plan. Purely it was felt at the time of the case conference that this is necessary in order to make sure that the monitoring and the action plan and follow-up and monitoring is robust within the Acute Directorate, purely because they know the system within the Acute 10:08 Directorate in terms of the operational management and how it best can be managed. So, that was the background at the time of the case conference at the end of January.

10:08

Subsequent to that, I understood there was a number of discussions within the Acute Directorate. Now, I wasn't party to that or I wasn't involved in those discussions. Talking to Siobhán Hynds and looking at other communication, I was aware that there was some 10:08 discussion happening within Acute Directorate in terms of putting that action plan together. We were to come together and meet before I and Siobhán Hynds would be meeting with Mr. O'Brien in order to inform him and get

his agreement to that. So yes, it was devised, developed and obviously drafted by the Acute Directorate team.

Now, I understood at that time as well that Siobhán Hynds was helping in supporting them in order to put that together in more kind of a document format. 10:09

3 Q. We know that you met with Mr. O'Brien and you discussed the action plan with him, and we'll come to that in a moment. But before you reached that stage of meeting Mr. O'Brien, did you sit down and meet with these other people, study the action plan, and give your approval for it? 10:09

A. I did give my approval for that. My recollection is that a small group of people met. Now, I'm uncertain who was -- I know it was myself and Siobhán, and there was Ronan Carroll possibly. My recollection is that a small group of people met to go through the action plan before I met with Mr. O'Brien. 10:10

4 Q. You say in your witness statement - I don't need to bring it up to the screen but if you need to look at it, it's at your bundle at page 84 - where you say that the return to work action plan monitoring arrangement was drafted by the Acute Directorate Management and agreed by the Oversight Committee meeting on 3rd February 2017. Now, I'm not aware of a record of any such meeting. Are you saying the Oversight Committee met on that date? 10:10 10:11

A. Now, I suppose on reflection this may be that the small

Stinson, Emma M

From: Carroll, Ronan
Sent: 14 December 2021 17:13
To: Stinson, Emma M
Subject: FW: Return to Work Action Plan February 2017 FINAL
Attachments: Return to Work Action Plan February 2017 FINAL.docx

Importance: High

Section 21

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

From: Hynds, Siobhan Personal Information redacted by the USI
Sent: 09 February 2017 12:23
To: Carroll, Ronan; Corrigan, Martina; Khan, Ahmed; Weir, Colin
Subject: Return to Work Action Plan February 2017 FINAL
Importance: High

Ronan / Martina

Thank you for your assistance with this action plan. Please see attached final draft for your review. This is the basis of what will be discussed with Mr O'Brien at our meeting with him today.

Dr Khan / Colin – for your review and comment please.

Many thanks

Siobhan

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

Personal Information redacted by the USI

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MR A O'BRIEN, CONSULTANT UROLOGIST
RETURN TO WORK PLAN / MONITORING ARRANGEMENTS
MEETING 9 FEBRUARY 2017

Following a decision by case conference on 26 January 2017 to lift an immediate exclusion which was in place from 30 December 2017, this action plan for Mr O'Brien's return to work will be in place pending conclusion of the formal investigation process under Maintaining High Professional Standards Framework.

The decision of the members of the case conference is for Mr O'Brien to return as a Consultant Urologist to his full job role as per his job plan and to include safeguards and monitoring around the 4 main issues of concerns under investigation. An urgent job plan review will be undertaken to consider any workload pressures to ensure appropriate supports can be put in place.

Mr O'Brien's return to work is based on his:

- strict compliance with Trust Policies and Procedures in relation to:
    - Triaging of referrals
    - Contemporaneous note keeping
    - Storage of medical records
    - Private practice
- agreement to comply with the monitoring mechanisms put in place to assess his administrative processes.

Currently, the Urology Team have scheduled and signed off clinical activity until the end of March 2017, patients are called and confirmed for the theatre lists up to week of 13 March. Therefore on immediate return, Mr O'Brien will be primarily undertaking clinics and clinical validation of his reviews, his inpatient and day case lists. This work will be monitored by the Head of Service and reported to the Assistant Director.

CONCERN 1

- That, from June 2015, 783 GP referrals had not been triaged in line with the agreed / known process for such referrals.

Mr O'Brien, when Urologist of the week (once every 6 weeks), must action and triage all referrals for which he is responsible, this will include letters received via the booking

centre and any letters that have been addressed to Mr O'Brien and delivered to his office. For these letters it must be ensured that the secretary will record receipt of these on PAS and then all letters must be triaged. The oncall week commences on a Thursday AM for seven days, therefore triage of all referrals must be completed by 4pm on the Friday after Mr O'Brien's Consultant of the Week ends.

Red Flag referrals must be completed daily.

All referrals received by Mr O'Brien will be monitored by the Central Booking Centre in line with the above timescales. A report will be shared with the Assistant Director of Acute Services, Anaesthetics and Surgery at the end of each period to ensure all targets have been met.

CONCERN 2

- 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.

Mr O'Brien is not permitted to remove patient notes off Trust premises.

Notes tracked out to Mr O'Brien must be tracked out to him for the shortest period possible for the management of a patient.

Notes must not be stored in Mr O'Brien's office. Notes should remain located in Mr O'Brien's office for the shortest period required for the management of a patient.

CONCERN 3

- That 668 patients have no outcomes formally dictated from Mr O'Brien's outpatient clinics over a period of at least 18 months.

All clinics must be dictated at the end of each clinic/theatre session via digital dictation. This is already set up in the Thorndale Unit and will be installed on the computer in Mr O'Brien's office and on his Trust laptop and training is being organised for Mr O'Brien on this. This dictation must be done at the end of every clinic and a report via digital dictation will be provided on a weekly basis to the Assistant Director of Acute Services, Anaesthetics and Surgery to ensure all outcomes are dictated.

An outcome / plan / record of each clinic attendance must be recorded for each individual patient and this should include a letter for any patient that did not attend as there must be a record of this back to the GP.

CONCERN 4

- 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.

Mr O'Brien must adhere to all aspects of the Trust Private Practice Policy, ' A Guide to Paying Patients' and in particular to 'Referral of Private Patients to NHS Lists which states that '*any patient changing their status after having been provided with private services should not be treated on a different basis to other NHS patients as a result of having previously held private status: patients referred for an NHS service following a private consultation or private treatment should join any NHS waiting list at the same point as if the consultation or treatment were an NHS service. Their priority on the waiting list should be determined by the same criteria applied to other NHS patients'.*

The scheduling of patient's must be undertaken by the secretary, who will check the list with Mr O'Brien and then contact the patient for their appointment. This process is in keeping with the practice established within the Urology team.

Any deviation from compliance with this action plane must be referred to the MHPS Case Manager immediately.

IV. The scheduling of private patients by Mr. Aidan O'Brien

12.1 In the 26 January 2017 Oversight Committee meeting, there was a discussion in relation to whether formal exclusion was appropriate during the formal investigation, in the context of:

a. Protecting patients;
b. Protecting the integrity of the investigation;
c. Protecting Mr O'Brien.

12.2 Mr Weir (CD & [then] Case Manager) reflected that there had been no concerns identified in relation to the clinical practice of Mr O'Brien.

12.3 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 this monitoring would look like, to ensure the protection of the patient.

12.4 A Return to Work Action Plan and monitoring arrangement was then drafted by the Acute Directorate management team & agreed by the Oversight Committee on 3rd February 2017.

12.5 This Return to Work Action Plan was shared with Mr O'Brien. He agreed to adhere to this plan during MHPS investigations.

12.6 As per the Return to Work Plan monitoring arrangements, I as Case Manager was to be informed of any deviation or departure from compliance with the Plan by Mr O'Brien. I received regular assurance reports. During the investigation period, I also requested assurance reports from Acute Directorate if needed to assure myself of compliance.

12.7 Although it wasn't written in the Return to Work Plan, the understanding among the oversight committee was that this Plan remained in-force during the period of MHPS formal investigations.

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RETURN TO WORK PLAN / MONITORING ARRANGEMENTS
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Any deviation from compliance with this action plane must be referred to the MHPS Case Manager immediately.

SIOBHAN HYNDS: (Inaudible). I suppose we are having the meeting today to set out to you what that framework looks like, so it is just reassurance then there's a compliance with the proposed framework. If you were in and out (inaudible).

MR O'BRIEN: I didn't realise since the immediate exclusion was lifted that that was an issue. [redacted] I felt freer to go to the hospital when --

SIOBHAN HYNDS: When it was lifted.

MR O'BRIEN: -- lifted.

SIOBHAN HYNDS: Mr O'Brien, I would ask you to take nothing other than -- away from that other than for your own safety and protection around this at the moment in terms of any further concerns. It was just to say to you to flag it.

DR KHAN: Right.

SIOBHAN HYNDS: In terms of concern 1 and untriaged referrals. That's basically the proposal in terms of they must be actioned in triage for any referrals for which you are responsible. This will include letters received via the booking centre and any letters that have been addressed to you and delivered to your office. It must be ensured that secretary records receipt of them all on PAS and then they must all be triaged. The on call week commencing on the Thursday, for seven days, so then all triaged referrals for that week that you are on as urologist of the week must be completed by 4.00 on the Friday when your consultant of the week ends. So that's a Trust --

DR KHAN: Within that period. But when do you think you will be -- or do we know when Mr O'Brien will be consultant of the week?

SIOBHAN HYNDS: I don't know that.

DR KHAN: So that will be something --

SIOBHAN HYNDS: That's once every six weeks, isn't it?

MICHAEL O'BRIEN: That might be something you want to consider in the job planning.

MR O'BRIEN: Yes. I think -- can I discuss this whole issue.

SIOBHAN HYNDS: Of course.

MR O'BRIEN: You know, this is the issue that was raised in the SAI.

DR KHAN: Yes.

MR O'BRIEN: And I find it remarkable because when I was replying to the SAI, which I did comprehensively, I didn't appreciate until I went through some other documents and minutes that I had held -- I, as lead clinician of MDT, I convened a meeting, a business

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meeting. I would have held monthly business meetings, particularly in the earlier part of the year. And this was in March 2015 I convened a meeting, which I think then took place on 2 April 2015 to discuss the triage of red flag referrals because I was aware that people were triaging them in different ways.

The assumption that I had had as lead clinician is that we are all doing advanced triage of red flag referrals, which mean that you look at all the details on ECR and if you reckon that someone with haematuria should have a CT urogram, followed by a flexible cystoscopy you organised it and you communicate with the patient and so forth.

So I held a meeting to get uniformity on this. I couldn't get agreement for advanced triage of the relatively small number of red flag referrals because, and I have it on record, it was too time consuming and there wasn't enough time with all of the other duties and responsibilities of urologist of the week to be doing is it.

And I -- you know in recent months, to my great regret and I tried to resist it, the urologist of the week has become fragmented. Some of my colleagues found it too onerous due to sleep disturbance, sleep deprivation ~~vacation~~ to do a whole week.

DR KHAN: Okay.

MR O'BRIEN: And I really do believe that the issue -- personally, if you want my view, I believe that it was an unfortunate association that the triage for letters was to be a duty allocated to the urologist of the week to be done whilst urologist of the week. And I personally believe that indeed all referrals should be triaged -- as you heard Colin Weir saying he can do 100 in an hour. I would argue that if a 100 can be done in an hour in any speciality, it shouldn't be a consultant that would be doing it. It could be a clinical nurse specialist that's doing it. I think it is a very, very serious issue that needs to be discussed within a department. That was one of my suggestions in my response to the SAI report.

I think this is a very serious issue and I do believe that when you are urologist of the week sometimes it can be so onerous that I have ended my 'urologist of the week', week at times without being able to get all of the red flag referrals done during that period and doing them the following weekend, particularly if I was doing advanced triage, which I have always done because I felt it was better.

So when you are looking at non-red flag referrals, they are generally speaking four times the number of red flag referrals, and you have a body of consultants who have stated on record that they didn't have the time to do all of the red flag referrals by advanced triage, I still maintain that this is an issue that needs to be discussed and whether there is another method of dealing with particularly the non-red flag -- I think personally, my own view is that red flag referrals can be done as a urologist of the week duty and four times

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that number of non-red flag referrals is something that we as a department should really reconsider as to when is the most appropriate time to be doing it and to have some kind of reasonably allocated administrative time to be doing it.

DR KHAN: This could be a part of the learning from this process that and your colleagues, if the whole team is of this opinion, then there must be something wrong with the system.

[redacted]: I think the only reason I raise that (inaudible) is that we are talking about making sure that patients are protected and dad is protected too. If it is the case that the completion of effective triage during the week when you are urologist on call has been either unfeasible or stretching them so far that it just cannot be done, then making it a strict commitment that you are just going to do it all can end up defeating the purpose ~~(inaudible).~~ Obviously you want to make sure that (inaudible) comply with but there is a live issue about whether this is reasonably compiled with.

MR O'BRIEN: I have seen John O'Donoghue sitting at 11 and 11.30 at night, after a long day sitting in the Thorndale Unit, triaging non-red flag referrals when he should have been in his bed in case he was called out at 3 o'clock in the morning. That's the reality.

SIOBHAN HYNDS: (Inaudible) the bit that is may be missing in the middle of that, and I'm not undermining anything that you saying there, the process that you have to follow to get to the point where that is then changed. Okay. So, you know, because if people continue to do and continue to do, then they will continue to do it. If there is an actual issue with the system that is in place, then it needs to be collectively raised and discussed and ~~(inaudible)~~bottomed out with agreement at a senior level in terms of what that change is going to look like.

Our understanding is that there are elective access targets that are departmentally set that have to be met in terms of triage. This is what this is in line with. Okay. And that is what is expected and that is why the consultants are asked to follow that and (inaudible) the timescales.

[redacted]: ~~(Inaudible)~~I don't think there is a dispute about whether the triage should be done within certain timescales. It is a question of whether it is the doctor as the urologist of the week should be doing it.

MR O'BRIEN: Absolutely.

DR KHAN: I suppose the answer to that is, I know because I have my teams and we have some systems changed because of the whole team coming up, so that the expectation from one consultant is the same as the other three or four consultants. So it is the whole system. If you feel that this is something that needs to be changed and it is part of this learning, and the whole team is saying the same thing, then if it is changed for -- the whole team will

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change all that.

[redacted]: Can I suggest that (inaudible) consider is that as part of the concern (inaudible) there should be a meeting of the clinicians involved (inaudible).

MR O'BRIEN: ~~(Inaudible).~~Early. That can be something that should be considered ~~-~~as a component of a new job plan as well.

DR KHAN: Yes. A job plan should be part of that and that is why the job plan is at the top of everything. That you have the job plan. If it is felt that, yes, in your job plan there should be not part of your job plan. That is fine. But because this is the arrangements -- monitoring arrangements which we are talking about.

SIOBHAN HYNDS: And this is the established practice that's currently there for the consultants in urology. So, I mean, this is in line with what is that current practice.

[redacted]: I understand.

SIOBHAN HYNDS: So we are starting at that point. If there are changes (inaudible).

MR O'BRIEN: Except for the fact that I did say two years ago that it was impossible to do but, you know something, it just wasn't listened to.

[redacted] I guess all I am saying is that --

MR O'BRIEN: And the reality is that the reason why this is an issue is because it was impossible to do and then in the non-urologist of the week weeks, when you are working electively, and you are doing additional, all of the additionality that I have already referred to, there just wasn't the time.

[redacted] I think I just want to suggest that there is a meeting to consider (inaudible) triage within, say you've probably got six weeks, you think, you're urologist of the week at the end of March?

MR O'BRIEN: Yes.

[redacted]: It doesn't come up until the end of March, so there is time to do that.

SIOBHAN HYNDS: There is time (inaudible).

MICHAEL O'BRIEN: Just note that.

DR KHAN: So we obviously we need to be making sure that we are not changing every system. The system is there. There is one system which is implemented for all consultants. Same as in my team, it is every consultant is the same -- doing the same when I'm on call (inaudible) week I'll be doing the same thing as any other consultant. So if someone is requesting it should be changed to me, if I am saying it is changed to me, the other consultant will come back and say it should be changed to me as well.

[redacted] Are you (inaudible) should be changed for you?

DR KHAN: It's the whole system change. And if a whole system change could be part of this

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whole, you know, there is obviously the first issue was the referrals and you are saying you have discussed it with the team and body of evidence and body of consultants saying that this is -- should be out of --

MR O'BRIEN: They didn't have time to do advanced triage, which literally just means that if you've ~~r~~ 20 red flag referrals in a week -- I've forgotten the number that we receive, 1400 I think per year -- that if you receive 20, or whatever it is, that they didn't have the time whilst urologist of the week, right, to get onto (inaudible) management and organise the CT and lift the phone and say I am doing this. They didn't have time to do it. But apparently have the time to do 80 altogether or 100 altogether. Right. And there are different ways of doing that because I have seen it~~there~~. There is the Colin Weir way.

[redacted]: (Inaudible).

MR O'BRIEN: And I proposed two years ago that we shouldn't be doing the non-red flag referrals at all at any time, when it was something that could be done by a clinical nurse specialist, and what we should be doing I thought was a reasonable duty as urologist of the week to be doing in as comprehensive and optimal way as possible the red flag referrals, but, no, they didn't have the time to do it.

SIOBHAN HYNDS: And ~~(inaudible)~~ are the other urologists of the same view in terms of that?

MR O'BRIEN: My colleagues didn't -- I couldn't get agreement for advanced triage of red flag referrals whilst urologist of the week because it was too time consuming and there wasn't enough time to do it whilst being urologist of the week.

DR KHAN: Okay. So there is some disagreements within the team as well? Okay. Going back to the point of there is a system in place and obviously there are two ways of doing it. Change the system for everyone and that would be if that is coming up as learning from this process. That's -- it is going to be for you on your own you can discuss this issue as your job planning meeting.

MR O'BRIEN: Yes.

DR KHAN: You have an opportunity that you can discuss it at your job planning meeting that you feel that this should be considered as part of your job planning and that could be done purely for that. It may be the case -- I don't know how they are going to arrange for that or who is going to do that, and we haven't got to that point of -- we did ask Colin Weir as clinical director to have this arrangement that your job planning would be completed before or in first few days of your starting of the job.

[redacted]: I just don't want it to lead to a situation (inaudible) end up not being able to (inaudible).

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DR KHAN: Yes.

SIOBHAN HYNDS: And I suppose that's the point (inaudible). That would be the point I would make very firmly to you. If you get back to work and you are in this system and you are working there and other things are being discussed and changed, flag that at as early a stage as you possibly can and keep flagging it to your -- the worst thing you can do -- like to your line manager.

DR KHAN: There's an escalation policy for raising (inaudible).

[redacted] Mr O'Briens son: In this context (inaudible).

DR KHAN: No, I mean for this and I know because I have four CDs -- five CDs under me and if there is a consultant who is raising something to line manager, which is the clinical director, next level, if it is not coming to that, they will come to me. I have open access for this as well. We have clear established rules that if this is not raised in this period of time (inaudible). I have already said to my team, if it is not resolved at my level, then go to medical director because that is the route. So there has to be clear roles and responsibilities and that should be addressed. Sometimes it is not strictly adhered to but obviously this is what it needs to be. What you are saying, Mr O'Brien, if you feel that you come back to work and you feel that, no, this is not right. Raise it. And escalate it as you go along. There is a medical leadership line manager structure which is the same as, you know, consultant to -- if there is a lead clinician. If there is no lead clinician, clinical director, (inaudible), medical director.

[redacted] Mr O'Briens son: It is interesting, it's in his appraisal. I know you mentioned (inaudible).

DR KHAN: (Inaudible).

[redacted] Mr O'Briens son: (Inaudible) last appraisal "whilst urologist of the week I do red flag referrals". I think it is in the (inaudible).

DR KHAN: You will be glad to know that we are, and I have advised that as case manager I would like to look at the appraisal process as well. If it was addressed in your appraisal, what was done. So you have addressed that in your appraisal?

[redacted] Mr O'Briens son: (Inaudible).

MR O'BRIEN: It is just in writing (inaudible) I just stated the duties that I undertake whilst urologist of the week and I just said "I triage red flag referrals."

DR KHAN: That's fine, so it will be looked at as part of this process. If it was addressed, at what levels it was addressed, why raised, why it wasn't addressed. So moving on, if you happy with that, next one.

SIOBHAN HYNDS: Number 2 is fairly easy in that don't remove any records off Trust

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premises.

MR O'BRIEN: Okay. If I am returning to do Armagh and South West.

SIOBHAN HYNDS: I knew that was going to be -- anything tracked out to you -- and that's why this next bit was in there -- anything tracked out to you, Mr O'Brien, should be for the shortest time possible for the requirement of you to treat a patient. Okay. So part and parcel of what we will look at, and particularly obviously with the notes that we still need to bottom out in terms of those 13, okay, but you need to be satisfied that if there is something tracked out to you that it is immediately back and therefore then it's not with you anymore or --

MR O'BRIEN: How do I do that?

SIOBHAN HYNDS: What's the process for things being tracked to you? What is your --

MR O'BRIEN: You tell me. I mean, you've charts tracked out to me from the 1980s before I became a consultant. You tell me.

SIOBHAN HYNDS: When were those returned?

MR O'BRIEN: Mmm?

SIOBHAN HYNDS: When were those returned?

MR O'BRIEN: What was?

SIOBHAN HYNDS: When you have a chart tracked out to --

MR O'BRIEN: I tell you the bottom line is. I do an Armagh clinic once a month usually, hopefully, on a Monday morning. It is the only day in the month when having done a clinic I hopefully will still not go to Craigavon for any reason. So I would dictate on those in the future on the Monday afternoon. I'll take them in on the Tuesday morning.

SIOBHAN HYNDS: Absolutely and have them returned --

MR O'BRIEN: With regard to South West Acute hospital, actually it is a very, very onerous clinic because you leave home at 8.30 in the morning. You arrive there before 10 o'clock. The first patient starts at 10 o'clock. You see eight in the morning and eight in the afternoon, ending at 5 o'clock. Now, because I am a bit of a soft touch, I've often gone to see patients on the ward after that and. I have seen members of staff after that. Then you can leave the hospital at 6 o'clock and you get home at 7.30 and so forth.

And what I would propose in the future, as actually before all of this happened, one of the things I would have done is a day surgical list on a Tuesday morning. I have said to Michael Young I am not doing any day surgery on the morning after I have been to South West Acute hospital. What I am going to propose instead actually is I am not going to have any duties on the Tuesday after I have been to South West Acute hospital, which happens once a month, should that be annual leave, and I will process them all that day.

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[redacted]: (Inaudible) where should the patient -- they just stay in the South West --

MR O'BRIEN: No, no, they come -- oh, no, I'm -- if the Trust insists, I will sit then for two hours or whatever and do them in South West Acute. You see, Martina Corrigan usually, but sometimes myself if they were late in getting them all together on a Friday, and sometimes they didn't get them altogether, I would have taken. But usually Martina took them in a box to home. Delivered them on a Sunday. And then I would take them back to the hospital.

One of the things I haven't even dealt with is this thing about all of the South West Acute hospitals, is that, you see, I would have come back on a Monday evening and one of my first tasks then was to sit down and start to organise the operating of the following week. One of the legacy issues is, you know, the length of time that it takes to review 280 people. I don't do that every -- I do that once a month and get -- and ring up people and organise their medication for coming in and so forth. And then when after I would have done that, I would have taken the most important people that I had seen at a South West Acute hospital who needed an operation or MDM discussion and I did all of those. So that in the ones that were returned, the 115 charts that were not processed from the South West Acute hospital, the other 62 per cent of those patients had all been dealt with.

DR KHAN: Can I suggest something? As part of your job planning that would be an opportunity and I would suggest even not to start doing South West to start with. It seems to be a quite busy clinic and there seems to be not enough (inaudible).

MR O'BRIEN: The only thing I would say about that is -- anyhow, it is all to be going scheduled you up until 13 March, so I would imagine -- and if I'm on call there may not be an opportunity in March. But I can tell you I had three months of highly selected ~~difficult~~ patients to be reviewed the first three months of 2017. And two clinics have gone already.

DR KHAN: Yes.

MR O'BRIEN: And these are cancer review patients and so forth, as a result of all of this~~.~~ ~~(Inaudible).~~

DR KHAN: I am just trying to -- maybe you need to balance that (inaudible) what is your requirements for the service and what is best for you as well, and sometimes you need to keep the balance. It seems like if you are seeing, whatever, six, seven patients or eight patients in the morning and in the afternoon are you getting enough time for doing -- ideally what I would like is that you by the time you have finished your clinic you have done your dictations. So that you are not --

MR O'BRIEN: That's not possible with that number.

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DR KHAN: That's what I am saying. Either reduce it down the numbers. If you have to do that clinic, reduce it down. That's an opportunity that you need to discuss in your job plan.

MR O'BRIEN: There's another way of doing it as well you see, and that is -- I mean I have read in that article that I was talking, the ENT clinics, there is a strong argument for having a separate time for administration. To take administration out of the clinic time altogether. So one of the merits of doing something the following day is that their PSA from the day before is already available.

DR KHAN: No, that's fine. I am just suggesting that perhaps you may consider maybe reducing your in-patient number. Maybe having a time -- admin time the next morning and some of those decisions needs to happen at the job planning meeting. But what you need to do, to ensure that you have sufficient time traveling and doing all that and all that and also admin and dictations because that's one of the -- well, possible suggestions would be that that the dictation are completed at the time of the clinic. And if that is the case, then Mr O'Brien requires or needs some time --

SIOBHAN HYNDS: Time (inaudible) for that.

DR KHAN: -- built in into the clinic for dictations.

[redacted]: This is point 3?

MR O'BRIEN: No, point 2 still.

[redacted]: No, (inaudible).

MR O'BRIEN: Right. Okay.

DR KHAN: It probably links to point 3 which is no outcome form -- okay. So the clinic must be dictated at the end of each clinic/theatre session via digital dictation. And if you are saying it is not going to be possible in the clinics, which are up in south Tyrone -- up in different places, the satellite clinics

MR O'BRIEN: Does it have to be digital by the way? I haven't used digital dictation yet.

SIOBHAN HYNDS: You haven't used that? Okay.

MR O'BRIEN: I'm still using tapes.

DR KHAN: There is some sort of training going to be.

SIOBHAN HYNDS: Yes, that's my understanding for the most efficient way of doing that.

[redacted]: It is fairly straightforward.

MR O'BRIEN: Except I can't do it from home that's the thing.

DR KHAN: I am just thinking why should you do it at home? Just that point of why do you have to do it? When you are home, you shouldn't be doing any work.

SIOBHAN HYNDS: When you're at home --

DR KHAN: When you're at home you shouldn't be doing dictations at home. But like, look,

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this is me just saying there should be --

SIOBHAN HYNDS: (Inaudible).

[redacted]: Is not possible to do digital dictation through a laptop, the Trust laptop that you have?

MR O'BRIEN: I don't know.

[redacted]: Is that not possible?

DR KHAN: I don't know. I think those machines (inaudible) connected to (inaudible).

[redacted]: (Inaudible) digital file just gets sent on to whatever secretary (inaudible).

DR KHAN: Yes. I am sure there must be a way of doing that.

MR O'BRIEN: It says here. It says on his Trust laptop.

DR KHAN: Yes, but the Trust laptop whether it is connected to --

MR O'BRIEN: I am connected by remote.

SIOBHAN HYNDS: But I suppose the point Dr Khan is making is that your work from home really shouldn't be happening now. Your job plan should take account of all the time you require, including for dictation or any other admin for your clinic, which leaves you where that isn't required of you at home. That's ideally where we would like to be. So anything we can reduce in terms of what you are doing at home is best.

DR KHAN: This is just me suggesting something. I am not doing your job planning anyway. So it is something that may not be possible or whatever. But I think ideally you would like to be in a position that when you go home you just go home.

[redacted]: It wouldn't be so bad.

DR KHAN: So being at home really ~~(inaudible)~~ rather than doing all that.

MR O'BRIEN: But that's how it used to be before remote access and when I -- that meant I never got home before 10/11 o'clock at night.

DR KHAN: So, again, the consideration should be given at the job planning meeting what is the right number of patients for you, especially those full-day clinic. That you should be able to complete your patient -- related admin or dictations at the clinic or (inaudible) to that. And you will know better and you should be discussing that at your job planning meeting.

[redacted]: So far as we leave today, I realise ~~(inaudible)~~it will be the subject of job planning, and that may change things, is it being said today that every clinic should be dictated by the end of the clinic? (Inaudible).

SIOBHAN HYNDS: That's essentially what we --

DR KHAN: That's what we (inaudible).

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[redacted] It's requirement of the return to work?

DR KHAN: Yes.

MR O'BRIEN: I can tell you like, see, on the Monday morning when I do an Armagh clinic and you could be finished at like 1 o'clock. That's without dictation. And the dermatologist, I think it is, is standing outside waiting to move in. You haven't time to do it.

SIOBHAN HYNDS: ~~(Inaudible)~~ well you need to ensure you are finished at 12.15 or 12.30 or whatever.

MR O'BRIEN: But in reality that doesn't happen because --

[redacted]: (Inaudible). What's (inaudible) that can be -- it is subject to a job plan, which you would approve as well, by making sure that the job plan actually meets your requirements as well. Because it may well be that job planning throws up something that we're not considering.

DR KHAN: Job planning is a separate process and it is -- it also means that job planning nowadays it's an agreement between the clinician and the line manager. So as Trust and clinician we all have job plans and if I don't agree there is -- so it means that if I don't agree what the Trust is asking me there is a process to that.

[redacted]: What I am saying is, for example, (inaudible), but dad was saying about the possibility of doing dictation for the Monday clinic on a free Tuesday morning for example. if that were to come out of a job plan because he had PSA, whatever that means, (inaudible).

MR O'BRIEN: No, SPA.

[redacted]: I don't know what means either.

DR KHAN: Supporting Professional ~~Administration~~ Activities(Inaudible).

[redacted]: If that can be agreed in the job plan then that -- but technically that break (inaudible).

SIOBHAN HYNDS: We can adjust that if that's necessary.

[redacted]: You can adjust that. So (inaudible).

MR O'BRIEN: I must say my preference would be, irrespective of whether it is by tape or digital, that for those outreach clinics, I know reality is different from a job plan and that is that you can leave Armagh, go home with the charts, dictate by tape or digital, whichever is the preference, and take them in the following morning. And equally well the following day after the South West acute hospital clinic. Otherwise.

[redacted]: They would have to think about that because you are not bringing files home ~~(inaudible)~~

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MR O'BRIEN: Well, I don't know then.

DR KHAN: I can be how the charts are transferred.

MR O'BRIEN: We take them all. We take them back.

DR KHAN: Yes.

[redacted]: So generally speaking would you suggesting that after you finish Enniskillen at 6 o'clock you would have to go back to Craigavon from Enniskillen.

DR KHAN: No, you shouldn't be travelling back to Craigavon for that. Why would you need to go back to Craigavon.

[redacted]: Because otherwise the files would be coming home.

SIOBHAN HYNDS: The files ~~(inaudible)~~I am assuming are travelling in the boot of your car?

MR O'BRIEN: Yes.

SIOBHAN HYNDS: I mean, and possibly what we need to look at (inaudible) is the transfer of the files and (inaudible).

DR KHAN: I would suggest that the files -- we just need to make an arrangement for these file transfers.

SIOBHAN HYNDS: They just come back.

DR KHAN: Transfer these charts. It shouldn't be you. Your responsibility -- you shouldn't be the responsible person to take charts with you and returning the charts. The Trust's responsibility is to provide you with the chart when you do the clinic.

SIOBHAN HYNDS: I understand there is a process in South West (inaudible).

DR KHAN: There is a process. We all do when (inaudible) clinic. When I do clinic in wherever I receive the charts there when I go there. Yes, there are sometimes hiccups first thing or whatever, but it is the Trust's responsibility. It shouldn't be yours that you take the charts with you in the boot of your car. Because taking any patient's confidential information with you is you are taking the responsibility essentially. Ideally you shouldn't be.

[redacted]: I just want to make sure you're not in a situation where you are breaching one of these requirements (inaudible) you are doing (inaudible).

MR O'BRIEN: Yes, but it is logistical things. It means that -- I know particularly at the end of the Enniskillen clinic, where very often I have done that entire stretch without anything other than a cup of coffee, that, you know, you're tired at the end of it. To sit down and then dictate on 16 patients after that and -- it's a strange place actually because there a kind of.

DR KHAN: (Inaudible).

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SIOBHAN HYNDS: (Inaudible).

DR KHAN: -- to give you an hour or something so that you can do dictation. And afternoon clinics should also give you some sufficient amount -- appropriate time at the end of the clinic that you will be finishing.

[redacted]: So you just need to look then at the logistics of making sure those files are being transported back to the appropriate premises.

SIOBHAN HYNDS: I am quite happy to ask at a senior level within acute services how we will do that logistically for you.

[redacted]: You can have them brought to your office for a Tuesday morning. If that were there ~~(inaudible)~~to be arranged if there was something additional to be done. I don't know.

DR KHAN: So I would suggest that you shouldn't be taking the charts with you. The charts will be available to you when you are doing the clinic and you shouldn't be responsible for the charts because that's one of the issues -- one of the concerns were the charts. So I would suggest that this should be looked at (~~inaudible)~~and the Trust are to provide charts to clinicians (inaudible).

MICHAEL O'BRIEN: (Inaudible) charts in the home.

DR KHAN: It could be sitting there and then someone (inaudible) take the chart (inaudible).

[redacted] Okay.

DR KHAN: We need to work around that.

[redacted]: Just the logistics.

DR KHAN: Logistics.

[redacted] That's fine.

DR KHAN: (Inaudible).

[redacted] In principle there's no difficulty with complying with any of that. You need to sit down and work out how that actually works in practice.

DR KHAN: And also the clinic dictation. So you were supposed to do clinic dictations in the clinic then you need sufficient time.

MR O'BRIEN: There needs to be then a significant reduction in the total number of patient to be seen.

DR KHAN: It has to be, that's fine. At this stage, Mr O'Brien, you need to be careful what you are taking on going forward. So you need to be, yes, there are requirements for patient care and everything else as well, but the balancing situation is that you need to be making sure that you are protected. You are safe going forward. Look, as a case manager I will recommend whatever needs to be done from the Trust point of view. The Trust should

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support you to ensure you are doing -- you are protecting yourself. You are doing your clinical duties but you are protecting yourself as well. I think it is fair enough doing that.

SIOBHAN HYNDS: (Inaudible).

[redacted]: Okay.

SIOBHAN HYNDS: And number 4 is --

MR O'BRIEN: Before you leave number 3. "All clinics must be dictated at the end of each clinic", that is what we have been discussing "or theatre session". Is theatre session very much intentionally in there?

SIOBHAN HYNDS: I suppose what we want to -- yes.

MR O'BRIEN: What do you mean by theatre session?

SIOBHAN HYNDS: Not losing sight of what is this about, this is about making sure that when you treat a patient the dictation is done. Okay. So that we don't have undictated~~declared~~ outcomes at any point in time.

MR O'BRIEN: But I don't take -- you see, I just want to clarify. There are some people actually would dictate a letter if they shook hands with you. And I actually disapprove of the letters that some people dictate immediately after they have operated on someone, which very often says Mr O'Brien had his prostate resected today and will have his catheter out tomorrow and will go home. And then he's still there five days later because he hasn't been able to have his catheter removed and you look at the inappropriateness that was sent. So I don't. So I just want to make sure that there's --

SIOBHAN HYNDS: My understanding from trying to gather some of this together is that at the end of each patient assessment or contact there should be something formally documented in terms of what happened, whether that is a referral on, whether there is no further action --

MR O'BRIEN: That's on an out-patient basis. Not on a theatre session.

SIOBHAN HYNDS: Okay. So what is a theatre session? What would you be --

DR KHAN: So documentation (inaudible)?

SIOBHAN HYNDS: Documentation (inaudible)?

MR O'BRIEN: You just do an operation note.

DR KHAN: (Inaudible) documentation should be sufficient.

MR O'BRIEN: Yes. You don't dictate letters after a theatre session. Except for day surgery I always do, because the patient has been admitted and going home immediately after the procedure.

DR KHAN: We will need to have some adjustment here to say for clinics but for theatre session, documentation?

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MR O'BRIEN: Yes.

DR KHAN: All dictation as appropriate.

MR O'BRIEN: You see, an elective in-patient theatre session the person is going to have a discharge notification done.

DR KHAN: Yes. It is a day surgery, yes.

MR O'BRIEN: Yes.

DR KHAN: Okay.

[redacted]: Okay. Happy with (inaudible)?

MR O'BRIEN: (Inaudible) at the end of every clinic. I still have concerns about that. I have no difficulty with clinic with outcome forms and all of that there. The irony is I introduced them to Craigavon hospital.

DR KHAN: What, sorry?

MR O'BRIEN: Clinic outcome forms.

DR KHAN: Okay.

MR O'BRIEN: "An outcome planned record of each clinic attended must be recorded for each individual patient. This should include a letter."

This is an interesting point. Is the letter always required?

DR KHAN: Should a letter for any patient that did not attend. Sorry, what letter?

MR O'BRIEN: Oh, "For any that did not attend, as there must be a record." I see. But for those people who did attend, is a letter always required?

DR KHAN: Well, from -- the letter to -- communication required. Some sort of communication to the multi-professional team or whoever is going to look after them. I guess that's part of our GMC requirements. That we need to communicate to a multi-professional team for our patient encounters. If you feel this is -- that this is what you are going to do and you are informing GPs, you always do that, inform GPs what is going to be -- what has done or what my plan is~~(inaudible)~~ and things like that.

[redacted]: Is that not what the clinical outcome form is for?

MR O'BRIEN: No, a clinical outcome form is for the Trust and for the secretaries to implement whatever.

DR KHAN: (Inaudible).

MR O'BRIEN: Yeah. But, for example, if I did see someone at urodynamic studies and they have a hypersensitive bladder and I arrange for them to be admitted for hydrostatic dilatation in a month's time, I traditionally would have combined those in one letter after the hydrostatic dilatation. I think -- I didn't know actually, and I am just asking, is there a requirement that you dictate a letter after each patient attendance?

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DR KHAN: It's a general requirement from GMC point of view. My understanding is, correct me if I am wrong, that we need to have a communication --

SIOBHAN HYNDS: You need to have some record ~~(inaudible).~~

DR KHAN: -- going out to multi-professional team once we have an encounter.

SIOBHAN HYNDS: Yes. So after every patient contact there has to be a record of what that contact was. So even if it is just I am referring them on in a month's time that's fine.

MR O'BRIEN: Okay.

SIOBHAN HYNDS: Okay. And this is just adherence to Trust private practice policy.

MR O'BRIEN: Can I ask actually? This report of these nine patients, the nine patients have yet to be identified to me, where did this report come from or who reported it and what's issue or how did it arise?

SIOBHAN HYNDS: Within the directorate I understand, within the Acute Services directorate, and it has come to us as part of this investigation. Who specifically I don't have that information for you at this stage. I would certainly provide that to you at the point when we put the concern to you when we have gathered all of that. I don't have it. But I know it was raised within the service.

MR O'BRIEN: It's remarkable.

DR KHAN: But I suppose going forward, the private practice policy I am sure you have some sort of information or you have looked at that Trust private practice policy. What really this is about is just to, you know, to adhere to the private practice policy really for the Trust.

SIOBHAN HYNDS: And the second part of that is about scheduling of patients. I know this has been a change in some other areas as well across the Trust. Scheduling patients then must be undertaken by a secretary who will check the list with you and then contact the patient as opposed to maybe the consultant themselves doing it. So that's in keeping with the established practice within the urology team is what I am led to understand. Is that not right?

MR O'BRIEN: Well, totally foreign to me. I do -- this scheduling of -- just go over that again? This is aside from the private practice. You're saying to me actually that my secretary would be scheduling my in-patient --

[redacted] (Mr O'Briens son): Private patients?

SIOBHAN HYNDS: A patient you would see as a private --

MR O'BRIEN: Right. Okay.

SIOBHAN HYNDS: -- and then is coming onto the NHS --

MR O'BRIEN: Yes.

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SIOBHAN HYNDS: -- list that's scheduled by your secretary, the list is checked with you and then contact made for their appointment.

DR KHAN: (Inaudible) admitted.

SIOBHAN HYNDS: As any other NHS patient.

[redacted]: (Inaudible).

DR KHAN: It is NHS patient, basically. It is nothing to do with your private patients. So if a patient who is coming back as an NHS patient, it has to go through the NHS patient route essentially.

MR O'BRIEN: Yes, but the NHS patient route is then determined by me.

SIOBHAN HYNDS: Yes.

MR O'BRIEN: Not by my secretary.

DR KHAN: Yes. ~~(Inaudible)~~it will be determined by you obviously. If you have seen a patient as a private patient and then that patient is coming back as an NHS patient, you just give it to -- look, this is an NHS patient, can you book it to my list, NHS clinic.

MR O'BRIEN: You mean you put it onto my list.

DR KHAN: Yes.

MR O'BRIEN: Yes.

MR O'BRIEN: My waiting list.

DR KHAN: Your waiting list. Yes, just waiting list.

MR O'BRIEN: I thought for a moment actually that you were going back to those days when there were schedulers scheduling the next operating list.

DR KHAN: No. (Inaudible). I suppose it's going back to -- I suppose what this is all about is just stick to the Trust private practice.

MR O'BRIEN: But the allegation is that there is a complete ignorance of clinical priority.

DR KHAN: Again, that's going back to -- the purpose of this is going forward, I suppose. This is going back. We need to lo~~o~~ek at -- obviously you don't agree with this allegation. We need to look it as part of the whole process.

SIOBHAN HYNDS: It is (inaudible) private patients who (inaudible).

MR O'BRIEN: It's not that I don't agree. I don't even know who the nine patients are. I would bet my bottom dollar that the person or persons who has made this allegation would have no idea whatsoever how distressed or otherwise or severely these patients need their TURP~~urp~~s done. I would bet equally well they have no interest in how many other NHS patients waited a significantly shorter time than other NHS patients.

[redacted]: (Inaudible).

MR O'BRIEN: And why it should be added in I find somewhat a deviation from the formal

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investigation in the first instance because it wasn't even an issue.

DR KHAN: Okay. That's part of the other process I suppose. What I can -- today we can say, look, going forward, look at Trust private patient policy.

MR O'BRIEN: I have looked at it. I have read it several times.

DR KHAN: Good.

MR O'BRIEN: Before this.

DR KHAN: Right, okay.

MR O'BRIEN: But as I was saying to Colin Weir, in our emergency theatre, in the old emergency theatre, there was a book and there were three clinical priorities: emergency, urgent and private.

DR KHAN: Okay.

MR O'BRIEN: And I asked the question, why is private a clinical priority? Of course it's not a clinical priority at all. ~~A p~~Private patients die. Private patients are emergencies sometimes and urgency sometimes. Only when that was raised by me did they eliminate it.

DR KHAN: Yes.

MR O'BRIEN: But that is -- this is here a fall-back by someone on that old-fashioned idea that private means something else.

DR KHAN: Okay.

[redacted]: (Inaudible).

DR KHAN: Fair enough. So you're happy with this arrangement?

MR O'BRIEN: Yes.

[redacted]: If there's any --

SIOBHAN HYNDS: Obviously you need to read through that and I mean if there's anything we've missed or (inaudible) that's absolutely fine. We would certainly (inaudible).

[redacted]: I think it's important (inaudible) to try to have a meeting just about this.

SIOBHAN HYNDS: Yes.

[redacted]: The other issues because then you -- it would take you ~~(inaudible)~~ longer to go through all of other issues and there's not -- none of them are particularly prioritise. We have provided a document to --

MR O'BRIEN: John Wilkinson.

[redacted]: John Wilkinson (inaudible) the last day, not least the timeframe and so on and all of that (inaudible). But (inaudible) here all day.

SIOBHAN HYNDS: I mean, I suppose just an assurance to yourselves, those will be

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considered in full and obviously responded to once they have been considered in full. So today was just about trying to deal with this in terms of getting you back to work and they can all -- that can be looked at. If that changes any of this, then that's fine. We can look at that as well.

[redacted]: Yes. No, that's okay. I think I just -- we've asked questions about the different points but it's just to make sure. He wants -- we want to make sure that there's compliance with everything that should be complied with. We just don't want to ever lead to a situation where over the next number of weeks, or whatever it is, something arises because --

MR O'BRIEN: Can we have some kind of meeting again on these issues because with regard to concern number 1 on the triage, which we have discussed quite a lot now already today, I mean I have put this on the record, but don't be bother putting on record (inaudible), I do have my concerns clinically that those -- some of my colleagues who did contribute time whilst urologist of the week triaging all the letters it was inappropriate that they did so and that sometimes that compromised the care of patients who should have been receiving the priority. So for me clinically this is an issue. And I would like sometime, maybe, I know, in two weeks' time, or whatever, that we could come back to see if I have been able to have this addressed. I am a little bit -- should I be the person that's addressing this whole issue or should it be addressed as part of this process?

DR KHAN: Yes. Okay. That's (inaudible).

MR O'BRIEN: That's a little bit of bit invidious of me to be going back ~~making~~ looking changes. You know what I mean.

DR KHAN: That's going back to -- there are two elements. To me there are two elements. One is the whole -- the current system. One is the current system in place for something for triage.

MR O'BRIEN: Can this process convene a meeting to discuss triage. (Inaudible).

DR KHAN: ~~(Inaudible).~~ I don't know. I'll be guided by …

SIOBHAN HYNDS: I am not sure this is the process for it. I think, as you say, there are two elements to it. There is one, the existing established process that we have in place at the moment, which is what we have and that's what we need to work to. But then there's a process in terms of, if you are dissatisfied or worried or concerned about that process in any such way ~~(inaudible).~~

DR KHAN: As part of your job plan.

SIOBHAN HYNDS: There is an escalation process through your normal line management channels. Now I know you are indicating to us here today that you feel that you have done

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that on occasions and that hasn't necessarily led to anybody doing anything about it.

I suppose the question for me in my head would be, have you escalated that at any point in time? I would suggest we start with your CD because he is the most appropriate person to and the person with the knowledge around it. Within this system if we were to do anything we have to go back to the clinical director anyway in terms of getting that knowledge.

MR O'BRIEN: So you're saying, in short, I should do it.

SIOBHAN HYNDS: ~~(Inaudible)~~what I am saying is through your line management. Your line management.

DR KHAN: It's a combined process. The responsibility falls on both parties. It is for the Trust and for you. It's that same as ~~seen (inaudible)~~ if I am going through my job planning the responsibility falls on me as the well as the Trust as well. Both need to agree to a position. And if you think as your job planning process you are not in agreement to that, there is a process to address that. So there is an escalation process if you don't agree to that. Facilitation and all those things. There is a separate --

[redacted]: (Inaudible) it's your primary point, the urgent job plan.

DR KHAN: Yes, job planning should address these -- some of these.

[redacted]: At the end of it all, as you appreciate from the meeting we had the last day, ~~(inaudible)~~ fundamentally was, you're saying that he's ended up having to do too much than he can actually do. So it would be concerning that just you, okay (inaudible).

SIOBHAN HYNDS: Back to the same issue again. Yes.

DR KHAN: Yes.

[redacted]: So it all comes back to the that job plan (inaudible).

SIOBHAN HYNDS: Yes, absolutely.

[redacted]: And the only thing that's beyond that is that post job planning and post whatever meetings we are going to have or take place over the next number of weeks, I suggest that the outcome of that may be something we want to consider as part of what concerns have to be complied with.

DR KHAN: Yes.

SIOBHAN HYNDS: And that will all form part of that there (inaudible).

[redacted]: That's fine.

DR KHAN: If you wish we can say here "subject to job planning" on these issues. You know, subject to job planning, that these ones -- you have addressed -- you have raised that triage is nearly impossible so we can put it as subject to job planning for yourself as well.

MICHAEL O'BRIEN: There's a couple of things about this return to work that I just want to

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ask about. The first one is that we obviously have a situation where there's an investigation going into whatever number of patient files. Now, it would seem to me likely to be the case, or it may well be the case, that dad is going to come into contact with those patients or patient files, or it may well be the case. How is that being managed to ensure that there is no suggestion --

SIOBHAN HYNDS: Of any interference by yourself?

MR O'BRIEN: I don't know. That's my concern.

[redacted]: Because he doesn't even know -- because he doesn't what patients there are for example. So how do we -- if you have a clinic and you request the file of a patient who had been at that clinic (inaudible) one of these numbers. How does that ~~(inaudible)~~ work?

SIOBHAN HYNDS: Right. The short answer to that is (inaudible) is that I don't know but I will find out for you. And certainly --

MR O'BRIEN: I just want to be accused of impeding or --

SIOBHAN HYNDS: Absolutely.

MR O'BRIEN: I don't know what that means -- of a formal investigation that in my view should have been completed by now.

[redacted]: Yes. And that was part 1 and the second part is, I have raised with you the last day about -- you have suggested that there's a number of people behind this who are conducting the investigation. We don't know who they are. You don't know whether if you were talking to them about something, does that potentially -- how does that relate to the investigation, enquiring about (inaudible).

DR KHAN: There not many and they are quite senior.

SIOBHAN HYNDS: There are urologists we are having to rely upon in terms of their specialist knowledge about the patient, about the patient care. Okay. So there is the head service that we are relying upon in terms of assisting us with some of the practicalities around how we monitor. There is the assistant director who is again responsible for the operational end of things.

[redacted]: Who's that?

SIOBHAN HYNDS: Ronan.

MR O'BRIEN: Yes.

SIOBHAN HYNDS: And Ronan is again assisting with input to this when we don't have the answers or we are looking for some information or we -- I mean, that will all form part of the -- in terms of being the gathering of the information that we require for the investigation, for example, those will be the key individuals we will have to engage with.

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DR KHAN: On top of the clinical director -- or the clinical director is also the investigator.

SIOBHAN HYNDS: is also involved as case investigator ~~(Inaudible).~~

DR KHAN: So Colin as a clinical director but also the case investigator. So from my point of view I would like assurance from these people that there is a balance going on. There going forward. So these arrangements as you have raised and the other arrangements and job planning and some concerns, and if there is something not going right, what is -- whose responsibility is, so I have asked that question as well. Roles and responsibilities. Because I am sitting here and don't want to be involved in these things. My role as a case manager~~ment~~ is once the investigation is completed, formal or informal, comes to me, that I need to make a judgment on the basis of the investigations. I have no role to investigate and I would like to keep myself out of that.

[redacted]: I guess I am just asking to help us understand how we can make sure that there will be no suggestion of in any way interfering with the investigation itself. And when you have an investigation that is going expansively into administrative practice it can touch on any patients that you have in your care. How do you ensure that you're not in any way (inaudible) but that's tricky I think.

DR KHAN: It is quite tricky but also quite complex as well because there is a large number of patients involved in that and there are going to be. So we need to have a system that these patients (inaudible).

SIOBHAN HYNDS: Again, Colin Weir, I think is key to this. He is the investigator and he's clinical director. He is best to guide on this and we can certainly get him to do that for you.

DR KHAN: Yes.

[redacted]: Okay.

MR O'BRIEN: That is a concern. It is also a concern of mine from the point of view of the patients because there is another reality here and that is that, you know, if I -- if I am not -- if I am quarantined from a whole load of patients and as a consequence they are not going to be reviewed by anybody else, because there's a limited capacity, you know, they're suffering. Like, as I was saying, I had certainly booked up until the first three monthly clinics of 2017 in South West Acute hospital. To my knowledge only two of those patients have been reviewed and there's a lot of people needing to be reviewed. I mean, I think a lot of these 668 patients with no outcomes formally dictated would have been cancer review patients that I would have done updates on Caps, which my colleagues ~~s~~ didn't do, instead of dictating letters, but these people all need to be reviewed. My concern on the one hand is, yeah, I don't want to be accused of anything more. And I have

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another concern that's for the patients themselves.

DR KHAN: Yes. And that's something for the Trust to address. Patients are obviously -- yes, they are your patients but the Trust has to address the other part of your concern that these patients need to be seen. And how they are going to be seen that's -- I think just for the sake simplicity if you leave that for the Trust to decide how they are going to be seen and who they are going to see or how they are going to be reviewed. At this point in time --

MR O'BRIEN: Once they have identified who they are.

DR KHAN: Yes.

MR O'BRIEN: Meanwhile I don't know who they are and I don't know who are the patients that are not those patients. It's impossible.

DR KHAN: Yes, but I am sure they are doing it.

[redacted] If you, for example, have outcomes that weren't formally dictated (inaudible) patient, what happens to the patient? Is there supposed to be a catch up there? Are you supposed to go back and do that now?

MR O'BRIEN: No, you see, these 668 patients that they were referring to they will all have had outcomes done. Outcome forms done. They didn't have a letter dictated. They had an updated done on Caps if they were cancer patients because I did updates on them until April of this last year when I got disillusioned seeing other people not -- never doing it and not doing clinical ~~summarise~~. summaries.

DR KHAN: So from April last year you haven't done the outcome and you haven't done the dictations?

MR O'BRIEN: No, no. The outcomes have all been done.

DR KHAN: Dictations.

MR O'BRIEN: I haven't uploaded updates. Caps is the cancer archival patient pathway system or something. Cancer patient, yes, something like that. And so that's where you --

DR KHAN: Update that.

MR O'BRIEN: You know, those MDM outcome things that you'll see in the front of charts and so forth and they go out in letter format. So I would have done those as updates so that the next time a person is discussed there is a complete linear history throughout. I would have done the outcomes. So the outcomes would have -- so review and whatever for MDM discussion and then that person. So I would have done a report in the third person, you know, patient was feeling well. PSA has gone up or whatever. And then it would have discussed at MDM and then that reportage of that episode would have gone out in letter form.

DR KHAN: Yes.

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[redacted]: Okay. Well it is just I suppose -- (Inaudible).

MR O'BRIEN: But you see the Trust are under the impression that, I think, there must be no outcomes formally dictated on these people and therefore there's no outcomes if you know what I mean.

DR KHAN: That is useful information which can be fed into the investigation. That it's not really that there was no dictation but you did part of that. You did outcome forms and you do that.

MR O'BRIEN: That's another part of the drip feed putting my case. I find that a concern in this whole process. I have to confess it's been such a stressful time and I've been quantifying of all of the additionality since 2012 and I haven't completed it yet. But I just do not know when is the best time to be doing this, because, as you have just said right now, it's very useful to know that because it can -- and when is it useful to know what? Do you know how much more I have to tell you.

DR KHAN: Yes. (Inaudible).

MR O'BRIEN: I'll just give you a snippet. I quantified all of my additional elective in-patient operating. Right. My additional. Over what I was job planned or expected to do. from 2012 through to the end of 2016. And that has required 3.78 additional hours per week.

DR KHAN: Nearly a PA.

MR O'BRIEN: A PA. Probably my administration time. And that's only one activity. I can tell you MDM and what I was previewing, four hours. Another one. Gone. Non-existent in the scam job plan. But I can tell you something, if I hadn't done any of that we wouldn't be sitting having this meeting with me and I feel very angry when it comes to that.

DR KHAN: Yes.

MR O'BRIEN: And for a Trust that has been completely derelict in its obligations to patients by sorting out those disparities. Either they don't know or they just -- this is a Trust that is dysfunctional in a vertical sense. You are talking about escalating up. I have escalated up before and I can tell you horror stories.

DR KHAN: Okay.

MR O'BRIEN: I mean, I remember once sitting with John Templeton many years ago and all of a sudden I realised he was doing you, know, nodding his head. I realised I'd been there before and nothing happens. And then you stop escalating. Because you have done it before.

DR KHAN: So (inaudible).

[redacted]: (Inaudible) Do you have any idea of when you're going to have a meeting with job plan you think in the week or so after?

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DR KHAN: Ideally it should be when you're first back in. That week. That week or the following week.

MR O'BRIEN: I think what I would like to do personally is I think the triaging issue is a big issue. And I -- secondly, moving onto concern number 2, I would like to have an agreement exactly on what -- I don't mind staying over in South West Acute hospital to dictate at the end of a clinic. I see a logistical real life problem with the Armagh clinic because when someone is knocking on the door and you haven't done the last six, what do you do with them? So I can see a real issue there.

[redacted]: (Inaudible).

MR O'BRIEN: And third, the private patient thing and (inaudible). What's the other thing?

DR KHAN: Again, going back to your Armagh patients, I would suggest you discuss that your patients should be reduced, that you should have a sufficient time at the end of the clinic before the finishing of the clinic, so the last hour or 90 minutes, so that you dictate before someone is knocking on the door. So the patient numbers can be adjusted to solve this issue easily. In the same form, South West as well. I would suggest that the Trust needs to make an arrangement for the charts to be transported to the clinic sites and it should be --

MR O'BRIEN: And returned from them.

DR KHAN: And returned. It is the Trust's responsibility, the transporting of charts, and that shouldn't be your responsibility for you to put the charts in your boot. So that makes one of the issues out of the way that you are keeping the charts in your boot or at home or whatever. Just keep that away and so on and so forth. Keep it simple.

MR O'BRIEN: I agree with that.

[redacted]: That's good.

DR KHAN: Those things can be easily -- and this is nothing new. We have done it for this number of clinicians and I've personally done some of the job planning and reduced the number of clinics so the clinician can finish the dictation at the end of the clinic and it's done and over. A number of my clinicians are consultant are remotely -- they're doing satellite clinics. The charts are dispatched in advance or on the day and it's there. And the consultant just does the clinic and go home or whatever needs to be done after that rather than keeping the charts .

[redacted]: (inaudible) better. Hopefully (inaudible) job planning.

DR KHAN: It should be. It should, yes.

SIOBHAN HYNDS: (Inaudible).

[redacted]: That would be the hope out of it all (Inaudible).

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DR KHAN: Hopefully, yes. But look --

MR O'BRIEN: The other thing about job planning is I'll not be doing any additionality again.

DR KHAN: That's fine.

MR O'BRIEN: Ever.

DR KHAN: That's fine. Why would you be doing it? In the first place, why should you be asked to do any additionality when you are -- you should be doing what's in your job plan. That's it. And I would suggest, I don't know what's your current job plan is, and I don't want to go into the details, but is your job plan 10 PA or 12 PA or what?

MR O'BRIEN: 12.

DR KHAN: Okay. Again, something to consider, keep the job plan PAs as whatever you can do. If it is a standard 10 PA job plan you'll get a day off as well in your 10 PA job plan. So again going back to the job planning would be crucial to all this. Why would you like to go back and do a 12 PA or a 13 PA job plan when you can do -- a standard consultant job plan is 10 PA.

[redacted]: That really only works if you have a sharing of the workload and the legacy workload. Remember we talked about the (inaudible) because I think the reality is that -- you know, I am sure you're the same in this. That you do end up as a professional feeling a sense of responsibility.

DR KHAN: Yes, I do it my (inaudible).

[redacted]: And you don't want to be copping off when whenever you have all of (inaudible) and it does weigh on you and that's the reality.

MR O'BRIEN: It was the reality for me. It's not the reality for everybody. I mean, I have colleagues who have no sense of responsibility for the person on the waiting list. And they describe them as a Trust issue, except for the fact that the Trust has never made it an issue for us.

[redacted]: But that's the – job plan (Inaudible).

DR KHAN: (Inaudible). They should be coming to you. Your job plan and obviously we can only do what we can do.

[redacted]: Thank you for doing this because obviously some work has gone into this as well.

DR KHAN: Yes. So you're happy with that in terms of -- is there anything else in your mind which we have not addressed in relation to this?

MR O'BRIEN: Yes, just with return to work, is just -- I think we have raised -- I don't have a concern about -- I am hopefully not a danger to patients. I don't really have concern about concerns being raised against me other than in this rather nebulous domain of impeding the

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investigation and how could that be at all seen to be. And when I met Thomas Jacob last nightweek, you know, in the lift going up to my office and so forth, I think he was going to my office to use it. It never would have occurred to me that that would be considered to be and that I would have to be -- you know. If that can be -- what can that be. That's my concern.

DR KHAN: Yes. I suppose we can move only forward.

MR O'BRIEN: No, but I see it going forward I am talking about it.

[redacted]: You maybe have a think about that particular aspect, because it would seem likely the chances are, over the next number of weeks or months, he may come into a contact with a patient whose file is the subject of the investigation and (inaudible).

SIOBHAN HYNDS: We do. We absolutely do. You know, we are -- you know the four main concerns we have. You know what we are looking at in terms of those concerns. And in terms of how then you return to work and ensure that (inaudible).

MR O'BRIEN: You see, the triaging retrospectively is not a concern from the point of view --

[redacted]: No, it's not that.

MR O'BRIEN: It's not -- yes, it's the charts.

[redacted]: (Inaudible) investigation will happen. No, it's the clinical (inaudible).

MR O'BRIEN: It's the clinics.

[redacted]: (Inaudible) the potential to cross lines (inaudible)

SIOBHAN HYNDS: Cross lines, yes.

[redacted] Yes (inaudible). That's just going to have to be thought about. But at the end of the day you just take your PAs with what you are adding to it and it is dated and you would think that should be fine shouldn't it.

SIOBHAN HYNDS: (Inaudible).

MR O'BRIEN: But what you're talking about here is -- let's say, for example, Siobhan had been the patient in 2015 and I said review in six months. The fact that the Trust can't honour that and it's two and a half years later is not any issue at all but that's just a rhetorical aside. So she comes along and I'm going to reviewing her. Why shouldn't it be reviewing her with a new dictation, a new outcome and if the Trust then wants to retrospectively come to the --

[redacted]: (Inaudible).

MR O'BRIEN: -- you know, look at the fact that she didn't have a letter dictated in 2015 that's not an issue. I just don't know how that's going to be handled. I think it is going to be very difficult for the Trust as an organisation. It's an enormous time consumption. If these figures are real, 600-odd patients who haven't had letters dictated, and they are clinically

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important patients, and, you know, they're not the only patients around that are clinically important. And I am not going to be -- am I expected to look up every person before they come to a review clinic to see whether the previous episode was dictated upon or not.

SIOBHAN HYNDS: I am not sure any of us can answer that. I think what we need to do is put in a place an early meeting with your line manager on your return to clarify all of those points for you in terms of giving you any assurances you need about what you should or shouldn't be doing, or who you should and who shouldn't be managing (inaudible).

[redacted]: (Inaudible).

DR KHAN: We need to work on this to see. We don't have the answer to that but we need to work on this issue.

[redacted]: (Inaudible).

DR KHAN: Yes.

MR O'BRIEN: My only concern in all of that -- my main concern is actually not me but it is for the patients you know. I am just concerned that impedance would be another reason for another delayed review or something of that nature. Anyhow, thank you very much.

DR KHAN: Okay. Thank you very much for coming in. You know, we will see how it works out. So you're planning to come back on the 20th.

MR O'BRIEN: Monday week.

DR KHAN: Monday week. And then obviously in the meantime I will let Colin know that we have discussed that and the job planning has to be upfront from the starting point. Happy with that?

MR O'BRIEN: Mmm.

DR KHAN: So that you'll linking with him anyway.

MR O'BRIEN: Yes.

DR KHAN: And he (Inaudible).

MR O'BRIEN: So if we could job plan during the second week when I've had the time to discuss some of these issues.

[redacted]: (Inaudible).

DR KHAN: Yes, it will be a short week for you anyway. It's 50 per cent in the first week and then 75 per cent in the next week.

[redacted]: You've got that time.

DR KHAN: You have that time in that week.

SIOBHAN HYNDS: Colin Weir as your line manager will also get the occupational health report between now and your return so he will be clear in terms of what your return includes. I would expect, as any line manager would, he will be asking to give you a call

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and to suggest what that looks like first morning and have a conversation with you in terms of what week 1 will look at and what week 2 will look like.

MR O'BRIEN: Okay.

DR KHAN: Okay. All the best.

MR O'BRIEN: Okay. Siobhan, thank you. Take care.

SIOBHAN HYNDS: Bye. All the best.

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Could you explain to us the format of the meeting which you held with Mr. O'Brien on the 9th February? Did you lead the meeting with him?

A. Yes. It was a meeting with Mr. O'Brien and it was myself, Siobhán Hynds. I led that meeting, explaining the purpose of that meeting. Essentially the main purpose of that meeting with Mr. O'Brien was to share the action plan and get his agreement in order to proceed to the return-to-work arrangement which was already agreed in the previous month. So, we did go in the details of the action plan with him, essentially going in terms of what are the main elements of the action plan and what is required from Mr. O'Brien's point of view, and then how they are going to be monitored. 10:15 10:16 10:16

10 Q. Just on this record, it doesn't appear to make any reference to any contribution from Mr. O'Brien at the meeting. Can one assume that he did contribute a viewpoint at the meeting?

A. The action plan was already established and we shared that action plan. I must say he did not contribute into the formation of action plan. However -- 10:17

11 Q. Sorry, just to cut across you. Did he contribute at the meeting to your explanations of what was required of him? 10:17

A. I don't recall the exact details of the meeting but he did show his agreement that he will adhere to the action plan. I was also aware that in another previous meeting, I think end of January - I didn't meet him but

Hynds, Siobhan

From: Carroll, Ronan [redacted]
Sent: 03 March 2017 10:23
To: Hynds, Siobhan; Corrigan, Martina
Cc: Chada, Neta
Subject: RE: Investigation

Importance: High

Siobhan
Update

1- Untriaged referrals updated yesterday – this pt in red text will require an SAI. At time of typing I don't know if pt has been informed re this confirmed diagnosis and the prognosis. I do not know if AOB has also been informed as he did not attend the MDT yesterday, where this pt was discussed

62 Day Pathway

- 19 patients in total
- **1 patient (50 year old) with confirmed High Grade Urothelial cancer, G3 pT4a. cancer (path confirmed today)** This patient has had TURBT so pathway has been closed at D209, he is listed for MDM discussion today re further management
- 12 are now closed,
- 3 awaiting diagnostics/results
- 3 awaiting TRUSB appointment.

31 Day Pathway (not tracked)

- 5 patients in total
- 4 closed – no cancer
- 1 patient declined offers as was feeling well and has been discharged.

2 - outcome of undictated outpt clinics – essentially has not started – consultants aware this needs to start and be completed
3 - trawl of PP's within 2016 operating – there are approx. 900 pts to go through on NIECR. About 450 pts have been checked and 6 out of the 450 have been seen by AOB at some point which is 1.3%

Monitoring of AOB work e.g. OPD, theatres etc has not yet commenced as prior to his return all the required activity had been reallocated to locum

Hope this help
Ronan

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

From: Hynds, Siobhan
Sent: 03 March 2017 00:50
To: Carroll, Ronan; Corrigan, Martina
Cc: Chada, Neta
Subject: Investigation

Ronan / Martina

Hynds, Siobhan

From: Khan, Ahmed [redacted]
Sent: 12 April 2017 13:03
To: Hynds, Siobhan
Cc: Chada, Neta
Subject: Re: MHPS Case Update

Siobhan, thanks. Would it be possible to summaries the progress of actions so far on time line. This would help us to keep track of this case's progress.
Thanks,
Ahmed

Sent from my BlackBerry 10 smartphone.

From: Hynds, Siobhan
Sent: Wednesday, 12 April 2017 00:16
To: Khan, Ahmed
Cc: Chada, Neta
Subject: MHPS Case Update

Dr Khan

On behalf of Dr Chada, I am sending you an update on the progress of the investigation relating to Mr A O'B.

To date Dr Chada and I have met with 4 witnesses and have taken comprehensive statements. These are currently being typed for agreement with the witnesses. We have identified a further 11 potential witnesses which we are currently arranging to meet with over the coming few weeks. With Easter holidays some of these meetings may be delayed long than we would ideally like.

We have established that all un-triaged referrals have now been looked at and we have been made aware of a number of referrals which, in the opinion of other Consultant Urologists, required to have been triaged as either red flag or urgent but were dealt with as routine due to non-triage. We currently understand this number to be 24 and of these 3 have been identified as SAI issues. A further 5 aware still unknown at present.

Of the notes that were missing, 13 patient files remains unaccounted for.

There has been slower progress with the undictated clinics as the work required in the review of these cases is significant. We have asked for an update on a sample of the patients to allow us to progress our investigation. As this work is slow, it may be prudent to discuss further with Dr Wright the possibility of getting further assistance with this work to move it forward. Dr Chada and I are happy to discuss further with you if required.

It is unlikely we will have completed our investigation in the next 4 weeks and therefore I will update you again in 4 weeks time. However in the meantime should you require any further information please let me know.

At a meeting with a witness this week, we were alerted to an issue whereby it appears Mr O'Brien is not assigning a clinical priority to his theatre lists causing difficulty in prioritisation of patients when sessions had to be adjusted / cancelled. Given the action plan in place and the issues of concern being investigated, Dr Chada has asked me to bring this to your attention as a matter of priority. Should you require any further detail please give me a call on [redacted]

Regards,

Neves, Joana

From: Khan, Ahmed
Sent: 15 May 2017 17:05
To: Wilkinson, John
Cc: Hynds, Siobhan
Subject: Re; MHPS Case update

Dear Mr Wilkinson,

As a case manager, I would like to update you the progress of Mr A OBrien's MHPS Case.

Update as at 15 May 2017

All witnesses have been scheduled and the case investigator hope to have these interviews complete by Monday 5 June. However, there is always the possibility that during the course of these interviews they may need to speak to other relevant witnesses which could delay this date. If there are no further witnesses, once these interviews are complete the case investigator should be in a position to meet with Mr O'Brien very shortly after 5 June.

In the update to you on 12 April it was noted that 24 referrals were considered to have required an upgraded referral to a red flag referral. Each case has now been looked at and of these 24, 4 cases have a confirmed cancer outcome. These 4 are in addition to the previous case in autumn of last year which was investigated by an SAI team . Therefore in total there are 5 cases. The other 4 cases will also require an SAI. I have notified Mr O'Brien regarding these SAI.

In respect of the un-dictated clinics, the look back exercise has been completed on 161 of the 668 and work is still on-going on the rest. For the purposes of the MHPS investigation, Dr Chada (case investigator) will use the sample of 161 cases to move forward with this process.

The investigation now needs to concentrate on the private patient concerns and a review of when patients were seen and if they were seen in non-chronological order is underway. It is hoped that this information will be available to us by end of May.

Whilst Dr Chada anticipate meeting with Mr O'Brien to discuss the investigation findings and to seek a response from him by mid-June, she will update me should there be any slippage to this timescale.

If you require any further information please don't hesitate to contact me or Ms Siobhan Hynds.

Regards,
Ahmed

Dr Ahmed Khan
Consultant Paediatrician
Associate Medical Director
Children & Young People Directorate
Case Manager –MHPS Case
SHSCT

Hynds, Siobhan

From: Corrigan, Martina [redacted]
Sent: 07 June 2017 18:25
To: Hynds, Siobhan
Cc: Carroll, Ronan
Subject: undictated clinics
Attachments: OC 1.pdf; OC2.pdf; OC3.pdf; OC4.pdf; OC5.pdf; OC6.pdf; OC8.pdf; OC9.pdf

Hi Siobhan

To update on the findings from the undictated clinics:

There are 110 patients who are being added to a Review OP waiting lists – a number of these should have had an appointment as per Mr O'Brien's handwritten clinical notes before now, however I would add that Mr O'Brien has a Review Backlog issue already so these patients even if they had of been added timely may still not have been seen.

There are 35 patients who need to be added to a theatre waiting lists, all of these patients he has classed as category 4 which is routine and again due to the backlog.

I have attached Mr O'Brien's sheets that he had given me in January after he had returned the charts.

I have now gone through all of the charts that were in the AMD office and will be back in Health Records tomorrow.

Katherine Robinson's team are currently recording the outcomes from these and these will all be backdated to when the clinics happened.

There were 3 patients whom the consultants have concerns on and I had arranged urgent appointments for them. One has since been sorted and no further concerns. The other two have cancelled their appointments themselves and have been rearranged for beginning of July so I will keep an eye on these and make sure there is no more concerns.

Other comments made by the consultant were:

1. Patient seen by 6 times at clinic and notes written in the patients chart but no dictated letter
2. Patient seen initially as a private patient and there is a letter in chart for private visit but none for NHS visit
3. Patient seen x 14 times at clinics (so well looked after) but no letters so how does the GP know what is going on?
4. Patient seen at clinic on 19/9/16 letter dictated retrospectively on 28/02/17.
5. According to PAS the patient attended the clinic but according to handwritten notes they DNA and Mr O'Brien had asked that they be sent for again
6. Patient seen on 11/04/16 but letter was dictated on 22/02/17.

If there is anything further in respect to this please do not hesitate to contact me

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

Southern Health and Social Care Trust

Quality Care - for you, with you

INVESTIGATION REPORT
Under the Maintaining High Professional Standards Framework

Mr Aidan O'Brien, Consultant Urologist

Case Investigator
Dr Neta Chada, Consultant Psychiatrist / Associate Medical Director
Assisted by
Mrs Siobhan Hynds, Head of Employee Relations

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REPORT OF FORMAL INVESTIGATION

1. Introduction

Mr Aidan O'Brien is employed by the Southern Health and Social Care Trust as a Consultant Urologist based in Craigavon Area Hospital. He was appointed to this role on 6 July 1992 and currently undertakes 12 Programmed Activities.

Mr O'Brien is one of 5 Consultant Urologists within the Trust and the team work a 'Consultant of the Week On-call' model with the consultant of the week responsible for triage of all referrals during their period on-call.

2. Context / Background

The Urology service in Craigavon Area Hospital has developed from a complement of 3 Consultants in or around 2012/13 to the current model with 5 Consultants and manages approximately 8,000 referrals per year. Each Consultant on-call manages 150 to 160 referrals during their on-call week. This model was adopted in 2014 and it was anticipated that the consultant of the week model, along with one-stop clinics for patients would allow more time to focus on cancer targets and inpatient emergency care.

Referrals to the service are received via a number of routes. The vast majority of referrals are received via an electronic CCG referral from a GP. Small numbers of other referrals are received via letter, from Trust Consultants or via the Emergency Department. All referrals are required to go through the Trust's Referral and Booking Centre for logging and then forwarded to the Consultant on-call for triage.

Currently there is an agreed triage system in place with 3 categories of patient urgency outcomes – routine, urgent and red-flag. (A red-flag referral is one where there is a suspicion / concern of cancer with a patient.) The referral will usually be sent to the Urology service with a GP categorisation on the referral determined by the GP. Triage is then completed by the Urologist, as the specialist medical practitioner, to determine if the GP categorisation is correct or if it requires to be changed. Once the referral is triaged, patients are added to the Urology waiting lists in chronological order according to their prioritisation.

All specialties including Urology are required to work to the nationally agreed 62 day pathway for all cancer patients

3. The initial concern

A Serious Adverse Incident (SAI) investigation was commenced within the Trust in April 2017 in respect of Patient 10, a patient of the Urology service. A referral had been received by the Trust in 2015 however the patient was not seen until February 2016. The patient was seen by Mr Mark Haynes, Consultant Urologist.

Mr Haynes reviewed the patient and the referral and was concerned about the delay for the patient. As a result Mr Haynes completed a Datix form to alert the Trust to the issue of concern.

Mr Anthony Glackin, Consultant Urologist chaired the SAI investigation which commenced in Autumn 2016. Through the SAI it was identified that the referral for Patient 10 had not been triaged. An initial look back exercise was undertaken and a number of other patients were identified as not having been triaged. Further assessment of the issue identified a significant number of patients who had not been triaged.

The issues of concern relating to Patient 10 were wider than the referral delay. There were issues of concerns in respect of the radiology reporting on diagnostic images however from a urology perspective, it was felt that the symptoms recorded by the patient's GP on the initial referral should have resulted in the referral being upgraded to a 'red-flag' referral and prioritised as such

4. Timeline of the Investigation

The dates below outline the key dates in respect of the background to the concerns and the management of the concerns under the Maintaining High Professional Standards (MHPS) Framework:

March 2016

On 23 March 2016, Mr Eamon Mackle, Associate Medical Director (Mr O'Brien's clinical manager) and Mrs Heather Trouton, Assistant Director (Mr O'Brien's operational manager) met with Mr O'Brien to outline their concerns in respect of his clinical practice. In particular, they highlighted governance and patient safety concerns which they wished to address with him.

Mr O'Brien was provided with a letter detailing their concerns and asking him to respond with an immediate plan to address the concerns. **(Appendix 1)**

Four broad concerns were identified:

- Untriaged outpatient referral letters

It was identified at that time that there were 253 untriaged referrals dating back to December 2014.

- Current Review Backlog up to 29 February 2016

It was identified at that time that there were 679 patient's on Mr O'Brien's review backlog dating back to 2013, with a separate oncology waiting list of 286 patients.

- Patient Centre letters and recorded outcomes from clinics

The letter noted reports of frustrated Consultant colleagues concerned that there was often no record of consultations / discharges made by Mr O'Brien on Patient Centre or on patient notes.

- Patient's hospital charts at Mr O'Brien's home

The letter indicated the issue of concern dated back many years. No numbers were identified within the letter.

April to October 2016

During the period April to October 2016, considerations were on-going about how best to manage the concerns raised with Mr O'Brien in the letter of 23 March 2016. It was determined that formal action would not be considered as it was anticipated that the concerns could be resolved informally. Mr O'Brien advised the review team he did not reply to the letter but did respond to the concerns raised in the letter by making changes to his practice.

November 2016

Mr O'Brien was off work on sick leave from 16 November 2016 Personal Information redacted by USI and was due to return to work on 2 January 2017.

An on-going Serious Adverse Incident (SAI) investigation within the Trust identified a Urology patient who may have a poor clinical outcome because the GP referral was not triaged by Mr O'Brien. The SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason.

December 2016

The concerns arising from the SAI were notified to the Trust's Medical Director, Dr Richard Wright in late December 2016. As a result of the concerns raised with Mr O'Brien on 23 March 2016 and the serious concern arising from the SAI investigation by late December

2016, the Trust's Medical Director determined that it was necessary to take formal action to address the concerns.

Information initially collated from the on-going SAI of Mr O'Brien's administrative practices identified the following:

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

As a result of these concerns, work was undertaken to scope the full extent of the issues and to put a management plan in place to review the status of each patient. The management plan put in place was to provide the necessary assurances in respect of the safety of patients involved.

28 December 2016

Advice was sought from the National Clinical Assessment Service on 28 December 2016 and it was indicated that a formal process under the Maintaining High Professional Standards Framework was warranted.

30 December 2016

Mr O'Brien was requested to attend a meeting on 30 December 2016 with Dr Richard Wright, Medical Director and Ms Lynne Hainey, HR Manager during which he was advised of a decision by the Trust to place him on a 4 week immediate exclusion in line with the Maintaining High Professional Standards (MHPS) Framework to allow for further preliminary enquiries to be undertaken. Mr O'Brien was accompanied by his wife, Personal Information redacted by the USI. **(Appendix 2)**

A letter was issued to Mr O'Brien in follow up to the meeting detailing the decision of immediate exclusion and a request for the return of all case notes and dictation from his home. The letter also advised Mr O'Brien that Dr Ahmed Khan had been appointed as Case Manager for the case and Mr Colin Weir was identified as the Case Investigator. **(Appendix 3)**

A note of the 30 December 2016 meeting was shared with Mr O'Brien. **(Appendix 4)**

03 January 2017

Mr O'Brien met with Mrs Martina Corrigan, Head of Service for Urology to return all case notes which he had at home and all undictated outcomes from clinics in line with the request made to him by Dr Wright on 30 December 2017.

20 January 2017

During the period of the 4 week immediate exclusion period notified to Mr O'Brien on 30 December 2016, Mr Colin Weir wrote to Mr O'Brien to request a meeting with him on 24 January 2017 to discuss the concerns identified and to provide an opportunity for Mr O'Brien to state his case and propose alternatives to formal exclusion. **(Appendix 5)**

23 January 2017

On 23 January 2017, Mr Weir wrote to Mr O'Brien seeking information from him in respect of 13 sets of case-notes that were traced out on PAS to Mr O'Brien but could not be located in his office and which had not been returned to the Trust with the other case-notes on 3 January 2017.

24 January 2017

The meeting between Mr Weir and Mr O'Brien took place on 24 January 2017 with Mrs Siobhan Hynds, Head of Employee Relations present. Mr O'Brien was accompanied to the meeting by his son, Michael O'Brien.

A note of the meeting was shared with Mr O'Brien. **(Appendix 6)**

26 January 2017

In line with the MHPS Framework, prior to the end of the 4 week immediate exclusion period, a case conference meeting was held within the Trust to review Mr O'Brien's immediate exclusion and to determine if, from the initial preliminary enquiries, Mr O'Brien had a case to answer in respect of the concerns identified.

A preliminary report was provided for the purposes of this meeting. **(Appendix 7)**

At the case conference meeting, it was determined by the Case Manager, Dr A Khan that Mr O'Brien had a case to answer in respect of the 4 concerns previously notified to him and that a formal investigation would be undertaken into the concerns.

The matter of his immediate exclusion was also considered and a decision taken to lift the immediate exclusion with effect from 27 January 2017 as exclusion was not deemed to be required. Instead, Mr O'Brien's return to work would be managed in line with a clear management plan for supervision and monitoring of key aspects of his work.

These decisions were communicated to Mr O'Brien verbally by telephone following the case conference meeting on 26 January 2017.

6 February 2017

A letter was sent to Mr O'Brien on 6 February 2017 confirming the decisions from the case conference meeting on 26 January 2017 and notifying him of a meeting on 9 February 2017 to discuss the detail of the management plan and monitoring arrangements to be put in place on his return to work. **(Appendix 8)**

9 February 2017

Mr O'Brien attended a meeting with the Case Manager, Dr Ahmed Khan on 9 February to discuss the management arrangements that were to be put in place on his return to work following the immediate exclusion period. Mrs Siobhan Hynds and Mr Michael O'Brien were in attendance at the meeting. The action plan was accepted and agreed with Mr O'Brien at the meeting. **(Appendix 9)**

20 February 2017

Between 27 January 2017 when the immediate exclusion was lifted and 17 February 2017, Mr O'Brien was unable to return to work due to ill health. He returned to work on 20 February 2017 in line with action plan agreed at the meeting on 9 February 2017.

January and February 2017

During January and February 2017, Mr O'Brien made a number of representations to Dr Richard Wright, Medical Director and Mr John Wilkinson, Non-Executive Director in respect of process and timescale. In considering the representations made, it was decided that Mr Colin Weir should step down as Case Investigator prior to the commencement of the formal investigation. Dr Neta Chada, Associate Medical Director and Consultant Psychiatrist was appointed as Case Investigator.

16 March 2017

The terms of reference for the formal investigation were shared with Mr O'Brien along with an initial witness list. **(Appendix 10)**

April, May and June 2017

During April, May and June 2017 the Case investigator met with all witnesses relevant to the investigation. Witness statements were prepared and issued for agreement.

Name	Job Title	Date
Mrs Martina Corrigan	Head of Service	15 March 2017
Mr Michael Young	Consultant Urologist	23 March 2017
Mrs Claire Graham	Head of Information Governance	03 April 2017
Mr Ronan Carroll	Assistant Director	06 April 2017
Mr Eamon Mackle	Consultant Surgeon	24 April 2017
Mr Anthony Glackin	Consultant Urologist	3 May 2017
Ms Anita Carroll	Assistant Director	19 May 2017
Mr Colin Weir	Clinical Director	24 May 2017
Mr Mark Haynes	Consultant Urologist	24 May 2017
Ms Noeleen Elliott	Personal Secretary	24 May 2017
Mrs Helen Forde	Head of Health Records	05 June 2017
Mrs Heather Trouton	Assistant Director	05 June 2017
Mrs Katherine Robinson	Referral & Booking Centre Manager	05 June 2017

(Appendix 11 to 23)

14 June 2017

Dr Chada, Case Investigator wrote to Mr O'Brien requesting to meet with him on 28 June 2017 for the purpose of taking a full response in respect of the concerns identified. **(Appendix 24)**

19 June 2017

Mr O'Brien requested to reschedule the meeting to secure his preferred accompaniment to the meeting. This was facilitated. A meeting on 29 June, 30 June and 1st July was offered. Mr O'Brien requested to defer the meeting until later in July until after a period of planned annual leave, and a meeting was confirmed for 31 July 2017.

05 July 2017

Mr O'Brien advised the date of 31 July was not suitable and a date of 3 August 2017 was agreed.

03 August 2017

A first investigation meeting was held with Mr O'Brien in order to seek his response to the issues of concern. **(Appendix 25)**

At the meeting on 3 August 2017 it was agreed that a response would not be taken in respect of term of reference number 4 in respect of private patients until patient information requested by Mr O'Brien had been furnished to him. It was agreed that a further meeting date would be arranged for this purpose once all information had been provided. Mr O'Brien's responses to the remaining terms of reference were gathered.

16 October 2017
A meeting date for the second investigation meeting was agreed for 06 November 2017.

06 November 2017
A second investigation meeting was held with Mr O'Brien in order to seek his response to the issues of concern in respect of term of reference 4. **(Appendix 26)**

At the meeting of 6 November 2017, Mr O'Brien advised Dr Chada that he wished to make comment on both his first statement and also the witness statements provided to him. He further advised that his priority for November and December was completion of his appraisal and that he would not be able to provide his comments during this period. It was agreed his timescales would be facilitated.

15 February 2018
By 15 February 2018, Mr O'Brien had not provided the comments he had previously advised he wished to make and therefore this was queried with Mr O'Brien and an update sought.

22 February 2018
No response was received and a further email reminder was sent to Mr O'Brien on 22 February 2018. On the same day, Mr O'Brien responded to advise that he had not had time to attend to the process since the meeting in November 2017. He requested a copy of the statement from the November meeting and indicated he would provide commentary on all documents by 31 March 2018.

In view of the timeframe to date, Mr O'Brien was asked to provide comments by 9 March 2018 rather than 31 March 2018.

16 March 2018
Comments on the documents were not received on 9 March 2018 and a further reminder was sent to Mr O'Brien requesting his comments no later than 26 March 2018. It was advised that the investigation report would be concluded thereafter if comments were not provided by 26 March 2018.

26 March 2018
No comments were received from Mr O'Brien.

29 March 2018
A final opportunity was provided to Mr O'Brien to provide comments by 12 noon on 30 March 2018. It was advised that the investigation report would be thereafter drafted.

30 March 2018
No comments were received from Mr O'Brien.

2 April 2018
Comments on the statements from the meetings of 3 August and 6 November were received from Mr O'Brien. Mr O'Brien also queried requested amendments to notes of meeting on 30 December 2016 and 24 January 2017.

In the interests of concluding the investigation report without further delay, all comments from Mr O'Brien have been considered and are appended with the relevant documents.

5. Terms of Reference for the Investigation (ToR)

The terms of reference as set for the Case Investigator were as follows:

Term Of Reference 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 tri-ages in 2015 or 2016 resulted in patients being harmed as a result.

Term Of Reference 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.

Term Of Reference 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 clinics.

(c) To determine if there have been delays in clinical management plans for these patients as a result.

Term Of Reference 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.

Term Of Reference 5

To determine to what extent 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.

6. Data Gathered

ToR 1: Un-triaged Referrals

Referrals to the Urology service, in the main, come from GPs via electronic referral to the Trust's Booking and Referral Centre (R&B Centre). A small number of referrals may be

received directly by Consultants from another Consultant, via the Emergency Department or via letter. All such referrals are expected to be logged through the R&B Centre.

The referrals are forwarded to the Consultant Urologist of the week who is responsible for triaging all referrals received during this period of time. From speaking with a range of witnesses, including a number of Consultant Urologists, this appears to be a well-known and accepted process. Red-flag referrals are expected to be reviewed and triaged within 24 hours and returned to the R&B Centre. All other referrals are generally completed within 2 to 3 days of the end of the consultant of the week period and returned to the R&B Centre.

The triage timescales of triage within 72 hours are in keeping with the Regional IEAP Standards for triage of referrals to secondary care. **(Appendix 27)**

Based on the triage decision by the Consultant Urologist, the patient will be placed on the urology waiting list according to priority i.e. red-flag, urgent or routine and in chronological order.

During the course of the investigation, it became clear that a number of people within the Trust were aware of problems in respect of Mr O'Brien's adherence to the triage process. The R&B Centre were not receiving referrals back within the agreed targets from Mr O'Brien when he was Consultant of the week. In order to manage this, a decision was taken during 2015 to introduce a default process whereby all patients were placed on the waiting list according to the GP categorisation of urgency if the referral was not received back from the Consultant Urologist. This default process was adopted and agreed by the Director of Acute Services at the time, Ms D Burns and a number of other senior Trust staff according to some witnessed interviewed. The rationale for this decision was to put in place a safety net to ensure patients were added to the waiting list. The reasons under-pinning this decision will be dealt with in section 7 of the report. Mr O'Brien's response will be dealt with in section 6 of the report.

As a consequence of the concern identified in respect of patient Patient 10 and the subsequent SAI investigation referred to in section 2, a look back exercise was undertaken to determine if there were any other un-triaged referrals that same week. It was discovered that there were others un-triaged and this in turn led to a review of all referrals. A large number of un-triaged referrals were subsequently located in an office drawer in Mr O'Brien's office by Mrs Martina Corrigan. **(Appendix 28)**

In total, it was found that there were 783 un-triaged referrals dating back to June 2015. The review of these referrals was undertaken by the remaining Trust Consultant Urologists, to determine the appropriate urological categorisation.

Each Consultant reviewed a portion of the 783 un-triaged referrals to determine if any of the referrals had GP categorisation which would have required upgrading i.e. referrals which had come into the Trust as routine or urgent and which would or should have been upgraded based on key indicators within the referral document.

Of the 783 un-triaged referrals it was determined that 24 referrals (including patient Patient 10) warranted upgrading to red-flag status based on the information available on the initial referral received by the Trust. A full assessment of each patient was undertaken and it was found that a further 4 patients (5 in total) had a confirmed cancer diagnosis.

The 24 patient referrals are contained within **(Appendix 29).**

UROLOGY RED FLAG UPGRADES AND OUTCOMES

Hospital Number	Patient Name	Red Flag STATUS	Comments
Personal Information redacted by the USI	Patient 10	**CONFIRMED**	**Renal**
	Patient 11	**CONFIRMED**	**Prostrate**
	Patient 13	**CONFIRMED**	**Bladder**
	Patient 12	**CONFIRMED**	**Prostrate**
	Patient 14	**CONFIRMED**	**Prostrate**
	Personal Information redacted by the USI	Closed	
		Closed	
		Closed	
		Closed	
		Closed	
		Closed	
		Closed	
		Closed	
		Closed	
		Closed	
		Closed	
		Closed	
		Closed	
		Closed	

Personal Information redacted by the USI			Personal Information redacted by the USI		Closed	
					Closed	
					Closed	
					Closed	
					Closed	
					Closed	
					Closed	

Patient 10 – is a 68 year old female patient diagnosed with renal cancer. There was a 64 week delay from when the referral was received to the patient being seen. This patient also was diagnosed with breast cancer.

Patient 11 – is a 69 year old male patient diagnosed with prostate cancer. There was a 207 day delay from when the referral was received to the patient being seen.

Patient 13 – is a 50 year old male patient diagnosed with aggressive bladder cancer. There was a 179 day delay from when the referral was received to the patient being seen. This patient should have been on the 62 day pathway and with treatment started within that timeframe.

Patient 12 – is a 74 year old male patient diagnosed with prostate cancer. There was a 151 day delay from when the referral was received to the patient being seen.

Patient 14 – is a 64 year old male patient diagnosed with prostate cancer. There was a 238 day delay from when the referral was received to the patient being seen.

UROLOGY RED FLAG OUTCOMES AND DELAY

Patient	Date letter received in Trust	Date Patient would have been seen if triaged (between 10 and 14 days)	Date Patient seen	Number of days delayed
Patient 10	29-Oct-14		06-Jan-16	64 weeks
Patient 14	06-Jun-16	15-20 June 2016	30-Jan-17	238 days
Patient 11	18-Jul-16	28 July- 2 Aug 2016	10-Feb-17	207 days
Patient 13	28-Jul-16	8 – 15 Aug 2016	23-Jan-17	179 days
Patient 12	08-Sep-16	18 – 22 Sept 2016	06-Feb-17	151 days

SAI investigations are on-going in respect of the additional 4 patients with confirmed cancer diagnoses.

All referral documentation was provided to Mr O'Brien for his comment as part of the investigation. His response to this matter is contained within section 6.

ToR 2: Patient Hospital Notes

On 3 January 2017, Mr O'Brien returned 307 sets of patient case-notes which had been at his home. They dated back to November 2014. Most of the notes related to patients seen by Mr O'Brien at the South West Acute Hospital (SWAH) in Enniskillen. **(Appendix 30)**

There is no Trust transport between Craigavon Area Hospital and SWAH and therefore an arrangement was implemented where Mrs Martina Corrigan, Head of Service, brought the notes for the SWAH clinics to the hospital for Mr O'Brien and Mr Young's clinics and the consultants were expected to bring them back to Craigavon after the clinics.

On review of the notes, there are 13 sets of notes which were tracked out to Mr O'Brien which have not been able to be located. Mr O'Brien provided a full response to the matter in respect of the 13 sets of notes. **(Appendix 31)**

As part of the review process Mrs Martina Corrigan, Head of Service undertook a search for the notes and was satisfied with Mr O'Brien's response in that she was unable to conclusively determine why the notes were missing. Many of the missing notes date back many years and a significant number were not Mr O'Brien's patient.

Hospital Number	Name	DOB
Personal Information redacted by the USI	Personal Information redacted by the USI	01/12/35
		20/03/35
		14/08/32
		28/08/89
		14/09/71
		27/03/65
		14/02/93
		27/01/52
		27/11/61
		23/02/93
		20/10/92
		11/11/91
		01/04/58

ToR 3: Un-dictated patient outcome from clinics

Most of the patient notes stored in Mr O'Brien's home were notes which had been taken to his SWAH clinics. As no transport is available between Craigavon Area Hospital and SWAH in Enniskillen, both Mr O'Brien and Mr Young who undertake clinics at SWAH undertook the practice of taking the notes from each clinic with them at the end of the clinic to be returned to Craigavon Area Hospital.

Mr O'Brien did not dictate the outcomes / letters from the SWAH clinics at the end of the clinics; instead he took the charts home to dictate them at home at another time. Mr Young dictated the outcomes at the end of each clinic and returned the notes directly to Craigavon Area Hospital the next day.

Alongside the clinic dictation, it is also the agreed practice that each Consultant should complete a clinic outcome sheet which should be returned to their secretary for immediate action of patients on to Trust waiting lists.

In January, when a large number of the patient notes from Mr O'Brien's home were returned, it was found that Mr O'Brien had a significant volume of clinic outcomes and dictation outstanding. In total it was found that dictation had not been completed for patients who had attended 66 clinics dating back to November 2014, affecting 668 patients.

A full review of the charts for each affected patient was undertaken by the remaining Trust Consultant Urologists. This review took approximately 6 months to ensure all patients were reviewed and to provide the Trust with an assurance that all necessary and appropriate actions were in place. This review was done by the Consultant Urologists during additional PA time agreed specifically for this work to be undertaken. **(Appendix 32)**

Examples of findings from the review of the patients are:

1.	Personal Information redacted by the USI	Patient seen 6 times and no letters on file for any of the attendances
2.		Letter done when patient was a private patient, no other letters on file
3.		Patient seen 14 times but no letters on file – not on a review list
4.		Patient seen on 19 September 2016, letter dictated on 28 February 2017
5.		According to PAS, patient attended on 19 June 2016 but note in the chart says DNA (discharge to GP) this has not been done.

6.	Personal Information redacted by the USI	Patient seen on 11 April 2016, letter dictated on 22 February 2017
7.		No Urology entries in the Chart or on PAS
8.		No Urology entries in the Chart or on PAS

Mr O'Brien provided a response to this concern and this is contained in section 6 of the report.

Private Patients

During the preliminary review of the concerns, a further concern was identified by Mr Mark Haynes, Consultant Urologist. Mr Haynes was concerned that Mr O'Brien may have added some of his private TURP patients to the Trust lists for procedures / surgery ahead of NHS patients with the same or greater clinical priority.

It was initially advised to Mr O'Brien that a review of his TURP patients had been undertaken however during the course of the investigation it was established that a full review of Mr O'Brien's private patients had been undertaken.

Of the patients reviewed, there was concern about 11 of Mr O'Brien's private patients who appeared to have had their procedure / surgery done on the NHS within much shorter timeframes than would be expected given their clinical priority. **(Appendix 33)**

Mr Michael Young, Lead Consultant Urologist was asked to review the 11 patients to determine if, in his opinion, there was a clinical need for the patients to have been treated in the timescales identified. **(Appendix 34)**

Mr Young's assessment is outlined in the table below:

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

Casenote	Date on Waiting List	Date Operation	Days from Added to WL to Operation Date	Is there a clinical reason why the patient should have been treated within such a short time? M Young
Personal Information redacted by the USI	22/02/2016	22/03/2016	29	No

Personal Information redacted by the USI	25/04/2016	04/05/2016	9	Reasonable – Red Flag
	11/04/2016	15/04/2016	4	No
	01/04/2016	27/04/2016	26	No
	08/07/2016	09/08/2016	32	No
	29/07/2016	21/09/2016	54	No
	04/12/2015	24/02/2016	82	Reasonable
	11/07/2016	17/08/2016	37	No
	08/10/16	02/11/16	25	No
	31/10/16	04/11/16	5	No
	16/02/2016	24/02/2016	8	No

Mr O'Brien was provided with the list of patients and the clinical information reviewed by Mr Young in order to respond to the issue of concern. **(Appendix 35)**

Mr O'Brien's response to the concern is documented in section 6 of the report.

7. Mr O'Brien's responses to the concerns

Meeting with Mr O'Brien – 30 December 2016

This was the initial meeting with Mr O'Brien. The meeting was an opportunity to advise Mr O'Brien of the concerns and to advise him of the management action to be implemented initially to allow further scoping of the extent of the concerns.

A copy of the note of the meeting was shared with Mr O'Brien**.** Mr O'Brien wrote to Dr Wright on 21 February 2017 with a number of suggested changes to the notes. Dr Wright amended the notes to the extent he accepted the representations made by Mr O'Brien and shared an amended copy of the notes **(Appendix 6).**

At the time of the meeting in December 2016 it had been identified that there were significant and serious concerns in respect of Mr O'Brien's administrative practices and there was concern that patients may have come to harm as a result of those practices.

The scale of the concerns at that time were

- 318 un-triaged referrals
- An SAI investigation looking at whether or not a patient may have had a poor clinical outcome as a result of delay in triage
- A backlog of 60+ clinics dating back over 18 months with approximately 600 patients who may not have had clinic outcome dictated and therefore it was unclear as to the management plan for those patients
- An unknown number of patient notes stored at Mr O'Brien's home.

During the course of the meeting, Mr O'Brien advised that the concerns needed to be considered in the context of huge pressure on him to operate and that clinical outcomes were compromised because of a lack of capacity within the Urology service. He advised that there was an inequity within the Department specifically in respect of the length of his waiting list in comparison to some other colleagues and this created the demand on him to operate.

Mr O'Brien requested that the totality of his work should be considered, and this meant he did not have time to triage referrals other than red flag referrals. Mr O'Brien advised that the triage of non-red flag referrals was a historical hangover from a time when it was felt there was not enough work to do when on-call and this was done to justify on-call time.

Mr O'Brien noted that he had raised 2 years previously that he did not have capacity to deal with non-red flag triage. He outlined that in his view you need to speak to patients rather than ticking a box and, that to do so, takes time.

Mr O'Brien advised that he had been asking for the approximately 2 to 3 years not to see any new patients because of the immorality of not being able to do what he had pledged to do within an appropriate time frame. He stated that as a consequence of operating, other duties get neglected. He said there were not enough hours to be faultless.

During the course of the meeting Mr O'Brien was asked to return all notes he had at home as a matter of urgency. Mr O'Brien stated that he could not return them without processing them, acknowledging they needed actions taken. However he was advised that he should return them without delay. Mr O'Brien confirmed he had all notes tracked out to him and he did not believe there were any missing.

Meeting with Mr O'Brien – 24 January 2017

A meeting with Mr O'Brien was held on 24 January 2017 during the initial 4 week immediate exclusion period to discuss with him the next steps in the case, to enable Mr O'Brien to state his case and to provide an opportunity to hear from Mr O'Brien his proposals for alternatives to formal exclusion. **(Appendix 5 – Letter of 20 January 2017)**

Mr O'Brien provided his comments to the Case Investigator in respect of the note of the meeting of 24 January. For completeness, both the note of the meeting and Mr O'Brien's comments are contained in **Appendix 6**.

At the meeting on 24 January 2017, Mr O'Brien was advised the 4 week immediate exclusion period had provided time for further scoping of the extent of the concerns.

Mr O'Brien was provided with an update on the scale of the concerns which were as follows:

- From June 2015 there are 783 un-triaged referrals which required to be tracked and reviewed to ascertain the status of the patients involved.
- There were 307 sets of patient notes returned from Mr O'Brien's home. 88 sets of notes retrieved from his office and 13 sets of notes which were tracked to Mr O'Brien were missing, dating back to 2003.
- 668 patients seen at Mr O'Brien's out-patient clinics had no outcome formally dictated – 272 from the SWAH clinic and 289 from other clinics. At this time 107 patients were still being investigated.
- A further concern had also been raised in relation to Mr O'Brien's private patients. A review had identified 9 TURP patients who had been seen privately as outpatients, then had their procedure on the NHS but whose waiting times were significantly less than those for other patients.

During the course of the meeting on 24 January 2017, Mr O'Brien referred to the issue of the triage referrals and advised that since the issue was raised with him in March 2016, he had been 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 provided an explanation in respect of each of the 13 sets of missing notes. He stated that he had never lost a set of notes in his career.

Mr O'Brien stated that he was surprised by the number of undictated outcomes from clinics in SWAH. Mr O'Brien stated he thought this number was about 110.

In respect of the concern regarding private patients, Mr O'Brien stated that he was concerned about the inference being made.

Mr O'Brien advised he would make a full response to the concerns in due course but he wished it 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.

Furthermore, Mr O'Brien advised of a large number of patient's awaiting admission for surgery and more particularly, those patients awaiting readmission for surgery. It is his contention that this cohort of patients is the cohort at greatest risk of suffering poor clinical outcomes as a consequence of delay in admission or readmission.

Mr O'Brien advised that he had undertaken many additional elective operating sessions in recent years in an attempt to minimise the number of poorer clinical outcomes and the severity of those outcomes. He believed this was the greatest issue of concern and felt this did not appear to be an issue or concern for the investigation.

Meeting with Mr O'Brien – 09 February 2017

Dr Ahmed Khan, Case Manager met with Mr O'Brien on 9 February 2017 to discuss the matter of his return to work following the decision to proceed with a formal investigation under the MHPS Framework and to lift the immediate exclusion of Mr O'Brien. The meeting was held to discuss the management action plan being implemented on Mr O'Brien's return to work, to provide assurances regarding patient safety and safe administrative practices during the course of the investigation.

The management action plan was discussed and accepted by Mr O'Brien. **(Appendix 9)**

Meeting with Mr O'Brien – 03 August 2017

Dr Neta Chada, Case Investigator met with Mr O'Brien on 3 August to seek a full response to the concerns identified during the course of the investigation process. Mr O'Brien has provided recent commentary in respect of the statement drafted for his agreement. Given the timing of receipt of this commentary and to avoid further delay with conclusion of the investigation, the drafted statement along with Mr O'Brien's comments have been included for completeness. **(Appendix 25)**

The statement is comprehensive and documents Mr O'Brien's responses to each of the terms of reference (except for term of reference 4). For the purpose of this section of the report, I have highlighted the salient points of Mr O'Brien's response.

Un-triaged referrals

Mr O'Brien confirmed that of the non-personalised referrals allocated to him i.e. those allocated to him as Consultant Urologist of the week, he triaged all red-flag referrals during 2015 and 2016 but did not triage the remaining referrals during 2015 and 2016 (i.e. he did not triage routine and urgent referrals). Mr O'Brien advised that in 2014 when the Consultant of the week model was introduced, he agreed with doing triage but soon found it impossible to do. He advised that he had highlighted that it was not possible to do triage when consultant of the week, and furthermore that it was unclear as to what the process was supposed to be.

Mr O'Brien advised that he was in agreement with the Consultant of the week model when it was introduced in 2014, he advised that there had been no Trust directive regarding triage but that it was the consultant clinical staff who agreed the triage process. Mr O'Brien confirmed he was present when the matter of triage was agreed with his colleagues.

Mr O'Brien confirmed that he had undertaken all red flag triage but the rest was not done because he did not have time to do so. Mr O'Brien outlined that there is a vast difference between triage and proper or advanced triage which he had raised at various meetings. He outlined his view that if consultants were not doing proper triage, why request Consultants to do it at all? Mr O'Brien stated it was his view that the triage being undertaken i.e. a look at the referral information and categorisation to determine upgrade based on key phrases or indicators, could be done by Advanced Nurse Practitioners.

Mr O'Brien confirmed he was aware that triage was the agreed system in place and outlined that he had raised it at various meetings because he found it impossible to do. He accepted that he did not specifically advise he was not undertaking triage and this is something he regrets. He outlined that as NICAN Chair he had endeavoured to get his colleagues to do advance red flag triage but this didn't happen.

Mr O'Brien advised that he felt that how triage was being undertaken by some of his colleagues was unsafe. He further advised that he believed inpatient care has been compromised by Consultants of the week conducting triage while being the Consultant of the week and quality of patient care had suffered as a consequence.

On commenting upon the 5 cases which have confirmed cancer diagnoses, Mr O'Brien was surprised that there were such a small number upgraded. He advised that it was heartening in a number of ways to find 2 of the cases are at an early stage. He noted the irony that one of the patients may have benefitted from the delay. Mr O'Brien commented that patient Patient 13 was really the only one patient of concern.

Mr O'Brien advised that he has read the referral for patient Patient 10 and he would have kept the triage category as routine as the only way the referral could have been upgraded would have been to review the digitalised images of the patient.

Patient notes

Mr O'Brien clarified for the purposes of accuracy that 288 charts were returned from his home in January 2018, the remainder were located on shelves in his office. He confirmed that the oldest chart held at his home was from April 2015.

Mr O'Brien stated that storing the notes at home didn't affect other specialities as he would always have returned the notes when requested.

Mr O'Brien advised that he did not believe there was any issue of concern for the patients as he had processed 62% of all patients seen at the clinics and these were the most urgent patients. The charts returned unprocessed amounted to 211. Mr O'Brien advised that there was no detriment to any patient as the patient would go back onto the waiting list at the point they should have been seen. Mr O'Brien advised that it needs to be considered in context – 'what is urgent today in terms of a referral may not been seen until next August in any event'.

Un-dictated clinics

Mr O'Brien accepted that there were 41 un-dictated clinics – these outcomes were returned to Martina Corrigan in January 2017.

Mr O'Brien explained that his practice was to record the outcome for a patient at the end of their attendances. Mr O'Brien advised that he would always have given a full update to the

patient at the clinic. He advised that he feels dictation compromises the length and therefore quality of appointment time and so he does this afterwards.

Mr O'Brien advised that the most important thing for him is theatre time, admin pales into virtual insignificance in terms of patients who are getting procedures done. Mr O'Brien further stated that he has a frustration with the preoccupation about dictating at the end of clinics by some of his colleagues.

Mr O'Brien advised that dictation was always done for urgent patient and an outcome may not have been done for every clinic attendance but there would be one outcome at the end of treatment.

Private patients

Mr O'Brien advised that he found this allegation deplorable and stated that there had been no comparable analysis done on figures which show private patients have not been given priority. Mr O'Brien wished to see the full list of patients referred to before responding to this concern.

Management knowledge of the concerns

Mr O'Brien advised that he had told a number of people within the Trust that he found triage impossible to do, which he felt was synonymous with saying that he wasn't doing it. He advised that he wished he had left the referrals back to copper fasten that he was not doing triage. He noted that he didn't do this as he was overwhelmed and asking for help was difficult.

Mr O'Brien stated that he had spoken with Michael Young about difficulties he was having with dictation and advised that Martina Corrigan knew about the charts at his home when he went off sick. Mr O'Brien stated, 'after 25 years having raised and raised issues, verbally in meetings, after a time I stopped doing it when it didn't achieve anything.'

Mr O'Brien noted the 23 March 2016 letter and advised that when this was given to him and he asked what he was to do about it – he received no reply. He stated that no particular plan was put in place to address the issue.

Mr O'Brien advised that he has always done a vast amount of additionality to his job plan which was done in place of his SPA time, admin time and his own time.

Meeting with Mr O'Brien – 06 November 2017

Dr Neta Chada, Case Investigator met with Mr O'Brien on 6 November to seek a response to term of reference 4 and to seek any final comments in respect of any issue related to the investigation. Mr O'Brien has provided recent commentary in respect of the statement drafted for his agreement. Given the timing of receipt of this commentary and to avoid further delay with conclusion of the investigation, the drafted statement along with Mr O'Brien's comments have been included for completeness. **(Appendix 26)**

Mr O'Brien raised a number of concerns in respect of this matter, these included:

- At the outset of the investigation and at a number of subsequent meetings it had been advised to Mr O'Brien that the issue of concern related to his TURP private patients. Upon enquiry by Mr O'Brien and further investigation by the Case Investigator, it was established that a review had taken place of all Mr O'Brien's private patients. The 11 private patients highlighted as concerning were not solely TURP patients.

- The list of 11 patients provided to Mr O'Brien for comment highlighted the date upon which each patient had been entered onto the waiting list and also the date the procedure was performed. Mr O'Brien disputed the dates on which the case had been placed on to the waiting list in the majority of cases. He advised that, for example, in one case there was a difference between the date a patient was added to the waiting list versus the date of consultation when a decision to proceed to surgery was made.

- Concern that another clinician could have arrived at a judgement regarding the clinical justification for admission, after a period of time, on the basis of a letter alone.

- Concern that a comparative analysis of the periods of time awaited by those patients admitted for procedure having had a previous outpatient consultation and those who had not, had not been undertaken.

In response to Mr Young's assessment of clinical need and the timescales identified Mr O'Brien provided a comprehensive response for each patient which is included in **Appendix 35**.

The table below highlights Mr O'Brien's analysis of the dates and waiting times in RED.

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

Casenote	Date on Waiting List	Date Operation	Days from Added to WL to Operation Date	Is there a clinical reason why the patient should have been treated within such a short time? M Young
Personal Information redacted by the USI	22/02/2016 (20/02/2016)	22/03/2016	29 (31)	No
	25/04/2016	04/05/2016	9 (46)	Reasonable – Red Flag
	11/04/2016	15/04/2016	4 (349)	No
	01/04/2016	27/04/2016	26 (25)	No
	08/07/2016	09/08/2016	32	No
	29/07/2016 (20/07/2015)	21/09/2016	54 (428)	No
	04/12/2015 (21/11/2016)	24/02/2016	82 (94)	Reasonable
	11/07/2016 (23/07/2016)	17/08/2016	37 (25)	No
	08/10/16	02/11/16	25	No
	31/10/16 (01/10/2016)	04/11/16	5 (34)	No
	16/02/2016 (30/01/2016)	24/02/2016	8 (25)	No

Mr O'Brien's comments in respect of witness statements

Mr O'Brien provided comments in respect of the witness statements gathered as part of the investigation. His comments are attached in full at **Appendix 23**.

The key issue outlined by Mr O'Brien in respect of many of the witness statements was surprise at the fact many witnesses reported having knowledge of concerns regarding his administrative practices but not addressing these with him directly and managers having been aware of the issues without addressing it directly with him.

General comments

Mr O'Brien raised concern at the outset about the Trust's decision to immediately exclude him from work, and what process was being followed. He also queried on a number of occasions why the Trust had moved to manage the concerns formally without giving him recourse to an informal process. Furthermore Mr O'Brien raised concern about the timescales for the preliminary screening of the concerns and also about the timescale of the investigation process. Responses were provided to Mr O'Brien in respect of these matters as they were raised.

8. Investigation Findings

As Case Investigator, I have been requested to investigate 5 specific terms of reference. I have reviewed and gathered a large volume of information as part of the investigation; however my findings from the investigation will focus strictly on the terms of reference provided to me.

The following are the findings from the investigation into concerns:

Term Of Reference 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 tri-ages in 2015 or 2016 resulted in patients being harmed as a result.

It is accepted by all, including Mr O'Brien, that a triage process was agreed sometime in 2014 when the service introduced the Urology Consultant of the Week model. Mr O'Brien describes agreeing and being supportive of the model in 2014 however he advised that very quickly after its introduction, he began to raise issue with the process, indicating to his colleagues that he was finding it impossible to do.

Mr O'Brien advises that he found it difficult to complete triage when he was the Consultant of the Week due to significant other workload pressures including ward rounds and also because of the high volumes of referrals each week.

Mr O'Brien's preference was that advanced triage should be done for red flag referrals only. Advanced triage is different from the agreed triage model being undertaken by the Consultant Urologists. The triage model agreed involves reviewing the referral information submitted to determine if there are key indicators which would highlight a referral categorisation requires to be upgraded. Advanced triage involves assessment of the required tests / investigations which should be undertaken prior to any attendance at a Consultant clinic for initial assessment or review. This allows the necessary information to be available to the Consultant when the patient is in attendance. Mr O'Brien was unable to get agreement with his colleagues to introduce advanced triage for red flag referrals.

Mr O'Brien described a situation where he would regularly raise the issue about triage at meetings and indicate he was finding it impossible to do the triage as Consultant of the weekj. Mr O'Brien's Consultant colleagues agreed that they had been present when he had raised this issue at meetings, though indicated they did not know he was not doing it.

The investigation further highlighted that it was a widely known fact among some staff within the Acute Services Directorate, that Mr O'Brien's triage was often not returned to the Referral and Booking Centre. Mrs Katherine Robinson, Referral and Booking Centre Manager reported that she had been aware over a number of years that Mr O'Brien had not returned triage decisions as was the expected practice. She reported raising the concern at Acute Services meetings and directly with 2 Directors dating back to 2014. Mrs Robinson reported that the problem only existed with Mr O'Brien and all other Urology consultants completed triage. There were periods of time when Mrs Robinson and others chased up the triage from Mr O'Brien however she reported that in 2014 she was advised to book the longest waiting patients onto the lists. She advised in 2015 a default system was set up such that if triage was not returned within 3 days the R&B Centre staff added the patients to the waiting lists according to the GP prioritisation.

Mrs Heather Trouton, Assistant Director and Mrs Martina Corrigan, Head of Service with responsibility for urology both advised that it was a known problem and frustration that Mr O'Brien did not routinely return all of the triage. They both advised that because of the concern that triage was not being returned, a default process was implemented, agreed at Director level by former Director of Acute Services, Mrs Debbie Burns. The default process was to ensure all patients were added to the urology waiting lists without any being missed and the patients were added to the waiting list according to the GP categorisation on the referral received by the Trust.

Mrs Corrigan provided me with e-mail examples of when she had chased outstanding triage with Mr O'Brien during 2015 and 2016 and Mrs Robinson advised that other Consultants were sometimes delayed with triage, though it was done but the problem with Mr O'Brien was persistent.

I interviewed Mr Michael Young who was the lead Urologist in 2014 / 2015 and he advised that at a point in 2014 he had assisted Mr O'Brien by doing his triage for him when Mr O'Brien had raised the issue about competing work and other professional priorities and indicating he could not get triage completed. Mr Young assisted Mr O'Brien with triage for a period of between 6 and 8 months.

Mr Eamon Mackle was the Associate Medical Director with responsibility for Urology up until mid-2016. Mr Mackle reported that he had experienced some workplace difficulties with Mr O'Brien dating back a number of years. Mr Mackle reported that Mr O'Brien had previously raised a complaint of bullying against Mr Mackle in or around 2012 and as a result Mr Mackle reported being very cautious in dealing with issues with Mr O'Brien.

Mr O'Brien disputes that a bullying complaint was raised against Mr Mackle. Mr Mackle's perception however is relevant as it would seem Mr Mackle took a step back from management of concerns in relation to Mr O'Brien as a consequence of this. (Mr Mackle informed me other managers had also advised him to take a step back, and other managers interviewed also understood Mr Mackle was advised to step back.) This is a theme throughout the witness statements. It is evident that many witnesses were aware Mr O'Brien was not undertaking triage as per the agreed process during 2014 and 2015 but there is little evidence to highlight clearly the actions taken by managers or senior clinicians to address the concerns with him during that period.

On 23 March 2016, Mr Mackle and Mrs Corrigan (on behalf of Mrs Trouton) met with Mr O'Brien to outline a range of concerns to him. The letter of 23 March which was given to Mr

O'Brien provides a clear account of the concerns at that time. Within the letter of 23 March, it seeks action to be taken by Mr O'Brien to address the concerns.

It is Mr O'Brien's contention that no support or management plan was discussed with him to assist him to address the concerns highlighted. I was unable to find any supporting evidence to suggest that any of Mr O'Brien's managers had met with him to discuss what was expected of him in terms of addressing the concerns. In fact, it would appear that when this letter was issued to Mr O'Brien, the extent of the issues of concern had not been assessed. Most witnesses described an awareness of the concern but described shock at the actual extent of un-triaged referrals discovered in December 2016. The 23 March 16 was a missed opportunity by managers to fully review and understand the extent of the issues. There was no management follow up to the letter of 23 March 16 with Mr O'Brien.

Nonetheless,, the responsibility for triage of the referrals was that of Mr O'Brien's. He is clear that he was aware of the agreed process and that during the course of at least 2015 and 2016, he undertook red flag triage only. All other referrals were set aside and triage was not completed.

I am in no doubt that Mr O'Brien knew a default process was happening, otherwise it would beg the question as to what he believed was happening to those patients.

There is no dispute to the fact that Mr O'Brien complained many times about triage. It is however accepted by Mr O'Brien, that he never said he was not completing triage. His colleagues were aware that he complained about doing triage but they did not have knowledge of the fact that he was not undertaking any routine or urgent referral triage. As a senior experienced Consultant, there was a responsibility on Mr O'Brien to make it clear and known that he was not doing triage and to seek assistance.

Mr O'Brien did however provide a context to why he was unable to triage routine and urgent referrals. Mr O'Brien outlined that the workload within the urology service and his own personal workload was unmanageable with long review lists. Mr O'Brien's review list, along with Mr Young's were longer than more recently appointed Consultants and he had requested on a number of occasions to refrain from seeing any new patients. This is something that did not happen. I accept that workloads within Urology, like many other specialties are heavy, and it can be difficult to manage all aspects of the workload.

I did however refrain from exploring this in any significant depth as the issue of concern relates to the fact that Mr O'Brien failed to properly highlight to the Trust that he was not undertaking this agreed aspect of his role. While there are differing views on what is a

manageable workload, all other Urology Consultants, managed triage alongside their other competing priorities. At no point did Mr O'Brien make it clear that he was only undertaking red-flag triage.

Therefore, in response to the specific term of reference:

It is accepted by Mr O'Brien that he did not undertake non-red flag referral triage during 2015 and 2016 and he also accepted that there were 783 un-triaged referrals during this period.

As outlined above, the reason for triage by the Consultant Urologist, is to ensure that, as the specialist, they review the referral information to ensure all referrals are properly categorised prior to being added to the waiting lists. The fact that this was not completed had the potential for all 783 patients to have been added to the incorrect waiting list.

We now know that of the 783 patients, 24 would have been upgraded to red flag status by other consultant urologists (and this has now been actioned.) The fact that they weren't upgraded on receipt of referral means the timescales for assessment and implementation of their treatment plans was delayed.

Of the 24 patients upgraded, we know that 5 of these patients have a confirmed cancer diagnosis. All 5 patients have been significantly delayed commencing an appropriate treatment plan.

Term Of Reference 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.

Witnesses indicated it was well known Mr O'Brien did not always return case notes. This was a particular issue in relation to SWAH clinics, as noted above. Managers were not aware of the number of notes, and nor could medical records staff identify that there were a large volume of notes tracked out to one individual.

I interviewed the Head of Information Governance for the Trust, Mrs Claire Graham and she referenced GMC guidelines in relation to note keeping and storage of notes. In particular she highlighted the regional guidance on Good Management of Notes/Records, as well as Health Informatics Unit guidelines, duty of confidentiality principles and data/information protection guidelines. Mrs Graham advised that when pulled from medical records, it was expected, in line with best practice, that case notes would be returned immediately after use. She highlighted that a large volume of notes being kept in a private home is a serious data protection/ information governance risk for the Trust.

I also interviewed the Head of Health Records, Mrs Helen Forde and the R&B Centre Manager, Mrs Katherine Robinson. I was able to establish that there is no clear system for tracking notes through PAS. Notes may be tracked out on PAS to a staff member without knowledge of their location. There is no mechanism for medical records staff to be able to determine that a bulk of records is tracked out to one individual for long periods of time.

I was advised that when notes were sought from Mr O'Brien for other clinics these were usually returned promptly. There was really only an issue if someone was admitted as an emergency, as notes were not available because they were not on the hospital site. It was indicated that at times Datix reports were completed by medical records staff in relation to notes not being returned. This would have been escalated to Martina Corrigan who addressed the issue with Mr O'Brien upon which the notes would have been returned. Martina Corrigan indicated the letter to Mr O'Brien in March 2016 did ask for all notes to be returned. She believed at that time 30 case notes were returned. Managers indicated they had no idea of the scale of records in Mr O'Brien's home. No check or review was done to determine the extent of the problem in March 2016 or at any other time prior to this investigation.

Mr O'Brien acknowledged he had returned the bulk of thecase notes to the Trust in January 2017 when the issue of concern was addressed under the MHPS process. He believed this had not had an impact on care from other specialities as he had always returned notes when they were sought for other clinics.

On returning the notes, Mr O'Brien had attempted to process as many as he could. He focussed on those he deemed most urgent. He indicated that those he had not processed still had lengthy delays after they were returned. He reported there was no detriment in any event to patients, as they were placed on the waiting list for procedure/investigation at the point they would have been when seen at clinic.

13 sets of notes are still missing. Dr O'Brien confirmed he did not have these and this has since been accepted by the Trust and the review team.

Mr O'Brien accepted he had kept notes at home but asserted that this did not impact on patient's clinical management plans/care.

Term Of Reference 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 clinics.

(c) To determine if there have been delays in clinical management plans for these patients as a result.

Mrs Robinson reported that she became aware in December 2016 from Noeleen Elliott, Mr O'Brien's secretary, that there were clinics which had not been dictated by Mr O'Brien. She reported this to be unusual for a Consultant. Mrs Robinson reported that Ms Elliot as Mr O'Brien's secretary would have known the extent of dictation not completed and that she should have been raising this with managers in the Acute Services Directorate. Ms Elliott, indicated that when she arrived to work with Mr O'Brien, the lack of clinics being returned seemed to be a long-standing way he worked and therefore she felt this issue was known. She therefore did not raise or report the issue.

When I interviewed Mr O'Brien he accepted that he did not dictate an outcome for every attendance by every patient at every clinic. I noted with Mr O'Brien that undictated clinics mean GPs don't know what is happening with their patients and there is nothing on NIECR for other Specialists to look at. Martina Corrigan indicated there had been a complaint from a GP and contact from an MLA as a GP didn't know what was happening with a patient.

Mr O'Brien acknowledged there were 66 undictated clinics and no dictated outcomes for these. There were no outcome sheets for 68 clinics. He noted he may have typed updates on the CAPP system for cancer patients, or they may have been discussed at MDM. Mr O'Brien stated that GPs have access to CAPP and that he personally explains all matters to the patient. Mr O'Brien reported that he didn't feel letters were that important. He went as far to say that he was frustrated by the obsession regarding dictation of outcomes for every attendance.

Mr O'Brien advised that he had requested not to be put on day surgery the morning after a SWAH clinic so he could get administrative work done. This was facilitated. Dictation was done for urgent patients. Mr O'Brien reported that he tended to dictate letters at the end of the care episode rather than after each attendance and he indicated he was unaware of any obligation to dictate on each contact. Mr O'Brien outlined that he didn't have enough time for administration. He explained he has undertaken additional clinics and theatre work, which he felt were more important and he did not believe this had resulted in delays in treatment.

Mr O'Brien at this time was not using digital dictation and there was no way of reporting on his dictation of clinics.

Mr O'Brien's Consultant colleagues undertook an extensive review exercise to ensure all patient's seen had an outcome dictated and a clear management plan for treatment. This piece of work was undertaken at significant additional cost to the Trust.

I appreciate that there are significant waiting times for routine assessments in Urology and that the affected patients have all been placed on the waiting list at the point they would have been had the dictation been undertaken in a timely manner. However, the absence of these patients on the waiting lists meant the Trust did not have a proper picture of waiting times or length of lists. It is the responsibility of a medical practitioner to ensure all patient notes / dictation are contemporaneous in line with GMC requirements.

Term Of Reference 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.

1. **Patient –** Personal Information redacted by the USI

This patient had an NHS/HSC operation completed 29 days (based on the findings of the review)(31 days based on Mr O'Brien's assessment) after a private consultation with Mr O'Brien.

Mr O'Brien advised that the timeframe was justified because of the patient's anxieties about a possible cancer and the fact that his mother was gravely ill at the time.

Mr Young advised there was no clinical justification for the timeframe.

From the information available, it would appear that this patient was seen in a timeframe which is significantly shorter than a patient referred directly to the urology service as a red-flag referral. Mr O'Brien's justification for the shorter timeframe was because of the patient's anxieties rather than because he believed there was a clinical indication of cancer. In fact, Mr O'Brien commented that he tried to convince the patient his swelling was benign but was unable to convince him.

2. Patient – Personal Information redacted by the USI

This patient had an NHS/HSC operation completed 4 days (based on the findings of the review)(349 days based on Mr O'Brien's assessment) after a private consultation with Mr O'Brien.

The patient was initially referred to Mr O'Brien privately in December 2014. Mr O'Brien met and assessed the patient privately on 02 May 2015 when a treatment plan was implemented for urgency and urge incontinence. A letter on file dated 11 April 2016 indicates that Mr O'Brien had recently again spoken to the patient and was made aware that the patient's symptoms persisted, to the extent that it was severely impacting on his quality of life and ability to care for and visit his terminally wife. It was for this reason, Mr O'Brien arranged for the patient to have a procedure on 15 April 2016 as an additional patient in SPA time.

From the date of the initial referral – Mr O'Brien's assessment of the timeframe of 349 days is correct. From the date of the most recent telephone assessment – in or around 4 days is correct.

Mr Young advised there was no clinical justification for the timeframe.

This patient appears to have had an NHS/HSC procedure undertaken within days of a second private contact with Mr O'Brien. Whilst the impact on the patient in terms of his quality of life appears to have been severely impacted, there would appear to be little clinical urgency for this patient to have been seen in such a short timeframe. Mr O'Brien justifies the short timescale because the patient was seen as an additional patient within his SPA.

While SPA time should not be substituted for clinical activity time, additional patients added to Mr O'Brien's operating lists should in all instances come from the Trust's waiting list in chronological order.

3. **Patient –** Personal Information redacted by the USI

This patient had an NHS/HSC operation completed 26 days (based on the findings of the review)(25 days based on Mr O'Brien's assessment) after a private consultation with Mr O'Brien.

The patient was an 82 year old lady assessed by Mr O'Brien privately on 24 March 2016. A CT scan confirmed the patient had a 1.2 cm kidney stone impacted in her upper left ureter causing intermittent renal outlet obstruction. She had an operation undertaken on 27 April 2016.

Mr Young advised there was no clinical justification for the timeframe.

4. **Patient –** Personal Information redacted by the USI

This patient had an NHS/HSC operation completed 32 days (based on the findings of the review)(investigations after 45 days and operation after a further 32 days based on Mr O'Brien's assessment) after a private consultation with Mr O'Brien.

The patient was a 34 year old man referred privately to Mr O'Brien for urinary symptoms including urge incontinence and nocturia. He was referred twice by his GP in February and June 2016. Mr O'Brien met with the patient initially on 25 June 2016. Mr O'Brien advised that he expedited the patient's investigations and operation as his symptoms resulted in the patient and his wife sleeping in separate rooms result in martial strain.

Mr Young advised there was no clinical justification for the timeframe.

Mr O'Brien does not advise of a clinical justification for the expedition of this patient's investigations or operation.

5. **Patient –** Personal Information redacted by the USI

This patient had an NHS/HSC operation completed 54 days (based on the findings of the review)(after 428 days based on Mr O'Brien's assessment) after a private consultation with Mr O'Brien.

The patient was seen by Mr O'Brien in July 2015. At this time, a clinical management plan was in place for the patient. According to the 11 September 2016 letter to the patient's GP,

Mr O'Brien advised the patient that he 'would be better served by having his prostate gland resected'. It is not clear if the patient was added to a Trust waiting list at that time.

Following further correspondence to Mr O'Brien from a Continence Nurse Specialist in or around 5 September 2016, he arranged for the patient to be admitted to the Urology Department on 21 September 2016 for resection of his prostate gland.

Mr Young advised there was no clinical justification for the timeframe.

6. **Patient –** Personal Information redacted by the USI

This patient had an NHS/HSC operation completed 37 days (based on the findings of the review)(after 25 days based on Mr O'Brien's assessment) after a private consultation with Mr O'Brien.

The patient was assessed by Mr O'Brien on 23 July 2016 when he reported that he found an 'indwelling urethral catheter to be particularly uncomfortable'. Mr O'Brien arranged for the patient to be admitted to the Urology Department on 16 August 2016 for prostatic resection.

Mr Young advised there was no clinical justification for the timeframe.

7. **Patient –** Personal Information redacted by the USI

This patient had an NHS/HSC operation completed 25 days (based on the findings of the review)(after 25 days based on Mr O'Brien's assessment) after a private consultation with Mr O'Brien.

The patient was reported as doing well on 28 July 2016 at the time of his discharge from Enniskillen Hospital. Mr O'Brien reported on 8 October 2016 that the patient remained well apart from discomfort associated with an indwelling urethral catheterisation. Mr O'Brien reported 'in view of the significant morbidity suffered as a consequence of bladder outlet obstruction, I have arranged for him to be admitted…..on 2 November 2016 for prostatic resection that day'.

Mr Young advised there was no clinical justification for the timeframe.

8. **Patient –** Personal Information redacted by the USI

This patient had an NHS/HSC operation completed 5 days (based on the findings of the review)(after 34 days based on Mr O'Brien's assessment) after a private consultation with Mr O'Brien.

This patient was assessed by Mr O'Brien privately on 1 October 2016. The patient was a 90 year old male who had a previous successful surgery in 2013. In October 2016, the patient reported urethral discomfort caused by continued catheterisation. Mr O'Brien reported that he expedited the patient for admission on 2 November 2017 to minimise the risk of recurrence of the previous morbidity.

Mr Young advised there was no clinical justification for the timeframe.

9. Patient – Personal Information redacted by the USI

This patient had an NHS/HSC operation completed 8 days (based on the findings of the review)(after 34 days based on Mr O'Brien's assessment) after a private consultation with Mr O'Brien.

This patient is the Personal information redacted by the USI The patient reported left flank pain around Christmas 2015 and Mr O'Brien reviewed her privately on 30 January 2016. The patient was assessed within the Trust by a Clinical Nurse Specialist on 16 February 2016. Mr O'Brien reports that no other patient was displaced.

Mr O'Brien reported 'finding she had a moderately severe hypersensitivity of her bladder' he performed effective hydrostatic dilatation of her bladder in addition to left uretheroscopy at an additional operating session on 24 February 2016.

Mr Young advised there was no clinical justification for the timeframe.

Urology Waiting Times for 2015 and 2016 were:

	NEW OUTPATIENTS			**SURGICAL PROCEDURES**		
	RED FLAG	URGENT	ROUTINE	RED FLAG	URGENT	ROUTINE
APRIL 2015	14 DAYS	16 WEEKS	53 WEEKS	48 DAYS	82 WEEKS	97 WEEKS
APRIL 2016	26 DAYS	40 WEEKS	73 WEEKS	65 DAYS	119 WEEKS	124 WEEKS

I am not persuaded by the justifications provided by Mr O'Brien for why the 9 private patients highlighted above were seen in the timeframes outlined. I would conclude that these patients seen privately by Mr O'Brien were scheduled for surgeries earlier than their clinical need dictated. These patients were advantaged over HSC patient's with the same clinical priority.

Mr O'Brien's explanation for patient Patient 124 was that he undertook surgery for this Personal information redacted by the USI an additional theatre session and therefore no HSC patient was affected. If an additional session was available in Theatre, patients from the waiting list should have been seen in chronological order.

Term Of Reference 5

To determine to what extent 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.

It was confirmed by a range of witnesses that they were aware of the difficulties in respect of Mr O'Brien's administrative practices.

Senior managers indicated they were aware of issues with regards to triage but not the extent of the issues. There had been attempts to raise this before 2016 with Mr O'Brien and in response, things would have improved for a while but then reverted again. I believe managers must have known there were significant ongoing issues of concern, given that a default system was put in place in 2015. However it was noted the default system meant this issue was no longer escalated to senior managers as the default system meant the triage was allocated as per the GP's impression. It was noted senior managers agreed with Mr Young that he would undertake Mr O'Brien's triage for 6-8 months whilst Mr O'Brien chaired a regional group. Clinics were also shortened to allow more admin time, extra PAs were paid for, admin time and no day surgery was scheduled after a SWAH clinic. It was indicated MDM letters which were always dictated were very long and detailed, and if theatres were unused Mr O'Brien would ask to increase his theatre time, i.e. additional time for his admin was being used in other ways.

Senior managers were aware Mr O'Brien took clinic notes to his home after the SWAH clinics and there were delays in notes being brought back. However, there is not a robust system in place for determining how many charts are tracked out to one consultant, nor how long the notes were gone for; as such managers were not aware of the extent of the problem.

The above issues were raised in the correspondence to Mr O'Brien in March 2016. However there appears to have been no management plan put in to place at that time and Mr O'Brien seems to have been expected to sort this out himself with no arrangements for monitoring if changes to practice were being made and sustained.

Mr O'Brien indicated he had raised issues about triage and the fact it could not be done in the manner expected, at various meetings over many years. He felt he was not listened to. Other consultant urologists interviewed reported the triage role could be very demanding, especially if the emergency work was busy, but they were completing it within a reasonable time frame. It would seem Mr O'Brien continually complained about the difficulties with triage but it remained unknown to his colleagues that he was not undertaking all triage.

Senior managers appear not to have known about the undictated letters. Reliance on a medical secretary to flag that dictation was not being done was not appropriate or sufficient. This is now hopefully addressed through use of digital dictation.

Senior managers also appear not to have known that private patients may have been scheduled with greater priority or sooner outside their own clinical priority in 2015 and 2016.

9. Conclusions

Having considered the information as outlined above I have concluded:

Mr O'Brien is an experienced and highly respected senior colleague. He is a dedicated doctor who strives to provide a high quality service to all patients. He is frustrated by the lengthy waiting times for assessment and treatment/surgery.

There were 783 un-triaged referrals of which 24 were upgraded and a further 4 with confirmed diagnoses of cancer (plus the original SAI patient.) There was therefore potential for harm of 783 patients.

It does seem that Mr O'Brien liked to do things his own way. He was in agreement with the triage process initially but found he was unable to manage it and stopped doing so. He believed advanced triage should be done instead. He raised the issues about triage at meetings but at no time did he advise anyone that he was not doing it. Nonetheless, it is

clear managers knew there was a significant problem with Mr O'Brien completing triage, given that a default system was put in place to address this very issue. It seems managers were not aware of the extent of the undone triage. Failure to triage has resulted in delays of diagnosis and treatment, given the diagnosis of cancer in five patients reviewed. This must be interpreted as harm.

Mr O'Brien stored excessive numbers of case notes at his home for lengthy periods. 288 charts were brought by him from his home and returned in January 2017. This is outside normal acceptable practice. There were 13 case notes missing but the review team is satisfied with Mr O'Brien's account that he does not have these.

There were 66 clinics (668 patients) undictated and 68 with no outcome sheets, some going back a few years. This is unacceptable practice. Mr O'Brien gave an explanation of doing a summary account of each episode at the end. He indicated patients were added to waiting lists at the point they should have been in any event. It was difficult to be clear if this resulted in delays in treatment given the lengthy waiting time in this specialty in any event. Nonetheless, I feel this delay with clinic letters was unhelpful in keeping GPs up to date with what was happening with their patients as often, despite lengthy discussions with the patient, they would go to the GP for further explanations/ clarification which the GP could not then provide. Further, it means the waiting list was not an accurate reflection of waits.

From the information available it does seem some patients were added to the theatre list schedule earlier than their clinical priority would have dictated.

Many of the problems outlined in the terms of reference were known to managers before 2016 and as a consequence I feel that there were earlier opportunities to address concerns (prior to 2016) and these opportunities were not taken in a consistent, planned or robust manner. Mr O'Brien indicated he raised concerns about triage repeatedly, and that managers were aware of the fact he had notes in his home. Nonetheless, as a senior and experienced Consultant, it was incumbent upon Mr O'Brien to ensure it was fully and clearly known that he has stopped undertaking all triage.

Whilst, there is little doubt Mr O'Brien is a skilled and conscientious doctor, a number of managers and colleagues reported he was felt not to be a team player, and chose to work in his own way, e.g. preferring to add on theatre lists rather than complete outstanding administration. I would conclude that Mr O'Brien did not always work to the Trust's expectations/requirements.

In January 2017, as part of the MHPS process, a management plan was put in place in order to safeguard patients and ensure there was no further risk to patient's while these matters were investigated. From January 2017, Mr O'Brien has worked rigidly to the action plan out in place and has met all requirements of the action plan on an on-going basis. I can only conclude therefore, that Mr O'Brien is capable of adhering to the required acceptable administrative practices continuing.

At no point during the investigation has any concern been highlighted about Mr O'Brien's hands on patient care / clinical ability.

Lastly, during interviews and in correspondence, Mr O'Brien has displayed some lack of reflection and insight into the potential seriousness of the above issues. His reflection on the patients with delayed diagnoses was disappointing and is noted above. He did not seem to accept the importance of administration processes – he did not feel regular dictation was important and he does his own thing about replacing administration time with extra operating lists, whilst at the same time reporting lack of administration time. He felt he couldn't do the triage in the way it was expected, but was also clear that he didn't agree with it anyway. I believe it appropriate and relevant to raise this with the case manager.

Dr Neta Chada
Consultant Psychiatrist / Associate Medical Director
Case Investigator

1.22 Witness statements were gathered between the middle of March 2017 and 5th June 2017, allowing for work commitments of witnesses and the Case Investigator (me), holiday periods and annual leave. I interviewed each witness accompanied by Mrs Hynds. I took copious notes as is my practice and Mrs Hynds also took notes. Whilst I led the interview, I asked Mrs Hynds to add questions or queries I had omitted if they would assist the investigation. At the end of each interview, I asked each witness if they had anything else to add that might increase my understanding of the issues under investigation or any other comments they felt were relevant. Some of the witnesses expressed concern about Mr O'Brien seeing their statement. Others found being involved in the investigation difficult and needed reassurance. To collate the statements, Mrs Hynds produced a draft of each statement and then I used my notes to add additional information or clarify issues. The statement was then shared with each witness, and they were asked to correct it as needed, sign it, and return it to Mrs Hynds. This process took a considerable amount of time. Some of the agreed statements were not back to the Case Investigator until mid-September, as witnesses remembered more things that they thought were relevant to the investigation and added those comments or clarified points to make them more easily understood. (I understand all the statements have been provided to the Inquiry Team.) I shredded my handwritten notes when I retired from the Trust in March 2020, due to GDPR regulations.

1.23 It was my view Mr O'Brien was essentially a witness as well as the subject of the investigation and I wrote to Mr O'Brien by email suggesting meeting dates towards the end of June 2017. I included as much of the information which had been gathered in relation to the Terms of Reference to date. Mr O'Brien suggested Saturday 1st July 2017. This was accommodated to the best of our ability. However subsequently Mr O'Brien felt it would be better to wait until the beginning of August after everyone's annual leave. (Annual leave of the Case Investigator, Mrs Hynds and Mr O'Brien.) This was facilitated. (I understand this has all been made available to the Inquiry Team in email correspondence from Mrs Hynds to Mr O'Brien and I, dated June 2017.)

1.24 I asked that information from the reviews (5 patients being diagnosed with cancer) was shared with Mr O'Brien if this was appropriate from the MHPS process point of view, as these were issues we needed to raise with him, and I felt he needed to be given time to reflect on these. (This was one of the issues that led to delays in the first meeting with Mr O'Brien,

clinical priority, so that this could be shared with Mr O'Brien. This was provided in an email from Mrs Corrigan to Mrs Hynds and I dated 14 September 2017.

1.27 Mr O'Brien was provided with a full witness list at the end of September when all the statements were received. (See Email from Mrs Hynds to Mr O'Brien dated 28 September 2017 *located at Relevant to PIT/ Evidence Added or Renamed 19 01 2022/ Evidence no 77/ No 77 – Dr Neta Chada/ 20170928 – E Strictly confidential)* To ensure balance, I also asked Mrs Hynds to enquire of Mr O'Brien if there were other witnesses he believed could provide information relevant to the investigation. Some of the statements were sent to him with that email and the rest were to follow. Mr O'Brien was also sent a draft copy of his own statement from the August meeting approximately a week before the next meeting, for any corrections/amendments. (There is email correspondence around 27 October from me to Mrs Hynds indicating how busy my clinical caseload was at that time, which had led to a delay in my reading the statement. This email *can be located at Relevant to PIT/ Evidence Added or Renamed 19 01 2022/ Evidence no 77/ No 77 – Dr Neta Chada/201710127 – E Statement Mr O'Brien*

1.28 The second meeting with Mr O'Brien occurred on 6th November 2017. An email suggesting dates in the third week of October was sent, but was not suitable to Mr O'Brien and the 6th November was agreed. This additional delay in dates being offered was due to the witness statements not all being received until the end of September and wishing to give Mr O'Brien a chance (3 weeks) to go through them and the other information he had requested.

1.29 At that meeting Mr O'Brien advised he wished to comment on his first statement (meeting in August), the statement which would be put together in terms of the current meeting (November) and wished to comment in detail on witness statements. He indicated however, his priority was to complete his appraisal and therefore he indicated he would not be able to provide responses in November or December 2017. Given the importance of annual appraisal, this was agreed by me. It was therefore my understanding that Mr O'Brien would get back to us with his commentary by January 2018.

1.30 By February 2018, Mr O'Brien still had not provided his comments. This was discussed by me as Case Investigator with Mrs Hynds, initially at the end of January and then again in

process a bit quicker, but Dr. Khan didn't make any specific suggestions. I think he shared that, I believe he shared that suggestion but I am not sure about that.

44 Q. If we just scroll back, I just want to underscore an issue that we will come back to later. If we go back to paragraph 35. You will note that it says halfway down that paragraph: 11:10

"The practitioner must be given the opportunity to see any correspondence relating to the case, together with a list of the people whom the Case Investigator will interview. The practitioner must also be afforded the opportunity to put their view of events to the Case Investigator and given the opportunity to be accompanied." 11:10

Again, in due course we will look at how that played out during this investigation, and in particular the fact that you, when you first interviewed Mr. O'Brien, he hadn't been provided with any witness statements; isn't that correct? 11:11

A. Yes. Yes, that is correct. However, we had a lot of discussion about the timing of interviewing Mr. O'Brien; Mrs. Hynds and I did. Maintaining High Professional Standards actually suggests that the subject of the investigation should be interviewed first. I knew that, I was aware of that. Having had sight of a lot of the documentation from prior to my 11:11

involvement, I felt that it wouldn't be fair to Mr. O'Brien for me not to at least be aware of some of the things that other witnesses had to say, because I felt that needed to be -- to be fair and equitable, I felt that needed to be put to Mr. O'Brien. I mean, I realised, of course, that we could always bring him back again. So, for that reason -- so this issue of not seeing the witness statements, absolutely, Mr. O'Brien hadn't the benefit of seeing those. At that time a lot of them weren't back -- 11:12

45 Q. I think we will come to that in some detail and we will explore -- sorry, I didn't mean to cut you off rudely.

In terms of your approach to this role, given your experience and your training, did you feel yourself well-equipped for it? 11:12

A. Yes.

46 Q. But that has to be set in the context of the strains, I suppose, of your everyday professional life in terms of fitting it in and doing it efficiently? 11:13

A. Yes. I mean, I think I had the appropriate training and the appropriate approach and appropriate seniority. If you are including in the appropriately equipped whether I had the appropriate time and resource, then no. I felt I was an appropriate person to do the investigation and, if I was doing it again, I suppose the issue would be of support. 11:13

47 Q. In terms of your, I suppose, initial briefing about the issues that have given rise to the investigation, that

Hynds, Siobhan

From: Hynds, Siobhan [redacted]
Sent: 14 June 2017 15:40
To: O'Brien, Aidan
Cc: Chada, Neta; Khan, Ahmed
Subject: STRICTLY PRIVATE AND CONFIDENTIAL - TO BE OPENED BY ADDRESSEE ONLY
Attachments: Letter to A O'Brien from Case Investigator 12 June 2017.docx

Importance: High

Dear Mr O'Brien

Please find attached letter from Dr Neta Chada, Case Investigator.

Kind 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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14 June 2017

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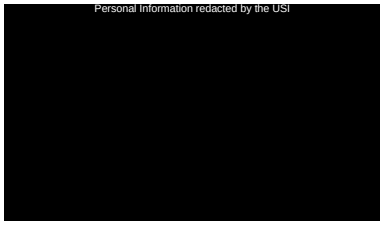
BY E-MAIL ONLY

Mr Aidan O'Brien



Dear Mr O'Brien

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

I refer to the on-going investigation under the Maintaining High Professional Standards Framework.

You will have received the witness list from me at an earlier date in the investigation and I can advise that I have now met with all witnesses I feel are appropriate to the investigation. If you feel there are any other relevant witnesses please let me know to ensure I can consider if I need to speak with them.

The next step of the investigation is to meet with you and therefore I would like to meet with you on Wednesday 28 June 2017 at 9.30am in the HR Meeting Room, Ground Floor, Hill Building, St Luke's Hospital site, Armagh.

I am sending you this as early notice of the meeting to enable you to arrange accompaniment should you wish to do so. You are entitled to be accompanied to this meeting as per Section 1 paragraph 30 of the Maintaining High Professional Standards Framework.

I would be grateful if you could confirm your attendance at this meeting as soon as possible via e-mail with [redacted]

Prior to our meeting I will send you details of the matters I wish to discuss with you to enable you to prepare for our meeting. You should expect to receive this information from Siobhan Hynds at the beginning of week commencing 19 June 2017.

Yours sincerely

_____

Dr Neta CHada
Associate Medical Director &
Case Investigator

Copy to: Dr A Khan, Case Manager

From: Aidan O'Brien [redacted]
Sent: 15 June 2017 22:53
To: Hynds, Siobhan
Cc: Chada, Neta; Khan, Ahmed
Subject: Meeting on Wednesday 28 June 2017

Siobhan,

I received your email this evening.
Regrettably, Wednesday 28 June 2017 would not be suitable for me to meet with Dr. Chada for two reasons.
Firstly, I would certainly wish to be accompanied by my son, [redacted] as previously.
However, he [redacted], a commitment he cannot avoid.
Secondly, I have scheduled operating that day, and have already committed to a number of patients.

I would be grateful if you would contact me on [redacted] to see whether there are other dates possible,

Thank you,

Aidan.

Hynds, Siobhan

From: Hynds, Siobhan [redacted]
Sent: 05 July 2017 11:14
To: Aidan O'Brien
Subject: RE: Meeting on 31 July 2017

Importance: High

Mr O'Brien

I can confirm Dr Chada is available to meet at 10am on 3rd August in the HR Department, Ground Floor, Hill Building, St Luke's Hospital site, Armagh.

I will ensure the relevant paperwork is sent to you in advance of this date for your consideration and preparation.

Regards,

Siobhan

From: Aidan O'Brien [redacted]
Sent: 03 July 2017 08:29
To: Hynds, Siobhan
Subject: Re: Meeting on 31 July 2017

Siobhan,

My apologies for the delay in replying to you.
I did so until after departmental scheduling last Thursday for the month of August 2017.

I will be on leave Tuesday 01 August to Friday 04 August 2017.
As I normally review Oncology patients on Fridays, I had scheduled to do so on Monday 31 July 2017 in order to avoid further delays in reviews.

The options for me are to meet with Dr. Chada on Monday 31 July 2017 and reschedule the Oncology Reviews to my usual day for doing so, Friday 04 August 2017.
Alternatively, I could work Monday 31 July 2017 as scheduled, and, leaving Tuesday 01 August for preparation, meet with Dr. Chada on Wednesday 02 August, Thursday 03 August or Friday 04 August, if any of those days would suit her.
My preference would be the latter option.
However, I will leave that to Dr. Chada.

I can meet with Dr. Chada in Armagh on any date,

Thank you,

Aidan.

-----Original Message-----
From: Hynds, Siobhan [redacted]>
To: Aidan O'Brien [redacted]
CC: O'Brien, Aidan [redacted]
Sent: Fri, 30 Jun 2017 15:40
Subject: Meeting on 31 July 2017

Mr O'Brien

From: Aidan O'Brien [redacted]
To: Siobhan.Hynds [redacted]
Subject: Formal Investigation
Date: Mon, 31 Jul 2017 10:06

Siobhan,

In preparation for the interview on 03 August 2017, I would be grateful if you would provide me with the following:

- A copy of the minutes of the meeting in December 2016 of the Oversight Group
- A copy of correspondence and / or communication with NCAS in December 2016
- An amended copy of the Note of the Meeting of 30 December 2016 (previously requested)
- An amended copy of the Note of the Meeting on 24 January 2017 (previously requested)
- A copy of the Trust's Policy and Procedure regarding Triage (previously requested)
- A list of the Witnesses and their statements

Thank you,

Aidan O'Brien

From: Aidan O'Brien [redacted]
To: Siobhan.Hynds [redacted]
Subject: Re: FORMAL INVESTIGATION
Date: Mon, 31 Jul 2017 13:16

Siobhan

In addition to my earlier request, could you please add the details of the 9 Private Patients included in the investigation and the name or names of those who identified them.

Aidan O'Brien.

Hynds, Siobhan

From: Hynds, Siobhan [redacted]
Sent: 28 September 2017 22:59
To: O'Brien, Aidan
Cc: Chada, Neta
Subject: Strictly Confidential - MHPS Investigation
Attachments: Witness Statement - Mrs A Carroll190517.pdf; Witness Statement - Mrs C Graham 030417.pdf; Witness Statement - Mrs H Forde 050617.pdf; Witness Statement - Mrs M Corrigan 150317.pdf; Witness Statement - Ms N Elliott 240517.pdf

Importance: High

Follow Up Flag: Follow up
Flag Status: Flagged

Mr O'Brien

At our meeting on 3 August you had requested a full list of all witnesses interviewed as part of the current MHPS investigation and you sought a copy of all statements.

I can confirm that 13 witnesses in total have been interviewed. This is the full list of witnesses identified by Dr Chada. They are:

- Mr A Glackin, Consultant Urologist
- Mr C Weir, Clinical Director
- Mr E Mackle, Consultant Surgeon
- Mr M Haynes, Consultant Urologist
- Mr R Carroll, Assistant Director
- Mrs A Carroll, Assistant Director
- Mrs C Graham, Head of Service
- Mrs H Forde, Head of Service
- Mrs H Trouton, Assistant Director
- Mrs M Corrigan, Head of Service
- Ms K Robinson, Referral & Booking Centre Manager
- Ms N Elliott, Secretary

I have attached 5 statements I have in PDF format and will attached the remaining statements as soon as I am able to convert them to PDF.

Should you feel there are any witnesses relevant to the current investigation that have not been interviewed, I would be grateful if you could let Dr Chada and myself know. It would be helpful if you could advise the relevance of any suggested further witness/es.

Regards,

Siobhan

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

Corrigan, Martina

From: Hynds, Siobhan [redacted]
Sent: 29 September 2017 09:06
To: O'Brien, Aidan
Cc: Chada, Neta
Subject: Strictly Confidential
Attachments: Witness Statement - Mr C Weir 240517.pdf; Witness Statement - Mr R Carroll 060417.pdf

Mr O'Brien

Please find attached a further 2 witness statements. I will get the remaining 5 to you as soon as possible.

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]

Click on the above image for SharePoint: Employee Engagement & Relations information

'You can follow us on Facebook and Twitter'

Corrigan, Martina

From: Hynds, Siobhan [redacted]
Sent: 07 October 2017 15:24
To: O'Brien, Aidan
Cc: Chada, Neta
Subject: MHPS Investigation - Strictly Confidential
Attachments: Witness Statement - Mr A Glackin 030517.pdf; Witness Statement - Mr M Young 230317.docx

Mr O'Brien

Please find attached a further 2 witness statements for your information. I will get the remaining 3 statements to you as soon a practicably possible.

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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'You can follow us on Facebook and Twitter'

Hynds, Siobhan

From: Hynds, Siobhan [redacted]
Sent: 25 October 2017 13:34
To: O'Brien, Aidan
Cc: Chada, Neta
Subject: Strictly Confendial
Attachments: Witness Statement - Mr E Mackle 240417.pdf

Importance: High

Follow Up Flag: Follow up
Flag Status: Flagged

Mr O'Brien

Please find attached witness statement from Mr E Mackle.

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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'You can follow us on Facebook and Twitter'

Corrigan, Martina

From: Hynds, Siobhan [redacted]
Sent: 02 November 2017 10:13
To: O'Brien, Aidan
Cc: Chada, Neta
Subject: Strictly Confidential
Attachments: Witness Statement - Mrs H Trouton 050617.docx; Witness Statement - Mr M Haynes 240517.docx

Importance: High

Mr O'Brien

Please find attached 2 statements from H Trouton and M Haynes.

Siobhan

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

Click on the above image for SharePoint: Employee Engagement & Relations information

'You can follow us on Facebook and Twitter'

6 November 2017

FILE REFERENCE: 12

AIDAN O'BRIEN
Accompanied by MICHAEL O'BRIEN
(SIOBHAN HYNDS & DR CHADA: 2nd MEETING)

Audio Transcription Prepared by:

Angela Harte
Personal information redacted by USI
[redacted]

DR CHADA: Things are busy I am sure.

MR O'BRIEN: Absolutely.

DR CHADA: There is such demands.

MR O'BRIEN: In general terms in the hospital in recent times it is very, very difficult because we simply don't have enough beds. In the past five weeks I have had 17 elective surgical admissions cancelled including red flags.

DR CHADA: Because there wasn't a bed.

MR O'BRIEN: Not only was there not a bed, in fact there were minus beds. At a stage there were 46 more patients in the hospital directly in beds that they shouldn't be in.

DR CHADA: I know. And of course this time of year, the winter pressures.

MR O'BRIEN: And it hasn't even started.

DR CHADA: I know. They were saying that the flu this year, we usually follow Australia, so the flu this year in Australia they were saying has been very significant. So they are very anxious about flu season as well.

MICHAEL O'BRIEN: Have to get a flu jab.

DR CHADA: Absolutely. (Inaudible).

SIOBHAN HYNDS: We had a leadership thing over in the Seagoe ~~(inaudible)~~ this morning. They were there with their vaccinations.

MICHAEL O'BRIEN: They were doing it at work but I was sick, couple of weeks ago so ~~--~~. (Inaudible).

DR CHADA: Okay. Thank you very much. Water is coming?

SIOBHAN HYNDS: It is coming.

DR CHADA: Thank you very much for coming, Mr O'Brien. I am really sorry the last time it ran on a quite a long time. I am sure you were exhausted with it all. But the reason we are meeting again today is because, I am going over your statement, that we were not able to address terms of reference 4 because you really had felt that you did not enough information to be able to address to terms of reference 4. So since then we have asked for some information to be forwarded to you and Siobhan tells me that you have been sent it and hopefully you will have an opportunity to do that.

So the point of the meeting for today really is just to specifically address terms of reference 4. Then there will be a separate statement issued to reflect the discussion today for you to have a look at and make sure you are happy about that. Then if you can make sure that both the initial statement -- if you're happy with or if you have any factual

corrections that you want made to that or if you feel that it is not detailed enough because it makes it unbalanced you can comment on that. It is supposed to be just a reflection of the discussion that day, as opposed to a response to what we have put to you. If you see what I mean.

MR O'BRIEN: Mmm.

DR CHADA: And Siobhan is going to send you the statement for today. She is going to try and get that to you before the end of the week, Mr O'Brien, because I appreciate it has been very difficult to get all these meetings coordinated and to get the statements in. I am sure you could just see the back of us soon enough. So Siobhan is going to try and get that to you at the end of this week. Then if you are happy with that, and get that back to her, then we will present our findings to the case manager and try and get that done before the end of this month. That is our timetable to give you some idea. So is that okay?

MR O'BRIEN: Just while we are on that subject actually. I just want to say to you that this month of November my top priority from the end of this meeting onwards is to get my appraisal done for 2016. This whole investigative process has obviously had a significant impact upon me and, if I may say so, even more so my wife. It has been a difficult time, back to work and fulfilling the terms or the conditions of return to work. But also, apart from all of that, I haven't been able to sort out in my mind the interface between the investigative process, which I thought would have been long since completed.

DR CHADA: So did we.

MR O'BRIEN: And that after its completion I would have been able to address my appraisal for last year. So I have asked Damien Scullion to do my appraisal. Important as completion of the investigation is, after all of this time, I have a greater priority for this month and that is to get my appraisal done.

DR CHADA: That's fine. At least we know where you are at. What I would say to you, Mr O'Brien, is that the two things that will be outstanding from your point of view and from our point of view from this investigation is that if we can have an agreement or signed statement back from you on that first one with any comments you want to make about that and then shave hive sends you out that should about that and then the one that Siobhan sends you out, that should be that bid one. We can pass then this onto the case manager and then there'll be another period of time then while the case manager is making more -- I don't know, getting information and things I suppose, reading there, that is going to take him some time.

I suppose what I am saying to you, if we can get these two statements in at least it would draw a line under that part. Then the case manager can work out what he is going

to do over the next few weeks and that will give you a chance to get your appraisal done. I think -- I am not telling you what to do but I suppose I am saying to you, if we can get these two statements in at least everything is with the case manager. We will (inaudible) report findings to the case manager and that is our bit. That gives you a bit of a hiatus to say, okay, let me get -- because getting information pulled together for your appraisal can be quite time consuming and then doing the appraisal itself can be quite time consuming I appreciate that. But I would like to think that we if we can get these two statements signed off to yourself and that you are happy that this is a true reflection of or a fair reflection is probably – of course these statements, Mr O'Brien, are not meant to be a verbatim account of everything that happened in the meeting because that would have taken page and pages and pages because it was a long meeting. This is supposed to highlight the main issues, the main points that you wish to make and hopefully then we can get that sort of sort.

So I appreciate you have been very patient. I appreciate this has taken a long period of time and what you don't want is to be pushed towards, at the end, right, get this signed off. But I suppose what I am saying to you is that there may be a natural hiatus anyway after these two statements are away, when the case manager is having a look, which will allow you to get some of those other things done. At least that will be that done and out of your head if you see what I mean.

MICHAEL O'BRIEN: Could I raise a point of clarity just about that then? A statement as part of an investigative process would you be expecting, or should it not be case, that if there were any points that we consider relevant, obviously this reflects the questions that you asked and the responses to those questions, but if there were other issues, bearing in mind that since that last interview we received the statements from the other people, that we consider to be relevant but weren't raised in the meeting, should they not be included in the statement?

DR CHADA: Not in these statements because these statements are a reflection of those meetings. I think there is an opportunity for you to put those points or for Mr O'Brien to put those points in written form and that can be added to the --

MICHAEL O'BRIEN: But that should be done before the investigation concludes. Yes?

DR CHADA: And you can put those to us and we can pass those onto the case manager. That is no problem. But these here -- the statements that we took from all of those other people as well by the way, this surprised everyone, is that we have put into a statement what they -- the discussion on the day. So if people wanted to add other information or if we wanted to say, look, I have copies of this, that or whatever, they can do that as an appendix or an addendum. But it was not part of the statement because the statement is a reflection

of what --

MICHAEL O'BRIEN: It is really a record of the interview.

DR CHADA: Yes, it is really a record of the interview.

SIOBHAN HYNDS: I understand what you are saying in terms of you now had sight of statements from others that you will want to make response to.

DR CHADA: Yes, of course.

SIOBHAN HYNDS: Absolutely and that will form part and parcel of the overall --

MICHAEL O'BRIEN: You see, they also give rise to queries.

DR CHADA: And that is what we would expect.

MICHAEL O'BRIEN: They also give rise to queries and it is something that maybe could be addressed later -- it may be best to go through the terms of reference for it -- about certain points that are made in it. I don't want to go through that today. We were told there would be another opportunity to address that.

But where statements are made about conversations that might have taken place about these issues or escalation, quite a few of the witnesses talk about that, but I am concerned is there not an effort to ~~(inaudible)~~ try and discover any of the contemporaneous records around that or any documentation around those issues? Are we not going to see that as part of the investigation?

SIOBHAN HYNDS: What the normal process would be is that if you have a response that you wish to make to anything that is contained in that we are absolutely happy to look at that response. It would be for the case manager to determine what weight needs to be placed on either. So if there is something that you have seen within a statement that you are in dispute of, for example, it is important that you do raise that. It will be for the case manager to look at it in the round with all the of the information that was gathered and the other information that is there.

I know what you are saying in terms of, are we not going looking for (inaudible).

MICHAEL O'BRIEN: If somebody raised -- if manager A made an issue to manager B, is there not a record of that? Because I don't understand, we can talk about things within his – he can respond to things that are within his direct knowledge. So if somebody said I spoke to Mr O'Brien about something. He can respond whether that happened, whether it didn't. What he can't do is if there is a statement saying manager A spoke to manager B about this which he has no knowledge of, we don't know, were these conversations happening in the background. There seems to be a lot of that in the statements. It was just a surprising feature of the statement just how much relay there seemed to be between people talking about these concerns but nothing to him.

DR CHADA: I suppose though, Mr O'Brien, your dad will know that the way doctors tend to be managed a lot of it tends to be verbal. Very few people send me emails about anything in terms of how I practise or my service or things like that. So I suppose what the case manager might do, he might look at the statement where manager A says I spoke to manager B and manager B hopefully then in their statement should say manager A came to speak to me about that. So those things should tally up. But in terms of, did people send e-mails to each other, I think there are a few emails going back and forth, but in the main when it says I spoke to, if you mean is there a minute of that, probably not.

MICHAEL O'BRIEN: There are examples I didn't want -- there are examples that I am aware of people saying these were raised at meetings, at management meetings, that I think Dr Rankin held at one point. I would have thought there would be minutes of that. There is a reference to a meeting with the medical director in January 2016. I thought there would be a record of that. So things like that we should be able to see that.

DR CHADA: What would be really useful ~~(inaudible)~~ actually and as Siobhan says, anything like that, where you say actually can we find out if there were minutes for that, by all means come back. This is supposed to be reflection of our meeting. We knew that there were bound to be things that have been raised in terms of the statements. There are bound to be. There are bound to be things that you don't agree with or that you do agree with or you think happened in a slightly different way. That is no problem. You know, so anything in statements that you want to query any further or that you want to know is there more information about or are there minutes for that, if you put that down and send that in, then we will present it to the case manager and the case manager can decide whether those are there, whether he wants to pursue those any further and, as Siobhan says, what weight they want to put on those.

So you can certainly do that. That is not for this statement. It is not really for -- I suppose what was never intended and what we certainly -- this is, as you say, a transcript of our meeting the last time. So what wouldn't be appropriate is for this to be changed on the basis of all those other statements that have come in. If there are issues raised in those statements, and, I suppose, I would send in another letter and say, thank you very much, we have received all these statements. We would like to make further comments. Then just list the comments.

If you want to do that statement by statement you can do that. If you want to do that as an overall, this not how I felt this meeting went, or the minutes for that meeting, that is fine, you can make those points, or you can do it statement by statement. But either way that is a different process than what we are here to do today or in relation to this statement.

MICHAEL O'BRIEN: But you are saying after you report to the case manager?

DR CHADA: No. What I am saying is that if you have a look at that and send it to us we will include that in our report to the case manager.

MICHAEL O'BRIEN: So it will happen before. That is what I wanted to clarify.

DR CHADA: Yes, yes. Of course, yes.

MICHAEL O'BRIEN: So if we asked for that information we could expect to receive either -- that we will get it or if you are saying we can't get it (inaudible) but beforehand?

DR CHADA: But just be clear, if we have it you would get it. This is a very transparent process. We have no -- I certainly have no hidden agenda here. If it is there, you can have it. Because my view about it is that you need to come from as an informed position as you possibly can in terms of what happened and how it happened and if it needs to change how it needs to changed and all those things.

SIOBHAN HYNDS: I suppose to give you a bit of an assurance, as part of those meetings with witnesses where information was referred to, if that was available we expected that was handed to us at the time.

DR CHADA: We did say can you bring it with you.

SIOBHAN HYNDS: So the expectation was that if that was there that we would have it. If there is something that you specifically want us to go and look for we can certainly do that. Again, I would go back to the fact that if it is not evidenced the weight upon which -- in terms of what will be placed on it, will have been taken into consideration as well.

DR CHADA: The case manager might take the view, that is your word against your word and therefore I am going to have to -- (inaudible).

MICHAEL O'BRIEN: It seems to me there is a lot of stuff that really shouldn't come down to one person's word against another. Even some of the smaller things, like when people talk about whether did my father get additional admin time to the other consultants, a very simple thing, and I would have thought it would be very easy to discover what admin time they all had. You certainly don't have any idea what the job plans are for your colleagues. You would never think to ask. They seem to know about his for some reason. But, you know, could we not put that to bed, things like that, is that the case? (inaudible).

DR CHADA: I don't think anybody said that they knew ~~(inaudible)~~ about the job plan. I think some of the witnesses have said that they were aware that there would have been extra admin time. I think that's what -- so not that they knew any detail about the job plan but (inaudible).

MICHAEL O'BRIEN: But is that the case? Is it the case that he had additional admin time?

DR CHADA: That is what we have been advised and that's in the statement.

MICHAEL O'BRIEN: I understand, but is that the case when you look at the job plans for the different consultants?

SIOBHAN HYNDS: The PA levels are certainly different.

DR CHADA: Yes.

SIOBHAN HYNDS: Yes.

MICHAEL O'BRIEN: For admin specifically?

SIOBHAN HYNDS: Specifically for SPA time.

DR CHADA: Yes.

MR O'BRIEN: No, admin time.

SIOBHAN HYNDS: Admin time, in terms of?

MICHAEL O'BRIEN: The job plan would have admin time. It is something like four hours a week.

MR O'BRIEN: I think so, yes. I have no idea what other people have for administration time. I had no idea whatsoever until the allegation was made by at least one witness in his belief that I had been allocated additional administrative time, I had no idea -- I had no idea that I had been allocated additional administration time and I have no knowledge of the administration time allocated to other people in their job plans.

DR CHADA: We can ask the --

SIOBHAN HYNDS: But I suppose it is important that, you know, we don't get any -- there are very specific terms of reference in terms of what we are looking at. Whilst~~ereas~~ we might have things in the statement that goes into commentary around other things, that doesn't necessarily mean that that is what is being investigated. So, I mean, every single point within every single statement is not for, you know, picking over and for us to go and try to reconcile is that correct or is it not. We will deal with those in the round and we will gather whatever evidence is there that supports or otherwise a version of what is being said. But to -- on that point, for example, in terms of whether there is additional admin time, we will look at the relevance of that to the overall terms of reference. And that is a point that we will get to whenever we pull all of the information together. At this point in time, what we are doing is gathering that information. The reporting on that will deal with all of that at that point in time. Is there things now that we need to go and reconcile in terms of what this person said, this is what this person said, is there something that then -- and you'll get that at that stage if that is something that you feel is necessary.

MICHAEL O'BRIEN: The things that are more concerning, what I am raising here, are the things that we can't speak to because he has no direct knowledge of them.

DR CHADA: I think, Mr O'Brien, what you do, is you raise that. So you have an opportunity

now. As I say, these statements are a transcript really but you have an opportunity now, having received all the statements from everybody, you have an opportunity to go through all of those and say, actually, I want to (inaudible).

SIOBHAN HYNDS: We couldn't possibly, you know, we don't know that or we don't have that ~~(inaudible)~~ information or that was not provided to us or --

DR CHADA: Or I don't agree with that.

MR O'BRIEN: So my concern about this, there are certainly issues that we will be querying and have grave concerns about, all I am just -- I have -- my overriding concern is that I would want those addressed or investigated or clarified as part of the process that is submitted to the case manager. So, basically, what I am just saying is, I don't want to be receiving my respondent statement of today and sending it off in return to you by next week some day with a load of issues that I have to address as part of this investigative process and I don't have the time to do it this month.

DR CHADA: That's fine. What I am saying to you, Mr O'Brien, is if you can respond I suppose to the statements and say, these are some of the issues that I want to raise, we will wait for that and that is absolutely fine. That's no problem so you can respond to that and ~~(inaudible)~~ you can say, look, these are some of the issues that I would like to raise to that. We will look through that. That will be put to the case manager. As I say, if there is further information that we can, on the back of some of those issues that you have raised, if there is information that we think is relevant and needs to be provided then we will chase that. We may already have it. It may already be there. Somebody might have sent us some emails. I know people did bring emails and various other bits of information around.

So if you get that letter into us whenever you can. I appreciate what you are saying, that you have got ~~to~~ ~~(inaudible)~~ other priorities at the minute. Okay.

Today is about terms of reference 4. So terms of reference 4 was in relation to the private patients and the impression that some people had that maybe private patients were being moved up the list. You had asked for additional information, Mr O'Brien, and this is some of the additional information that has been sent to you. Some of these referrals. Some of these patients who would have been seen privately in the Hermitage and then added onto an operation list.

So what you have there is a copy of some case notes, the date on the waiting list, the date of the operation and then the days between the time that they were added to the waiting list to the operation date and then a review of whether:

"Is there a clinical reason why they should have waited such a short time compared to

Comac, Jennifer

From: Khan, Ahmed
Sent: 21 November 2017 09:01
To: Wilkinson, John
Subject: FW: MHPS Case Update

Importance: High

Dear John, please see MHPS case update.
Regards,
Ahmed

From: Hynds, Siobhan
Sent: 20 November 2017 20:00
To: Khan, Ahmed
Cc: Chada, Neta
Subject: MHPS Case Update
Importance: High

Dr Khan

Case Update on behalf of Dr Chada.

Dr Chada met with Mr O'Brien on 6 November to discuss the final issues outstanding as part of her investigation. No further meetings are planned and a report will be completed as soon as possible for your consideration.

Mr O'Brien will require to sign of

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teams and on reflection it is likely this delay provided some 'breathing space' to focus on other priorities.

24.16 At the meeting on 3 August 2017, the concerns were put to Mr O'Brien for his response with the exception of the issue related to private practice. Mr O'Brien asked for the specific patient information to be furnished to him in order to make a response. This was reasonable in my view and we agreed to arrange another date for the purposes of dealing with this concern when he had all of the required information.

24.17 During the first half of August 2017, I was working on finalising and getting agreed statements signed and returned from the witnesses. I reviewed my e-mails during September 2017 and cannot determine what progress was being made during this time from that review. In October 2017, co-ordination of the second meeting with Mr O'Brien was on going and correspondence was sent to him on 16 October 2017 advising of a meeting date for the second investigation meeting on 06 November 2017.

24.18 From my perspective, there is an unexplained delay during September and some of October 2017. During the investigation there was time spent reading and commenting on documents, setting up meetings with witnesses, writing up notes and drafting documents. I cannot attribute any of this work to the delay in September and October following a review of my e-mails at the time.

24.19 On 6 November 2017, the second investigation meeting was held with Mr O'Brien in order to seek his response to the issues of concern in respect of term of reference 4. At this meeting, Mr O'Brien advised Dr Chada that he wished to make comment on both his first statement and the witness statements provided to him. He further advised that his priority for November and December was completion of his appraisal and that he would not be able to provide his comments during this period. It was agreed his timescales would be facilitated.

24.20 Again, on reflection I along with Dr Chada should have insisted on a commitment from Mr O'Brien to prioritise the comments on his witness statements

and return them sooner. Mr O'Brien was not expressing any urgency to get matters completed.

24.21 By 15 February 2018, Mr O'Brien had not provided the comments he had previously advised he wished to make and therefore I e-mailed Mr O'Brien seeking an update. I did not receive a response and so followed up with a further email reminder on 22 February 2018. On this date, Mr O'Brien requested a copy of the statement from the 6 November meeting and indicated he would provide commentary on all documents by 31 March 2018.

24.22 It was evident to me by this stage that the timescale was drifting and that there was a lack of urgency on the part of Mr O'Brien to engage to assist in bringing the process to a conclusion.

24.23 I liaised with Dr Chada and we agreed that this was too long given the extended period already afforded to Mr O'Brien and therefore I e-mailed him to ask him to provide comments by 9 March 2018 rather than 31 March 2018.

24.24 Mr O'Brien did not provide his comments by 9 March 2018 and therefore I sent a further e-mail on 16 March 2018 requesting comments no later than 26 March 2018. I advised Mr O'Brien at that point that Dr Chada would progress with the investigation report and conclude without his comments if they were not provided by 26 March 2018. Mr O'Brien did not comply with my request and did not provide his comments by 26 March 2018.

24.25 It was increasingly concerning to me by this point that Mr O'Brien was either working to his own initially requested deadline of 31 March 2018 and ignoring the timescales set by Dr Chada or was purposely delaying the conclusion of the process. At this point Mr O'Brien had his original statement for comment for almost 6 months.

24.26 I wrote again to Mr O'Brien on 29 March 2018 advising that he was required to provide comments by 12 noon on 30 March 2018 after which the

Hynds, Siobhan

From: Chada, Neta [redacted]
Sent: 12 February 2018 10:45
To: Khan, Ahmed; Hynds, Siobhan
Subject: RE: MHPS Case Update

Follow Up Flag: Follow up
Flag Status: Flagged

Hi ahmed

The last we spoke to this doctor he was to get back to us – he had explained he wanted time out to sort out his appraisal. So I think we are waiting for him to get back to us, rather than any delay on our part

neta

From: Khan, Ahmed
Sent: 07 February 2018 13:05
To: Hynds, Siobhan
Cc: Chada, Neta
Subject: RE: MHPS Case Update

Dear Siobhan, I haven't heard any updates for this case in last couple of months. kindly let me know the progress.
Thanks,
Ahmed

Dr Ahmed Khan
Consultant Paediatrician
Associate Medical Director
Children & young people Directorate
SHSCT

From: Hynds, Siobhan
Sent: 20 November 2017 20:00
To: Khan, Ahmed
Cc: Chada, Neta
Subject: MHPS Case Update
Importance: High

Dr Khan

Case Update on behalf of Dr Chada.

Dr Chada met with Mr O'Brien on 6 November to discuss the final issues outstanding as part of her investigation. No further meetings are planned and a report will be completed as soon as possible for your consideration.

Mr O'Brien will require to sign off his statement from the first meeting with him which has not yet been

Comac, Jennifer

From: Wilkinson, John
Sent: 22 February 2018 10:33
To: Khan, Ahmed
Cc: Wilkinson, John
Subject: RE: MHPS Update

Hi Ahmed
Thanks for this Ahmed.
Very useful to see where we are with this.
I trust this can be expedited as soon as possible.
Regards
John

From: Khan, Ahmed
Sent: 22 February 2018 10:28
To: Hynds, Siobhan
Cc: Chada, Neta; Wilkinson, John
Subject: RE: MHPS Update

Siobhan, thank you very much for this update.
Regards,
Ahmed

Dr Ahmed Khan
Consultant Paediatrician
Associate Medical Director
CYPD, SHSCT

From: Hynds, Siobhan
Sent: 15 February 2018 14:54
To: Wilkinson, John
Cc: Khan, Ahmed; Chada, Neta
Subject: MHPS Update
Importance: High

Mr Wilkinson

MHPS Case Update:

Dr Chada and I met with Mr O'Brien in November 2017 to discuss the final issues outstanding as part of the MHPS investigation, Mr O'Brien provided a written response to the issues raised. Prior to this meeting all witness statements were collated, agreed and shared with Mr O'Brien for his review.

All evidence / documentation has been gathered & reviewed.

No further meetings are planned with Mr O'Brien prior to completion of a final report for consideration of by the Case Manager unless he should request a further meeting which to date he has not.

At our last meeting with Mr O'Brien he noted with us that he was not in a position at that time to sign and agree his initial statement as he had commentary to make. He also advised he had comments on each of the witness statements provided to him. He advised that he had priorities prior to Christmas which would prevent him providing his comments. It was agreed that we would wait on receipt of these.

I have not received any feedback from Mr O'Brien and it has been my delay in following this up with Mr O'Brien. My apologies for this delay. I have now chased this up with Mr O'Brien. I will continue to do this and will provide a final date for receipt on his reply.

In the meantime we will begin to draft the final report. I will provide a weekly update going forward and will confirm a date for finalisation of the case report.

Please come back to me if you have any queries.

Regards,

Siobhan

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

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Hynds, Siobhan

From: O'Brien, Aidan [redacted]
Sent: 22 February 2018 19:12
To: Hynds, Siobhan
Subject: RE: MHPS Process

Follow Up Flag: Follow up
Flag Status: Flagged

Siobhan,

It would appear that I have misunderstood the arrangements and commitments agreed at our last meeting.
I was of the understanding that I would next receive your Note of that meeting in November 2017, and that then I would reply with suggested amendments to both Notes, and with comments upon witness statements etc.
I had been checking emails to ensure that I had not overlooked a further communication, and wondering why there had been such a long delay.
I now understand why that has arisen.
I have not had time to attend to the process since November 2017.
I would be grateful if you would provide me with the Note of the Meeting in November 2017, and any other documentation which I have previously requested.
I will then endeavour to revert to you as soon as possible thereafter, and within a specified timeframe, such as by 31 March 2018,

Aidan.

From: Hynds, Siobhan
Sent: 22 February 2018 18:43
To: O'Brien, Aidan
Cc: Chada, Neta
Subject: RE: MHPS Process
Importance: High

Good Evening Mr O'Brien

Can you please update as per my e-mail below.

Many thanks

Siobhan

From: Hynds, Siobhan
Sent: 15 February 2018 13:25
To: O'Brien, Aidan
Cc: Chada, Neta
Subject: MHPS Process
Importance: High

Good Morning Mr O'Brien

I hope you had a good Christmas and New Year break.

It has been some weeks now since we last engaged about the ongoing investigation process under the MHPS Framework. When we last met with you, Dr Chada and I had advised that we were at the conclusion stage of our investigations and the meeting with you in November was the last meeting we felt was required.

At that meeting we had outlined that we would require your first statement to be agreed and returned. You indicated that you had comments to make and undertook to do that before returning it to us. I am checking to see if you have this now finalised and are in a position to return this to us?

You had also indicated that you wished to make comment on the witness statements shared with you and you indicated you would also do this and provide those comments to us. Can you advise if this is complete and if you are in a position to share this with us.

I appreciate that when we met you had indicated you had a number of priorities to deal with in December outside of the MHPS process and would not be in a position to return your comments prior to January. We would like to try to bring this process to a conclusion and I would be grateful if you could come back to me as soon as possible on these matters.

I have the notes of our meeting in November to share with you which will also require your agreement. We do however have your written statement on those issues in full so that is a smaller matter to be finalised.

I look forward to hearing from you.

Kind Regards,

Siobhan

Mrs Siobhan Hynds
Head of Employee Relations
Human Resources & Organisational Development Directorate
Hill Building, St Luke's Hospital Site
Armagh, BT61 7NQ
Tel: Personal Information redacted by USI Mobile: Personal Information redacted by USI Fax: 028 3741 2620

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Corrigan, Martina

From: Hynds, Siobhan [redacted]
Sent: 04 March 2018 14:03
To: O'Brien, Aidan
Cc: Chada, Neta
Subject: Statement 2 - Mr A O'Brien 061117 (names redacted)
Attachments: Statement 2 - Mr A O'Brien 061117 (names redacted).docx

Importance: High

Mr O'Brien

Please find attached notes from the November meeting for your agreement.

I would be grateful for an update from you regarding your comments on the previous meeting notes (statement1) and the witness statements.

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]

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Hynds, Siobhan

From: Hynds, Siobhan [redacted]
Sent: 04 March 2018 14:23
To: Wilkinson, John
Cc: Khan, Ahmed; Chada, Neta
Subject: RE: MHPS Update

Importance: High

Follow Up Flag: Follow up
Flag Status: Flagged

Mr Wilkinson

MHPS Case Update:

Mr O'Brien has been provided with all documentation for his comment to enable the final report to be written. I have been in contact with Mr O'Brien regarding a final date for submission of his comments back to Dr Chada. I have asked for this to be complete by Friday 9 March 2018. To date I have not had a response from Mr O'Brien regarding this deadline date and I have today asked for a further update from Mr O'Brien.

I will continue to keep you informed in terms of the finalisation of the report.

Regards,

Siobhan

From: Hynds, Siobhan
Sent: 15 February 2018 14:54
To: Wilkinson, John
Cc: Khan, Ahmed; Chada, Neta
Subject: MHPS Update
Importance: High

Mr Wilkinson

MHPS Case Update:

Dr Chada and I met with Mr O'Brien in November 2017 to discuss the final issues outstanding as part of the MHPS investigation, Mr O'Brien provided a written response to the issues raised. Prior to this meeting all witness statements were collated, agreed and shared with Mr O'Brien for his review.

All evidence / documentation has been gathered & reviewed.

No further meetings are planned with Mr O'Brien prior to completion of a final report for consideration of by the Case Manager unless he should request a further meeting which to date he has not.

At our last meeting with Mr O'Brien he noted with us that he was not in a position at that time to sign and agree his initial statement as he had commentary to make. He also advised he had comments on each of the witness statements provided to him. He advised that he had priorities prior to Christmas which would prevent him providing his comments. It was agreed that we would wait on receipt of these.

Hynds, Siobhan

From: Hynds, Siobhan [redacted] >
Sent: 29 March 2018 22:17
To: O'Brien, Aidan
Cc: Chada, Neta
Subject: RE: MHPS Process

Importance: High

Follow Up Flag: Follow up
Flag Status: Flagged

Mr O'Brien

I refer to my e-mail below. I have received no comments from you as you had previously indicated you wished to make.

Dr Chada is writing the investigation report from midday tomorrow. I wanted to let you know this to ensure that you have a final opportunity in advance of 12 tomorrow to send through any comments you wish to make. In the absence of this, as previously advised, the report will be based on the statements available.

Kind regards,

Siobhan

From: Hynds, Siobhan
Sent: 16 March 2018 10:10
To: O'Brien, Aidan
Cc: Chada, Neta
Subject: MHPS Process
Importance: High

Dear Mr O'Brien

Further to my e-mails of 23 February 2018 and 4 March 2018 which are attached for your information.

I would be grateful if you could confirm if you are in a position to return your comments on the 2 statements previously sent to you and any other comments you wish to make on the documentation shared with you to date.

If comments have not been received by return before 4pm on Monday 26 March, Dr Chada will proceed to finalise the investigation report based on the information available.

Regards,

Siobhan

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

Corrigan, Martina

From: Aidan O'Brien <[redacted]>
Sent: 02 April 2018 21:14
To: Hynds, Siobhan
Cc: Chada, Neta
Subject: Investigation
Attachments: Comments relating to the Respondent Statement of Thursday 03 August 2017.docx; Comments concerning the Respondent Statement of the Meeting of 06 November 2017.docx; Comments concerning Witness Statements.docx

Siobhan,

Thank you for your email of 04 March 2018.
Thank you for the draft Respondent Statement relating to the meeting of 06 November 2017.

I have attached comments concerning the proposed Respondent Statements of 03 August 2017 and of 06 November 2018.
I have also attached comments relating to the Statements of Witnesses.

I also take this opportunity to remind you that I had written to Dr. Wright on 14 February 2017 with details of factual errors and omissions in the Note of the Meeting I had with him and Ms. Hainey on 30 December 2016.
You had written to me on 01 March 2017, advising that you would arrange an amended Note to be sent to me, taking consideration of my comments.
I still have not received an amended Note.

You had also provided me on 06 February 2017 with a Note of the Meeting of 24 January 2017 with Mr. Weir and with yourself.
I submitted proposed amendments to that Note on 28 March 2017.
I still await an amended Note.

I particularly would be grateful if you would clarify whether it is intended to provide amended Notes, and if so, when I might expect to receive them.

Thank you,

Aidan.

Southern Health and Social Care Trust

Quality Care - for you, with you

21 June 2018

BY E-MAIL ONLY

Mr Aidan O'Brien

Personal Information redacted by the USI

Dear Mr O'Brien

Re: Formal investigation under Maintaining High Professional Standards Framework

I write further to the investigation under the Maintaining High Professional Standards Framework.

This investigation has now concluded and I am in receipt of the investigation report from the case investigator, Dr Neta Chada.

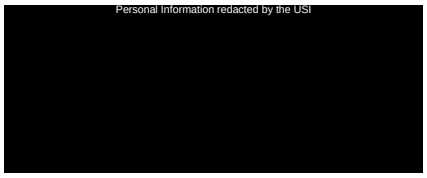
In line with the Maintaining High Professional Standards Framework, I wish to share with you, a copy of the investigation report inclusive of all appendices. You are invited to make comments to me in writing on the factual accuracy of the report and to include any mitigation you wish to be considered.

Given the confidential nature of the report I do not wish to post this to you and therefore a copy of the report is available for your collection from my secretary, Ms Laura White in Trust Headquarters.

I would ask you to collect this report as soon as possible and before Monday 25 June 2018. Your comments should be returned to me within 10 working days thereafter. I would therefore expect to receive your comments by Monday 12 July 2018.

If you have any queries regarding this matter please do not hesitate to contact me.

Yours sincerely



Dr Ahmed Khan
Acting Medical Director / Case Manager

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Personal Information redacted by the USI

had been returned. This included Personal Information redacted by the USI. He stated he recalls Personal Information redacted by the USI as her chart was not available to him and he stated he had returned Personal Information redacted by the USI's 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 O'Briens wife 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. Mr O'Briens son 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. Mr O'Briens son 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

Note of Meeting with Mr Aidan O'Brien, Consultant Urologist – 30th December 2016

Present:

Mr O'Brien (accompanied by his wife, Personal Information redacted by the USI)
Dr Richard Wright, Medical Director
Ms Lynne Hainey, Employee Relations

Introductions were made and Dr Wright thanked Mr O'Brien for attending the meeting. It was explained that the reason the meeting had been called was to make Mr O'Brien aware that concerns had been raised with Dr Wright on the back of a Serious Adverse Incident (SAI) Investigation. Dr Wright noted that some of these concerns had been raised with Mr O'Brien previously and attempts had been made to resolve the matters informally, with no success. Ms Hainey made Mr O'Brien aware of the nature of the concerns that had been raised with Dr Wright ie concerns relating to his administrative practices, and the possibility that patients may have come to harm as a result of those administrative practices. In particular:-

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

   Ms Hainey referred to the ongoing SAI investigation relating to a Urology patient who may have a poor clinical outcome due to the lengthy period of time taken by Mr O'Brien to undertake triage of GP referrals. Mr O'Brien was also informed that the SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason.

2. That there is a backlog of over 60 undictated clinics going back over 18 months and therefore there is 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 Mr O'Brien may have had their notes taken back to his 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.

Mr O'Brien advised that he was not aware of the cases in question being investigated under SAI, and that he had no involvement in the SAI process. Dr Wright advised that he would raise this with the SAI Team, stating that the process remains ongoing and they may not have contacted Mr O'Brien yet because he had been on sick leave.

Dr Wright advised that nevertheless concerns had been raised with him in relation to Mr O'Brien's administrative practices and because of the seriousness of these, and the fact that informal steps had been unable to resolve the issues previously, a decision had been taken to investigate the matter formally in accordance with the Maintaining High Professional Standards Framework and associated local guidance. Ms Hainey provided Mr O'Brien with a copy of both documents for his information, explaining that these outline the process by which an investigation is undertaken and Mr O'Brien's rights in the process.

Dr Wright confirmed that a Case Manager and Case Investigator had been appointed (Mr Ahmed Khan, Case Manager and Mr Colin Weir, Case Investigator). Ms Hainey explained that Mr Weir will be supported in the investigation by a representative from Human Resources (as yet to be appointed). Dr Wright advised that a Non-Executive Director will also be appointed to oversee the investigation process, and the detail of this person to be communicated to Mr O'Brien asap.

Mr O'Brien was informed that as an interim precautionary measure, he was being placed on immediate exclusion with full pay. He was informed that the decision had been taken by the Oversight Committee in the Trust and that NCAS had been informed of this prior to the meeting. It was explained that this would be for no longer than 4 weeks, and that during that time, further preliminary information would be collated to decide the scope of the investigation, and therefore the Terms of Reference for investigation which would be forwarded in due course. Mr O'Brien was informed that a meeting would be arranged to take place with him during the 4 week period, and that he would be kept informed of any progress in relation to the investigation.

Mr O'Brien advised that the concerns needed to be considered in the context of the enormous pressure on him to operate. He stated that clinical outcomes are compromised because of a lack of capacity. He stated that there is an inequity within the department and gave an example that in October, he had a waiting list of 288 for inpatient admission whilst a colleague had a waiting list of 29. He advised that he had previously asked through his Clinical Director that this situation be addressed. But that because of the waiting list the demand on him was to operate.

Mr O'Brien stated that it was important to appreciate the totality of the work that he does, and as a result he does not have time to triage non red flag referrals. He advised that the referral of these was a historical hangover from the time when it was felt there was not enough to do when on-call. The triage of non-red flag referrals was undertaken to justify on-call time. Mr O'Brien advised however that this time is now spent on operations eg the last week he was in work, he undertook 21 operations whilst on-call.

Dr Wright noted the points made by Mr O'Brien and advised that whenever an investigation is undertaken, there may be criticisms of the Trust, and its systems but that would have to await the outcome of the investigation.

Mrs O'Brien stated that her husband had worked for 25 years as a Consultant in the Trust and that during that time he had worked 70-90 hours per week including week-ends. She advised that when taking someone off the waiting list in chronological order ie those longest on the waiting list, her husband is conscious that so much could have changed for the patient during the intervening period and so he would take the time to ring and speak to the patient to find out how doing etc. Mr O'Brien advised that he had 19 additional theatre sessions and 15 extra oncology sessions, and is under pressure to do all.

Dr Wright advised that he is well aware of the work that Mr O'Brien does for the Trust, but that given the concerns that have been brought to his attention, the matters have to be investigated. Ms Hainey stressed that it is an investigation to establish the facts and that Mr O'Brien would be given every opportunity to respond in full as part of the investigation process.

Mrs O'Brien stated her view that the system needs to change as there is too much work being placed on Consultants. She advised that when she worked as a nurse practitioner 40 years previous, it was her role to triage the referrals. Mr O'Brien reiterated that he had raised two years previous that he did not have capacity to deal with non-red flag triage. He said that it is his view that you need to speak to patients rather than ticking a box, and that to do so takes time.

Dr Wright referred to the need to return any notes as a matter of urgency. Mr O'Brien was requested to return these to Martina Corrigan, Head of Service for Urology by 11.00 am on Tuesday 3rd January 2017. Mr O'Brien stated that he could not return these without processing them. Dr Wright stated that the notes needed to be returned by the above date and time, as he was accountable and needed to deal with the matter. He stated that if there were notes missing, this was a very major problem that would need to be dealt with through Information Governance. Mr O'Brien advised that he has all the notes that are tracked out to him. Both Mr and Mrs O'Brien queried what happens with the patients given that Mr O'Brien has not processed them, and would be the best person to process the cases. Dr Wright advised that he will deal with this. Mr O'Brien asked for a deferment of two weeks to allow him to process the files and Dr Wright advised that no deferment could be granted. Ms Hainey reiterated that in the interests of all parties, and of the investigation process, that the notes needed to be returned as per Dr Wright's management request.

Mr O'Brien said that he was shell-shocked. Mrs O'Brien said that there would be no better person to process the cases. Dr Wright said Mr O'Brien had been asked to return all the information in March 2016 but did not. Mr O'Brien said that the emphasis for him at that time was operating. It was made clear that the notes had to be returned as requested and that anything associated with the care of those patients would be reviewed by others. Ms Hainey asked Mr O'Brien to comply with the request and Mrs O'Brien stated that she was concerned about how the cases would be dealt with. Dr Wright advised that he would take responsibility for this. He advised that the matter would have to be reported to the Chief Medical Officer who would be querying where all the notes are, and therefore that it is imperative that Mr O'Brien return the notes as requested.

As it was obvious that both Mr and Mrs O'Brien were upset, Ms Hainey asked if anyone wished a glass of water or cup of tea/coffee. This was declined. Mrs O'Brien stated that there was too much bureaucracy in the Health Service and she felt this was a major issue. She advised that Mr O'Brien's SPA time was spent operating or reviewing cancer patients, and that he took time in December to do his appraisal. Mr O'Brien said that he had been pleading for the past 2-3 years that he should not see any new patients because of the immorality of not being able to do what he had pledged to do. He said that as a consequence of operating, other duties get neglected. He said that there were not enough hours to be faultless, that he had tried in the past without sleeping or without food.

Mr O'Brien stated that he was devastated by what had been communicated to him today. Dr Wright queried if Mr O'Brien's job plan was unrealistic. Both Mr and Mrs O'Brien stated that the job plan is OK but things are allocated to SPA time that are not admin work. Dr Wright stated that if the job plan does not cover all the work have to do, then it is not right. Mrs O'Brien stated that the first job plan was 15.5 when in reality it should have been about 18. She said that now the job plan is 10 sessions. Mrs O'Brien stated that she and her children have sacrificed their family life for her husband's job and 'this is how we are repaid' referring to the discussion taking place.

It was again reiterated that there is an obligation to address concerns when these are raised, and that Dr Wright had been made aware of serious concerns about Mr O'Brien's administrative practices which may have / has the potential to lead to harm for patients.

Mr O'Brien was made aware of the paragraphs in the MHPS documentation relating to exclusion. He queried if he can continue to work with private patients. Dr Wright suggested that he take advice from his union, but said that as RMO, he would discourage this. Dr Wright suggested that Mr O'Brien ask his colleagues to review any private patients that he has.

Mr O'Brien was made aware of support services available through Care-call and OH. He was advised that an OH appointment would be made for him and would be communicated to him. Prior to meeting concluding, Mr O'Brien apologised to Dr Wright.

the kinds of experiences or learning that you took from your involvement in those cases before grappling with the Mr. O'Brien investigation?

A. All four cases were very significant cases, I suppose, so my experience of Maintaining High Professional Standards was of its use in situations which were complex and significant issues being raised. I found Maintaining High Professional Standards difficult to use in terms of time scales where -- and so I knew that from even before being asked in relation to Mr. O'Brien. Time scales were not met in any of those cases, I remember that vividly. I think that's one of the biggest issues for me in terms of learning, was that Maintaining High Professional Standards really very difficult to keep to the time scales. Very clear in terms of what the Case Investigator role is but again not a lot of additional information in relation to guiding that role. I suppose that's... 10:34 10:34 10:35 10:35

26 Q. You seem to highlight that one of the main things you take from those experience is managing the time scale. I suppose by the time it gets to a formal MHPS investigation, it involves a degree of seriousness or gravity and, perhaps in very many cases, complexity. We will look in due course at how time moved on in the O'Brien investigation. 10:35 10:36

But at this stage of our discussion this morning, can you see anything in terms of learning from those experiences that either yourself, as the Case

Investigator, can do better, or is it a case of Trusts who own these processes building a better infrastructure and support network around the investigations?

A. One of the things that I am minded of on reflecting on those cases was the impact on the subject of the investigation. I do think that that probably influenced me in terms of the investigation into Mr. O'Brien. You know, there's a difference between being told you are being managed under the Trust guidelines, which tends to be at an informal level, although that is part of Maintaining High Professional Standards still, and then being told that you are being investigated under the auspices of Maintaining High Professional Standards. 10:36 10:36 10:37

My memory of all four of those prior to Mr. O'Brien was how anxiety-provoking it was for people. They were afraid of the process and anxious about the outcome. 10:37

I'm so sorry, I have lost the track of your question, Mr. Wolfe.

27 Q. Yes. I asked the question from the angle of whether you, as the practitioner leading the investigation, or the Trust who owns the process, if there is impact on the practitioner as you describe, whether the delays that seem to punctuate the process -- perhaps inevitably because of complexity or whatever else -- can that be better managed by the investigator or is 10:37

there a need for better support by the Trust for the investigation in order to move it along with greater efficiency?

A. I think Maintaining High Professional Standards is not fit for purpose. The reason I say that is because Maintaining High Professional Standards requires really that it should be a medic that undertakes the investigation for, I think, very good reason. However, medics have other responsibilities, either clinical responsibilities or, in my case, both clinical and management responsibilities. There's an onus on the Case Investigator being somebody who is, I suppose, of a reasonably -- in a reasonably responsible position because you don't want an investigation carried out by somebody who is, you know, at a lower level or the same level in terms of perception. The difficulty with that is that people in that position are people who have additional responsibilities. As a consequence, you are trying to undertake a complex investigation, maybe interviewing lots of different witnesses, as was the case in some of these other investigations as well, who are very anxious. At the same time, you are running -- you are doing your clinical job, which, in my case -- I am not sure if this is helpful to the Panel -- but I ran an acute service, so I essentially ran an emergency service. I was the consultant for Home Treatment Crisis Response Services. That is an alternative to hospital admission. So, all my clinical work is not work that can be put off to another time.

10:38 10:38 10:39 10:39 10:39

I can't cancel Outpatient clinics, I can't cancel theatre lists, not that I would anyway. I have to be honest and say I wouldn't do that anyway for an investigation because I don't think putting other patients' quality of service, impacting on that is appropriate. 10:40

But all my work in any respect, in any way, in any event, was acute work, and these are things that can't be put aside. These are people who are acutely mentally ill, who, if it wasn't for my service, would have to be admitted to hospital. There aren't enough beds in hospital and therefore it's very important that we can safely manage those people who are acutely ill, presenting with some risk, in the community. So, you are doing that. 10:40

I was also the Associate Medical Director. Just to put that in context, you are responsible for performance of the biggest number of consultants, bar anaesthetists, in the Trust. Mental health and disability has the most significant number of consultants bar anaesthetists, so it's a big consultant body, along with junior doctors. Then there's the governance issues that you are directly responsible for. In the 15 months that this investigation took, there were also 30 ongoing Serious Adverse Incidents in mental health and disability, which I would have been aware of. 10:40 10:41

I chaired one SAI in mental health and disability. For me to chair -- for the Associate Medical Director to

chair an SAI within the Directorate suggests that there was something quite complex about it, maybe involving outside agencies.

I also chaired an SAI in the Acute Hospital across, I believe, ED and Children's Services, and Medicine was involved in that as well. Again, for someone from outside Acute Services to be asked to chair that suggests a very significant degree of complexity. On top of all of that, we had a double homicide in the Trust in this period. I suppose the reason I'm explaining this is that in terms of Maintaining High Professional Standards, it's my belief that the investigation is done to the best of your ability within time constraints that are available, and I'm not sure that that's the correct way to carry out an investigation if you want a more robust outcome. 10:41 10:42 10:42

I'm not sure how much time this Inquiry has but I suspect that time has been set aside -- in fact, I know that time is set aside specifically for it. No time is set aside for Maintaining High Professional Standards investigations in terms of my job plan, or in anybody else's. I mean, I was assisted by Mrs. Hynds, and no additional time was set aside for her either. 10:42 10:43

28 Q. Mm-hmm. So, the picture emerging from your evidence so far is that you, a senior practitioner, with perhaps more experience than most in the role of an MHPS investigator -- you have gone through four

investigations -- you are asked to do this; can you refuse, in real terms --

A. Yes.

29 Q. -- or is it part of your nature perhaps to assist the employer where you can, despite the pressures? 10:43

A. You can refuse. This is done as a voluntary additional activity. It's not my nature to assist the employer. It is, however, my nature to ensure that patient service, patient care, quality of service to patients, is considered and regarded with seriousness. 10:44

I felt that given my experience to date, and the fact that I had very little contact with the Acute side, so I was outside of a lot of these issues, I felt that probably did lend to me being able to carry out an 10:44 in-depth and reasonably robust investigation. You want to be helpful, and I suppose you want to be helpful also because you feel that if an issue arises within your own directorate that requires somebody from outside it to come in and take an independent hands-off 10:44 look at it, that they will do that. You know, if everybody said no, then we would never get anywhere. Nowhere is that appropriate, you know. Complaints and issues of concern need to be investigated and addressed, so I felt a moral obligation to do so. 10:45

30 Q. If the likely candidate for Case Investigator is a person like you, can one assume that the experience that you face of other responsibilities, the need to progress an investigation and the risk that, as you

have just pointed out, of a less than robust investigation or less robust than you would like it to be, if that's the experience of others, what is to be done, in your view? You have described MHPS as not being fit for purpose but assuming we need some form of framework to look at matters of this nature, what is to be done to avoid a situation where you aren't able to devote all of your energies in a consistent way to the investigation, risking delay and risking less than robust outcomes? 10:46

A. I think to the Panel, I suppose I have a number of comments in relation to this. An investigation which takes 15 months is not helpful to the person under investigation or to the Trust. I was aware that there was an action plan in place, which I suppose lent some degree of assurance that things weren't being allowed to continue in the previous manner. That helped to some extent. However, I think there's no doubt that, having a shorter timeframe for an investigation, where issues are looked at very quickly, recommendations are made quickly and that the Trust can implement those quickly is what's required.

In terms of how that happens, I don't believe that anybody can be a Case Investigator -- and, as you have indicated, Mr. Wolfe, I have some experience in this -- I don't think you can be a Case Investigator without time set aside for it. Further, I also think -- and I have reflected a lot on this through this experience

123 Q. Now, in terms of the witnesses you spoke to, 13 interviews were conducted between the 15th March and the 5th June. If we just have up on the screen, please, the timeline for that, TRU-00671. You started with Ms. Corrigan and, just over a week later, Mr. Young, and then a gap of just over a week, Mrs. Graham and so on. 14:21

Would it have been ideal, Dr. Chada, to have had, I suppose, less gaps in terms of gathering information/evidence from witnesses rather than spreading it over a three-month period? 14:21

A. In terms of the overall timeframe, clearly it would have been preferable to see people fairly close together in terms of comparing what different people have to say. That would have been helpful. The timings relate to me providing dates to Mrs. Hynds about when I was available; people were providing dates to Mrs. Hynds about when they would be available. Taking into account all of that, and I have to absolutely acknowledge that one of the things that I believe I advised Mrs. Hynds was that this investigation would not impact on patient care, so I tried very hard to facilitate timings around -- I didn't want outpatient clinics cancelled, I didn't want theatre lists cancelled, so things like that had an impact. On reflection and in terms of the time that it took, you know, perhaps that was a foolish aspiration that I had, but -- but, look, that's what we did. Yes, 14:22 14:22 14:22

came from Dr. Wright, is that right? Is that correct?

A. Yes, that's correct.

48 Q. Your witness statement, if we just turn that up, please, WIT-23760. You say at 1.5, if we can just move through this fairly swiftly, that you were approached by Dr. Wright in late February 2017. I should ask you, there's no such thing as a formal letter of appointment or letter of instruction setting out what you were -- I see you smiling as if that's pie in the sky. Why is it pie in the sky? 11:14

A. No, no. It's not that it's pie in the sky but I would bring you back to what I said earlier. This is a voluntary role, this is a "Dear Neta, will you please", and I think that's how that happens or at least has happened to date. I am not saying that's ideal. To date you get a phone call completely out of the blue saying we really need somebody get senior and away from the main hospital to deal with something. I mean, all of the cases in which I was either Case Investigator or Case Manager were outside of my Directorate, so they are all cases where I'm felt to be very independent. So this is a phone call. This is usually a lengthy phone call but a phone call nonetheless. 11:14 11:15

49 Q. Yes. I'm not sure we need to go through it all. You summarise in 1.6, 1.7 into 1.8, the kinds of things that you were told. You were advised that issues had been first raised by clinical and non-clinical managers with Mr. O'Brien in March 2016 in relation to his areas 11:15

a misunderstanding from one person can then affect how others view their roles and responsibilities in the process?

A. Yes, I accept that. I mean, ideally where you want to be with this is you would like to have these people who undertake these roles trained at a very close time to the point at which they undertake the role. In practice again, that's very, very challenging because you don't know when cases are going to land. You don't know, you know -- so from 2017, and we had a fairly substantive cohort of individuals who attended that training, probably very many of them had never undertaken the role of Case Manager or Case Investigator since, so it becomes almost a bit defunct. Then it's about, right, okay, we need to identify somebody for these roles and you're going back to either people who have been trained but trained quite a period of time before that, or you're trying to get formal training in place. So it is challenging, there's no doubt about that. I fully accept what you're saying in terms of you are doing that internally and that refresher piece, there is that danger. Absolutely. 10:37 10:37 10:38 10:38

43 Q. The other side of that coin is the individuals who are being asked to take on the role of Case Investigator and Case Manager are full-time employees with very busy practices -- 10:38

A. Absolutely.

44 Q. -- who don't have time, one would assume, to look at

the fine detail of the MHPS framework or the Trust guidelines, so a refresher at the point of need might be something that the Trust considers to be entirely appropriate. My question was merely aimed at if the person doing that in future -- 10:39

A. Doing that. Yes I accept that.

45 Q. You've accept that point and I don't need to go any further with that.

Now, Mr. O'Brien raises an issue that at WIT-82617, 10:39 where he considers that the Trust preferred the MHPS Framework rather than The Trust guidelines. I just want to read out what he says about that at paragraph 42. 642; I think my number 6 has fallen off. I'll just read that paragraph and you can comment on it 10:39 if you think appropriate. He says:

"I wish to reiterate my concern and dissatisfaction in respect of the length of time the Trust took to conduct and complete the formal investigation using the MHPS 10:39 Framework, and which was in breach of The Trust's own policy, namely the Southern Trust Guidelines for handling concerns about doctors and dentists' performance (September 2010). Under That Trust policy, the investigation regarding my practice should have 10:40 been undertaken and concluded within four weeks from the date of exclusion on 30th December 2016. The Trust did not comply with that policy, and indeed during the course of the investigation, the Trust ignored it,

more proactive in terms of understanding what the investigator is doing, at what time and in what period he or she is doing it, the particular challenges faced in terms of gathering evidence and receiving evidence and, to some extent directing, not necessarily the minutiae of the investigation but directing in broad terms where the investigation should go?

A. There are a couple of points in your question that I would like to address in sequence. I think the first thing is that resource allocation, the time, the protected time. I'm now aware that nobody has received any protected time for doing this MHPS investigation. I had a busy caseload. I was also a medical management role in my directorate. We were going through a major reconfiguration for Children. We were going through some other important pieces of work, which I can expand on, if you like, at some stage. But no protected time in my job plan or in my working day. I feel that was one of the important factors.

I believe that I did try to address that as a Case Manager. I believe I wrote to -- I asked, actually, this question from the Case Investigator and I did discuss with the Medical Director. I think we need to understand the line management structures of all those people are different. So, for instance, my line manager was Medical Director but my appraisal line manager was my Operational Director. The same as for the Case Investigator, she had her own operational line

25. Having had the opportunity to reflect, outline whether in your view the MHPS process could have been better used in order to address the problems which were found to have existed in connection with the practice of Mr. O'Brien.

25.1 On reflection, the MHPS process was ongoing since earlier in 2016, with some informal measures. However, there appears to have been no real focus on outcomes and follow-up.

25.2 There were number of missed opportunities, especially there being no follow up after handing a letter of concern to Mr O'Brien in early 2016.

25.3 This MHPS process was progressing well in the first few months. However, planning of large numbers of interviews and statements was challenging. Perhaps better planning, organising and scheduling of these interviews may have improved the progress.

25.4 Then the non-engagement of Mr O'Brien for periods may have been avoided if the Medical Director, who was his Responsible Officer, had intervened earlier. I, as Case Manager, had discussions with the Medical Director (Dr Wright) regarding this. I believed Dr Wright had spoken to Mr O'Brien but Dr Wright would be able to provide this information.

25.5 Appropriate training and skills development is vital to carry out these roles effectively.

25.6 Dedicated and protected time is necessary in order to carry out these roles. This MHPS role was an 'add-on' for the professionals involved in investigating.

25.7 Developing experts into the role of MHPS Case Investigators and Case Managers would provide persons with the skills necessary to do the job better.

12.1 Section I. The investigation's Terms of Reference required significant additional work to be carried out so that concerns could be properly quantified and understood. The senior clinicians were therefore required to trawl through undictated clinics, look at private patients and assess the referrals for patients who had not been triaged, i.e., providing the information needed to inform the investigation with facts and figures. These clinicians all also had a service to run. A number of the other witnesses needing to be interviewed also had competing managerial and other demands. There were difficulties in arranging meetings with Mr O'Brien due to the clinical commitments both of Mr O'Brien and my own clinical commitments, as I was also a full-time clinician, and the other demands on Mrs Hynds' time. Annual leave also became an issue as the investigation progressed over the summer months of 2017. Indeed, in an effort to expedite the process I had agreed to a suggestion by Mr O'Brien that we would meet him on 1st July which was a Saturday, however, Mr O'Brien later indicated he would prefer to wait until the beginning of August. Delays were also incurred with people being on annual leave/sick leave impacting on their ability to attend interviews for witness statements and review and return their witness statements. A number of the witnesses were clearly very anxious about their statements and took a long time to return them. As Case Investigators, we felt it was important for Mr O'Brien to have had sight of all the witness statements prior to the second meeting. Mr O'Brien indicated he was of the same opinion. Mr O'Brien was given time to respond to the witness statements. Mr O'Brien provided a commentary at a time from all the information being provided to him and indeed to avoid further delay with concluding the investigation, Mrs Hynds and I agreed Mr O'Brien's drafted statement and his comments on it would be included in full as appendices.

12.2 Section II. The preparation of the investigation report also was a time-consuming process as the investigators considered all the information available to them, and had to consider whether they had sufficient information to draw informed conclusions. We also had to ensure we had addressed the issues that had been raised in the Terms of Reference. There was a lot of information to go through and we had to ensure we had properly understood processes, outcomes and what had happened and why. We needed to ensure we understood what Mr O'Brien's role was in what had happened and the outcomes.

12.3 Section III. As indicated above, the commentary provided by Mr O'Brien was somewhat delayed and was therefore added in full to the Report along with the drafted

1.36 Mr O'Brien responded on 2nd April 2018 with several queries, many of which related to the preliminary investigation and processes, as well as comments on his two statements and the witness statements; however, it was agreed by myself and Mrs Hynds that, in order to ensure the Investigation Report was concluded without any further delay given the investigation had started over a year earlier, the commentary from Mr O'Brien would be appended in full to the report so that it could be considered in full by the Case Manager. Mr O'Brien was informed of that decision by email.

1.37 The details in the investigation outline the extent of the 'Look Back Exercise' and data gathering that was undertaken. This included checking each set of case-notes returned by Mr O'Brien from his home to see if management plans had been actioned and to dictate on letters as needed, to look at where private patients were being added to waiting lists and assess if the level of prioritization was appropriate, and to go through all the untriaged referral letters which had been uncovered during Mr O'Brien's Consultant of the Week rotas. It was an extensive piece of work that we were asking managers and clinical staff to carry out. It was also agreed that Consultant Urologists would be asked to look at the patients who had been added by Mr O'Brien from his private patient list into NHS theatre lists, as well as reviewing charts which had been returned from Mr O'Brien's home without dictation. The former was to consider if private patients had effectively been allowed to 'jump the waiting list', and the latter to ensure any investigations/treatment which needed to be arranged for the affected patients had been actioned

1.38 At meetings with Mr O'Brien, it became clear he had a number of concerns and reservations about conclusions reached by other clinicians in reviewing cases including his private patient list and the triage list. He also had concerns about the process itself and about the delays. I understand the reasons for the delays were outlined to him, including the complexity of some of the background work that needed to be undertaken to inform the questions, clinical pressures on other staff etc. It was also highlighted to him that some of the delay had been as a result of his own requests for delays and his non-response to emails.

2. Provide any and all documents within your custody or under your control relating to paragraph (e) of the Terms of Reference except where those documents have been previously provided to the Inquiry by the SHSCT. Provide

Urology Services Inquiry

11. Outline all steps you took, information you considered and advice you received from the designated HR Manager, NCAS or any other person in preparing the investigation report into concerns relating to Mr. O'Brien dated 12th June 2018.

11.1 I met with Mrs Hynds and we considered the Terms of Reference and the information that was required in order for us to be able to fully address the issues raised in the Terms of Reference. I established what audits and reviews were being undertaken/needed to be undertaken to gather the information. We discussed the timeframe and the fact information needed to be gathered to ensure we could appropriately put questions to Mr O'Brien. Mrs Hynds and I went through the Maintaining High Professional Standards process and Guidelines. Mrs Hynds clarified the training I had received. She advised me NCAS had already been consulted.

11.2 As part of the investigation, face-to-face interviews were carried out with a number of witnesses. Statements were produced and the witnesses were asked to factually check their statements. The information gathered from audits, reviews, SAIs, clarification about undictated clinics and missing records was gathered. The information about Mr O'Brien's private patients was gathered and Consultants were asked to comment on whether those patients should have been added to theatre lists at that particular time, and to consider what triage rating they would have given to referral letters which had been allocated to Mr O'Brien for triage but which had not been triaged by Mr O'Brien.

11.3 Mrs Hynds advised me of the timeline of the investigation to date and outlined the meetings that had already been undertaken with Mr O'Brien. She advised me Mr O'Brien had initially been immediately excluded and had been asked to return all casenotes and undictated charts/dictation from his home. She indicated Mr O'Brien's exclusion was subsequently lifted and it was planned that Mr O'Brien would return to work with a clear management plan for supervision and clear monitoring arrangements. Mrs Hynds also advised me Mr O'Brien had been off work due to unrelated health problems. I am not aware of the parameters under which Mr O'Brien returned to work, or whether they were adhered to. This was not my role under MHPS.

an agreeable date to sit down and discuss this. Suggestions were made that you would meet at the end of June 2017; Saturday the 1st July was suggested by him; you agreed with that and then it seemed to fall away as a date that could work, but it was agreed then that 3rd August 2017 would be the date to meet. Have you any reflections upon the difficulties associated with meeting with him? Was that just one of those things, trying to marry diaries? 14:57

A. Yes. I think at the time I thought, well, this is a man who is under a lot of pressure. He wasn't well the previous year. I knew Mr. O'Brien had had surgery; I didn't know what was the reason for surgery. It wasn't appropriate information for me to know. I knew that he hadn't been well, and someone had mentioned to me - I think it may have been Mrs. Hynds - that Mr. O'Brien had reportedly lost ten pounds in weight, so I was conscious that this was a man who was under some pressure. So, at the time I felt that I was trying to be accommodating. 14:57 14:58 14:58

On reflection and as things progressed, and as a psychiatrist, I felt that there was a bit of passive aggressive behaviour evident from Mr. O'Brien. I felt that he -- on reflection, I felt he was trying to manage the timeframe; there was a level of control trying to be exerted. I didn't think about those things in the initial period at all, I have to say, I didn't really know Mr. O'Brien that well. But as the 14:58

Hynds, Siobhan

From: Hynds, Siobhan [redacted]
Sent: 19 June 2017 17:03
To: Aidan O'Brien
Subject: RE: Meeting on Wednesday 28 June 2017

Many thanks. I will come back to you as soon as possible.

Siobhan

From: Aidan O'Brien [redacted]
Sent: 19 June 2017 15:05
To: Hynds, Siobhan
Subject: Re: Meeting on Wednesday 28 June 2017

Siobhan,

I appreciate Dr. Chada's flexibility regarding this meeting.
I believe it would be better to defer meeting to later in July.
We have also scheduled our clinical commitments until end of July 2017, and so would prefer not to have to cancel appointments, admissions etc.
The only day prior to end of July when i could have attended, Thursday 27, my son cannot.
Therefore, I propose that we could meet with Dr. Chada on any day during the week beginning Monday 31 July 2017.
I do have a clinic on Monday 31 July 2017, but it has not been booked yet, so it can be rescheduled.
I would be grateful if you would advise, as soon as possible, which day it would be, so that my son can block that day, providing that it suits Dr. Chada to meet that week,

Aidan.

-----Original Message-----
From: Hynds, Siobhan [redacted]
To: Aidan O'Brien [redacted]
Sent: Mon, 19 Jun 2017 12:24
Subject: RE: Meeting on Wednesday 28 June 2017

Good morning Mr O'Brien,

I have been in contact with Dr Chada this morning regarding your e-mail below. In terms of when she can meet with you, Dr Chada had hoped to meet with you before July in order to avoid annual leave arrangements of all parties. However, if you would rather meet later in July when both yourself and Dr Chada are back from leave this can be facilitated.

Alternatively, Dr Chada is happy to try to facilitate Saturday 1 July if this is your preference? Dr Chada has a number of pre-planned appointment on Saturday 1 July am and if she is unable to change these, she would be happy to meet in the afternoon of the 1st July.

Please let me know which option you would prefer. If it is the 1st July, I will ask Dr Chada to confirm a time as soon as practicably possible.

Many thanks

Siobhan

From: Aidan O'Brien [redacted]
Sent: 19 June 2017 00:33
To: Hynds, Siobhan
Subject: Re: Meeting on Wednesday 28 June 2017

Siobhan,

I become urologist of the week from 09.00 am on Thursday 29 June 2017, obviously for one whole week.
An important component of that whole week is the handover ward round from one consultant to the next, beginning at 09.00 am that morning.
I do not know how important it is that I meet with Dr. Chada around that time, rather than later.
If it is, then the most suitable day to have the meeting would be on Saturday 01 July, as one of my colleagues would probably be available to cover my absence, particularly with regard to operating, though I have not asked any of them yet.
Would that be possible?
Otherwise, I will be on leave the week beginning 10 July 2017, and would be available all of that week,

Aidan.

-----Original Message-----
From: Hynds, Siobhan [redacted]
To: Aidan O'Brien [redacted]
CC: Chada, Neta [redacted]; Khan, Ahmed [redacted]
Sent: Fri, 16 Jun 2017 10:15
Subject: RE: Meeting on Wednesday 28 June 2017

Dr O'Brien

There is no difficulty with rescheduling. Dr Chada was holding the 29am also and the 30th may be possible – would either of these dates in the morning suit you?

I am in a meeting this morning but will aim to give you a call before the end of the day.

Regards,

Siobhan

From: Aidan O'Brien [redacted]
Sent: 15 June 2017 22:53
To: Hynds, Siobhan
Cc: Chada, Neta; Khan, Ahmed
Subject: Meeting on Wednesday 28 June 2017

Siobhan,

I received your email this evening.
Regrettably, Wednesday 28 June 2017 would not be suitable for me to meet with Dr. Chada for two reasons.
Firstly, I would certainly wish to be accompanied by my son, [redacted] as previously.
However, he [redacted] a commitment he cannot avoid.
Secondly, I have scheduled operating that day, and have already committed to a number of patients.

I would be grateful if you would contact me on [redacted] to see whether there are other dates possible,

Thank you,

Aidan.