1.13 A list of witnesses was agreed by Mrs Hynds and I after reviewing the Terms of Reference. I quickly realized this would only be a few of the people who would need to be interviewed. The list was shared with Mr O'Brien with the information that this was an initial list, and we may identify others in the course of the investigation as it progressed. I am unable to recollect exactly how the witness list was put together. Certainly, I am aware of having input into the witness list, in that I realised we needed to speak to the current managers of the service to begin with (Mr Ronan Carroll and Ms Martina Corrigan), as well as the Clinical Director (Mr Young) to understand how the service functioned and his account of the issues. Having read the investigation and chronology to date, I felt it was important also to interview Mr Eamon Mackle, who had previously been the Clinical Director and whom I understood had raised issues with Mr O'Brien previously, as well as Mr Weir who also had clinical managerial responsibility more recently.

1.14 The list of witnesses grew as I gained more information from the first interviews and, by April, a further eleven (approximately) witnesses had been identified whom I believed could inform the investigation.

1.15 Dr Khan regularly emailed Mrs Hynds and me about the investigation to ask about progress and to keep track of the investigation timeline. Mrs Hynds kept Dr Khan updated with the interviews and the progress of the other information-gathering that was being undertaken, for example, the information on untriaged referrals and whether they had been examined by other urologists and what the outcome was, and the undictated clinics, etc.

1.16 I realized this was creating a lot of additional work for the urologists, and I suggested via Mrs Hynds that Dr Khan should approach Dr Wright and discuss the possibility of further assistance to move that part of the investigation on more quickly. I felt it was important we had as much information as possible before we met Mr O'Brien so that he would know the extent of the issues and have an opportunity to address those concerns. This information is all included in emails from Mrs Hynds to Dr Khan through the course of the investigation and I understand the Inquiry Team has been provided with those.

1.17 It became clear this was a complex and far-reaching investigation and we would not meet the (frankly totally unrealistic) timeframes suggested by the MHPS framework. The

After the investigation ended, and there were queries from the General Medical Council, the Medical Director contacted me and let me know about the queries and asked me to provide the answers to questions which were in my remit, as quickly and fully as possible.

8.5 Designated Board Member

There was email contact with the Designated Board Member (Non-Executive Director) in relation to the process of the investigation and the timeframe, as indicated above. Otherwise, I had no contact with the Designated Board Member. (Mr Wilkinson.)

8.6 The clinician who is the subject of the investigation

I believe I contacted Mr O'Brien by telephone to explain I had been asked to be the Case Investigator given Mr Weir, the previous Case Investigator, was required to step down because of a potential conflict. Beyond that time, contact with Mr O'Brien was always through the Employee Relations representative, Mrs Siobhan Hynds, to ensure one point of contact for Mr O'Brien. Mr O'Brien also contacted the Case Investigator (me) through Mrs Hynds or the Case Manager rather than contacting me directly.

Mr O'Brien was interviewed on two occasions, once earlier in the investigation and again later in the investigation after he had the opportunity to review the witness statements to allow him to comment. Mr O'Brien was provided with witness statements as they were being returned and signed. Some of the statements took longer to get back. Mr O'Brien reported dissatisfaction at both the length of time and the form the investigation was taking.

8.7 As Case Investigator I had direct contact with the following people involved in the investigation: the people interviewed for witness statements, the Case Manager and the clinician who was the subject of the investigation. I had limited contact with the Medical Director as outlined above. I had no direct contact with the Designated Board Member. Most of the email contact with the people involved was through Mrs Hynds, who did all the organizing and keeping Mr Khan appraised of the process. This entailed a substantial

amount of work on her behalf. I did not have any contact with external persons or bodies, though am aware the investigation had been progressed to a formal investigation following discussion with the National Clinical Assessment Service.

9. With regard to Section I paragraph 29 of the MHPS framework, what processes or procedures existed within the Trust to provide a clear audit route for initiating and tracking the progress of investigations, their costs and resulting actions? Who was responsible for ensuring such processes were in place and what role, if any, did you have as the Case Manager in relation to these matters?

9.1 I was not the Case Manager. I am aware the Case Manager tracked the progress of the investigation (as did I and Mrs Hynds). The Case Manager would have contacted us about delays and timeframes. The Case Manager was advised the time the investigation was taking was because of the need to interview a number of witnesses who had competing clinical demands, and the delays at the request of Mr O'Brien. I believe Mrs Hynds updated the Case Manager on a regular basis by email and by phone.

9.2 I don't believe any of us (the Case Manager, Mrs Hynds who was assisting me, nor I) were made aware of the costs as such, though all of us knew there were extra sessional payments being made to Consultants in Urology for review of clinical data (look-back exercise) to inform the Investigation.

9.3 I am not aware of any formal processes undertaken which would have provided a clear audit route for initiating or tracking the progress of investigations. Nor am I aware of a process within the Trust to be able to audit who was carrying out investigations though I understand a record of trained individuals was kept, and a record of completed investigations was also retained. (For example, I was able to access information from Medical HR for this statement about investigations with which I had previously been involved.) Whatever processes were in place, they were through the HR/Employee Relations Department. I had no role in relation to this.

Investigation in relation to Mr O'Brien

c. I liaised with Case Investigator, Dr Chada, multiple times during the MHPS investigation. Mostly these were informal discussions. This included on a range of matters such as the progress updates of the investigation and reasons for delay in completing the investigations and what could be done to progress things. It was unclear to me as how these communications were meant to take place because the Guidelines and MHPS Framework are unclear in this regard. Dr Chada also sent me investigation progress update reports by email in May, June, and October 2017 and in June 2018 after the investigation completed and her report was available to me.

d. At the end of her investigation, I received her detailed report.

7.4 **Chief Executive**:

a. I didn't get to meet with the Chief Executive during 2017. However, I met with the new Chief Executive (Shane Devlin) multiple times during 2018, especially after my appointment as Acting Medical Director in April 2018. I updated him regarding the MHPS investigations. He was already aware of delay in the investigation during 2017. As indicated above at Question 1, after receiving the Case Investigator's Report in June 2018, I also sought his advice during the process of making the MHPS determinations. I shared the Case Investigator's report with him. I informed him that there was evidence to support all of the allegations with regards to Mr O'Brien. I do not exactly remember the details of our conversation, however, he offered the advice that I base my report and recommendations as per the evidence presented to me and in accordance with the MHPS framework and Trust Guidelines. I naturally followed this advice and it was consistent with my own approach in any event.

Email correspondence attached. This can be located at Attachment folder S21 31 of 2022- Attachments 16 & 17.

7.5 **Medical Director**:

a. I liaised with and met the Medical Director (Dr Richard Wright) many times during the MHPS process. After my nomination as Case Manager, I had several meetings in the beginning of 2017 regarding this case. Then I had meetings with him regarding the Return to Work Action Plan and its monitoring arrangements and regarding this MHPS investigations. During later part of 2017, I had discussions with him in relation

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice No.41 of 2022
Date of Notice: 29th April 2022

Addendum Witness Statement of: Dr Neta Chada

I, Neta Chada, will say as follows:-

1. I wish to make the following amendments to my existing response, dated 24th June 2022, to Section 21 Notice number 41 of 2022.

2. At paragraph 8.4 WIT-23774 I have stated, '*I had no direct contact with the Medical Director (Dr Richard Wright) other than when I was asked to engage in the investigation process when the previous Case Investigator had to be replaced*'. Having considered the extract from Dr Wright's witness Statement to the Inquiry at 7.3 iii (which can be found at TRU18427- TRU 18428), Dr Wright states, '*Dr Chada (the new case Investigator) was an Associate Medical Director with extensive experience in carrying out similar MHPS investigations. I would have interacted with her on multiple occasions over the relevant time period, however, not specifically in relation to the Urology MHPS investigation. I do recall asking her on at least one occasion how the MHPS investigation was proceeding and hearing that the investigation was behind schedule because of difficulty in agreeing interview dates with Mr O'Brien. I was not surprised or unduly concerned as in my experience this is a common area of difficulty with MHPS investigations*.'

3. I did not recall this discussion until I read Dr Wright's statement. I do, however, now recall that I did speak to Dr Wright informally about how the investigation was progressing at an AMD meeting (Associate Medical Directors/Management meeting) that we were both attending. I explained that it was slow and outlined

the reasons for this. This was not an in-depth discussion and was essentially a mention 'in passing'.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Personal Information redacted by the USI

Signed: Dr N Chada., FRCPsych.
Consultant Psychiatrist

Date: 20.03.2023

"Time scale in decision: The Case Investigator should, other than in exceptional circumstances, complete the investigation within four weeks of appointment and submit their report to the Case Manager within a further five working days."

You have touched on the difficulty around that already, and I want to explore that again in greater detail as we go on.

Just in terms of the Case Manager's role, that's Dr. Khan, did he at any point suggest to you any methodology or assistance that could be brought to bear to move this matter on quicker or more efficiently? I know that he was kept in the loop in terms of the timeframe and he asked questions about the timeframe. My question is more specific: Did he make any suggestion to you in terms of how this ought to be progressed?

A. No, Dr. Khan did not. I think, in terms of time span, there was discussion with Dr. Khan about some of the things that were taking longer. For example, the numbers of triage, those numbers were already identified by the time my investigation started. However, the lookback in terms of their notes and records that were brought back from Mr. O'Brien's house, that was taking a lot of time for the consultant urologists. I did inquire through Mrs. Hynds whether additionality could be used to try and get through that

manager and then professional line manager. The same works for the HR. I had no authority or responsibility in terms of providing that. All I was trying to do is to raise that issue with the Medical Director and the Oversight Committee to address this lack of understanding that this is a complex investigation and it takes more time than you think initially. Initially I was told that it would take three months and then it should be finished, and we know it took much longer than that. So, that the first point. 11:06 11:07

The second point you made about the proactiveness. I think there's a balance to be made there in terms of how much involved the Case Manager should be, or could be in my case at that time. I think I reflected on that, and I reflected in my statement as well, that I could have or should have been more proactive in terms of pushing this investigation through the process and getting it finished. I did try that, and I've put a number of elements in my statement what I tried in doing that, but not interfering with the investigator's role and not letting the investigator feel that the Case Manager is nearly taking over or addressing some of those. So, there is a distinction between those. And those fine lines between those balanced approaches, I believe, comes with experience and expertise. Also, developing competencies and training and understanding. 11:07 11:07 11:08

That is my reflection in terms of not knowing when you

away in terms of the timeframe and everything. So I had, I would say, quite a good understanding and working relationship with her during the course of this. However, I did not feel that I need to or I should be interfering about an actual investigation, purely for the purpose of independence, letting the investigator do the job, and then I will take ownership of that investigation as my role of Case Manager, perhaps. 10:56

On reflection, I may have or I should have done a little bit more prompting. I did some. I spoke to Medical Director, I discussed with Dr. Chada, I spoke to Ms. Siobhán Hynds on a number of occasions. However, we know now it took up quite a lengthy period of time. 10:56

33 Q. Looking at paragraph 35, for example. It says:

"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". 10:57

We'll go on and look at some detail in terms of Mr. O'Brien's complaints about the process. He wrote to you, for example, on 30th July setting out some concerns. I don't wish at this point to go into the detail of those but when concerns arise in a process such as this, do you think the Case Manager has a role 10:57

4.5 My background in working in mental health and the training I have received through that has also meant I am accustomed to listening, hearing, considering, and looking for other sources of corroboration.

5. Specifically, what if any training or guidance did you receive with regard to the conduct of investigations under Section I paragraph 31 of MHPS and the Trust Guidelines

5.1 Guidance was provided by staff from Employee Relations who had extensive experience of using the Maintaining High Professional Standards Framework. In this particular case, appropriate advice was appropriately sought from a specialist within the field (the Clinical Director, Mr Young) in cases where questions of clinical judgement were raised. Confidentiality was maintained. The investigation was primarily carried out by face-to-face interviews with witnesses, recorded at the time and then set into a statement and sent back to the witness for factual checking. All meetings were carried out by both me as Case Investigator and Mrs Hynds. Mrs Hynds provided guidance about the MHPS and Trust Guidelines in relation to all of this, though I had copies of both and referred to them as needed.

5.2 A written record was kept of the investigation by Mrs Hynds. We both also took notes of each interview and we used both sets of records to collate each witness statement. Mrs Hynds prepared the first draft, and I would have checked her draft against my own notes and made amendments as needed, before it was sent back to the witness for a further check. It has always been my practice to take very detailed notes, and to ensure records are accurate and comprehensive.

5.3 I attended a Medical Leadership Forum at which staff from NCAS undertook training on 24 September 2010. There was a specific 'Handling Concerns about Doctors Workshop' undertaken by an NCAS representative. (I have forwarded details of the course to the legal team which can located at *S21 No 41 of 2022 Attachments, Handling Concerns slides 2010 medical forum*. I had further training from NCAS staff specifically in relation to Maintaining High Professional Standards Framework Investigations on 7 and 8 March 2017 through the

Medical Management Training and Development Programme. This covered the roles and responsibilities of investigators and other people under the Framework and the training was titled, 'Case Investigators Training Workshop.' (I have copied this course programme to the legal team for it to be appended to this statement and *can be located at S21 No 41 of 2022 Attachments, Programme C1 SHCT170307-08 Delegate v2 Draft).* I have also had training in relation to investigation of serious adverse incidents (SAIs) and managing concerns in relation to trainee doctors, in my previous role as the Regional Advisor for Psychiatric Training in Northern Ireland. This is a role I undertook for almost five years. In my remit as a medical member of the Mental Health Review Tribunal I was required to assess patients and critically evaluate information and treatment plans as an independent expert. I provide reports for court as outlined at paragraph 4.4 above.

6. The Inquiry is interested in your experience of handling of concerns regarding any staff member. Prior to your involvement in respect of the case of Mr O'Brien, specify whether you ever have had occasion to implement or apply MHPS and/or the Trust Guidelines in order to address performance concerns and outline the steps taken.

6.1 I have previously had experience of using the Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance in relation to investigations about senior trainees as well as consultants. I have carried out at a number of such investigations which involved interviewing witnesses, interviewing the doctor concerned, drawing conclusions from the investigation and, if appropriate, making suggestions towards recommendations to the Case Manager/Medical Director. On all occasions I was assisted by a senior member of staff from Medical HR or Employee Relations. On one occasion I undertook the Case Manager role.

6.2 I have also informally addressed concerns in relation to trainees in my roles through NIMDTA and as Associate Medical Director. Some of these would be in relation to concerns about psychiatric trainees and some would have been under the Trust Guidance in relation to trainees in other specialties. I have also dealt with complaints made by trainees about training which required investigation and interviews. A number of these would have ended at the informal level, as the level of concern was less significant, was a single incident and /or

Southern Health and Social Care Trust

Medical Leadership Network

Handling Concerns Workshop
24th September 2010

Southern Health and Social Care Trust

Southern Health and Social Care Trust

Objectives

- To understand the Trust's guidance on Handling Concerns
- To discuss the internal and external support available for CDs and AMDs
- To clarify the CD and AMD roles in applying the Guidance

Southern Health and Social Care Trust

Workshop Outline

- Background to workshop – Dr Loughran
- NCAS – Dr Colin Fitzpatrick
- Trust Guidance- Vivienne Toal and Siobhan Hynds
- Case Studies to explore CD and AMD roles

National Clinical Assessment Service

Case investigator training workshop

For Southern Health and Social CareTrust

Tuesday 07 – Wednesday 08 March 2017

09:15-16:45 (Day 1) and 09:00-16:00 (Day 2)

Seagoe Parish Centre, 46 Seagoe Road, Portadown, BT63 5HS

DRAFT DELEGATE PROGRAMME

This two-day workshop has been designed specifically for anyone who undertakes the case investigator role in investigations about practitioners, which may emerge from the processes underpinning revalidation or from concerns raised about performance. The workshop is interactive and uses case studies to explore and develop the key skills and knowledge required by case investigators.

Learning objectives
By the end of the two-day programme, delegates will be able to:

- Explore how concerns about a practitioner's practice arise and identify the most common factors affecting performance
- Explain why the decision to investigate is made and suggest other options to resolve performance concerns
- Describe roles and responsibilities of those involved in investigations
- Plan for an investigation which meets national requirements
- Describe the principles of robust and meaningful terms of reference and know how to work within them
- Collect, review and weight evidence
- Conduct an investigative interview using a structured approach
- Recognise the key skills and attributes of a case investigator
- Recognise their own limits of competence and access sources of support and expertise
- Reference relevant national/local standards
- Write an investigation report with conclusions
- Describe the potential legal challenges to an investigation.

Pre-reading
Questions to consider prior to attending the workshop:

- What is the role of the Case Investigator?
- When might an investigation of a concern be necessary?
- What is the purpose of an investigation?

Draft programme

This programme is indicative of the content areas which will be covered. Timings are flexible and will be tailored to focus on areas of particular interest to delegates.

Facilitators: Dr Colin Fitzpatrick, Senior Adviser (NI) and Dr Grainne Lynn, Adviser, National Clinical Assessment Service

DAY 1

08:45-09:15	*Registration and refreshments*
09:15	Welcome, introductions and overview of the workshop
09:35	**Dealing with concerns about a practitioner's practice:** • Performance concerns • Overview of investigations • Frameworks for managing concerns: - Toolkit for managing performance concerns in primary care - PLR - MHPS • Workshop A: Dealing with concerns about a practitioner's practice.
10:45-11:00	*Break and refreshments*
11:00	**Investigation roles and responsibilities:** • Case investigators • Case managers • Responsible officers • Decision making groups • Other stakeholders/parties, including clinical experts • Supporting the practitioner.
11:30	**Starting the investigation:** • Linking with the case manager • Terms of reference • Planning the investigation • Principles of investigation • Bias and prejudice (perceptions and reality).
12:00-12:45	*Lunch*
12:45	**Workshop B: Critiquing terms of reference and responding to a case manager's request.**

13:45*	**Gathering evidence:** • Sources of potential evidence • Evidence log • Documentary evidence • Evidence/comments from the practitioner • National and peer standards and guidance • Weighting and judging evidence • Workshop C: Investigation of Dr Purple – review of documentary evidence.
	**Refreshments available from 15:15*
15:45	**Gathering evidence:** • Collecting evidence from interviews • Inviting witnesses to interviews • Structuring interviews • Workshop D: Investigation of Dr Purple – interviewing witnesses (trainer-led role play).
16:35	Briefing on homework
16:45	*Close*
Homework	**Approx 1 hour to be undertaken in advance of Day 2** Prepare for Workshop E: Investigation of Dr Purple – interviewing witnesses (delegate-led role play)

DAY 2

09:00-09:15	*Registration and refreshments*
09:00	Review of day 1 – learning points
09:10*	**Workshop E: Investigation of Dr Purple – interviewing witnesses (delegate-led role play)**
	**Refreshments available at 11:00*
11:15	**Report writing:** • Drafting a witness statement • Following up with witnesses • Structure • Workshop F: Investigation of Dr Purple – report writing.
12:45-13:30	*Lunch*
13:30	**Workshop F: Investigation of Dr Purple – report writing (cont)**
14:00	**Supporting the practitioner**
14:05	**What happens next?** • Presenting the management case • Consideration of report • Outcomes • Remediation.
14:25	**Responding to legal challenges – the role of the case investigator**
14:40-14:55	*Break and refreshments*
14:55	**Workshop G: Investigation of Dr Purple - responding to legal challenge**
15:40	**Support for case investigators**
15:50	**Review of learning**
16:00	*Close*

Learning methods

There will be a number of opportunities for delegates to discuss and explore their own experiences and case studies in an appropriately confidential setting. Case studies will be used as learning tools for individual skills development and sharing of learning and experience.

NCAS' Statement of principles

During the workshop NCAS will present fictional learning material, which has been compiled through NCAS' work, to enable the sharing of your and NCAS' experiences of dealing with concerns about practitioner's performance. When discussing your own experience of cases, please make every effort to ensure that any information which identifies individuals or organisations is removed and fully anonymised. If you do hear information about a case which leads to, or gives the impression of, identification of the details of the case please treat this information as **strictly confidential**.

For more information about NCAS' Statement of principles please access our website on http://www.ncas.nhs.uk/events/confidentiality-principles/

overarching thing and Dr. Fitzpatrick talked to that.

14 Q. You also trained on the 7th and 8th March 2017 shortly after you had been appointed to the role of Case Investigator. I suppose before you got in too deep into that investigation -- let's just bring that training up, WIT-23794 -- it is described as Case Investigator training workshop and it's a two-day workshop. Is this the one that you attended? 10:28

A. It is, indeed. Yes.

15 Q. Yes. If you just scroll down. Learning objectives are set out. Was this training attended by you because you had recently taken appointment as a case investigator or was it planned? 10:28

A. I believe it was already planned and I was invited to attend. It was fortuitous that it happened to be at this time. I was very grateful that I was getting an update at this stage. 10:29

16 Q. In general terms, do you think training in the operation of NCAS and the local Trust guidelines is essential, or do you derive more from familiarising yourself with the documents and doing the job of Case Investigator or Case Manager? 10:29

A. I think the training is very important because there would have been case studies and there would have been examples, so an opportunity to understand how the process is worked through, which, I mean Maintaining High Professional Standards as a document is reasonably lengthy. You will be aware, Chair, that the section on Case Investigator is about a page, which isn't really 10:29

terribly detailed. Therefore, this type of training -- this was a two-day training programme -- really expanded a lot on that, which I thought was very helpful.

17 Q. Is there anything in particular about your training experience -- or your experience of training, I should say -- that has caused you to reflect that things could be improved in any way in the training that you receive, or were you basically content with it? 10:30

A. I thought the training was very good, and there was a mixture of people who attended this training which I thought was helpful as well. I think Maintaining High Professional Standards leaves a lot to be desired as a document. But the training, I thought, was very good. I thought it was well put together and I thought it covered a number of relevant areas. 10:30 10:31

18 Q. You have reflected in your statement that as an Associate Medical Director perhaps in particular, you had significant experience, perhaps, of managing performance amongst colleagues. You say in specific terms, if we can go to WIT-23773, that you have been involved in some six cases using the MHPS format. If you just scroll down. What you are setting out here is an e-mail that you received from Zoe Parks when compiling your witness statement. She says: 10:31 10:32

"To the best of my knowledge I have you down for the following six cases. There are also a few other investigations that I know you were involved with but

Handling Concerns about Doctors' and Dentists' Performance' ('Trust Guidelines'). Policies and Procedures for Handling Concerns

3.1 I believe I have specifically addressed the issues raised in this Section 21 notice in my answers above and have added the additional information to each further question below.

4. In your role as Case Investigator what, if any, training or guidance did you receive with regard to:

I. The MHPS framework;

II. The Trust Guidelines; and

III. The handling of performance concerns generally.

4.1 I previously attended the National Clinical Assessment Service training on Case Investigation in the Trust. This was an intensive two-day training programme in March 2017, and a previous similar training event in 2010. (See below para 5.3.) I specifically asked to attend the update event in March which was to include training on the investigation role and responsibilities under the MHPS Framework.

4.2 I am aware of the Trust Guidelines for Handling Concerns about Doctors and Dentists' Performance. These Guidelines were issued in September 2010. As a Clinical Director and then Associate Medical Director, I would have had cause to refer to these Guidelines on several occasions. I believe the Trust Guidelines were mentioned at various AMD forum meetings and development days. I have not retained the agendas for those days. I have been involved with other investigations as a Case Manager and Case Investigator. Assistance and guidance were provided by staff from Medical HR and Employee Relations as needed.

4.3 As a medical manager, I was regularly involved with managing performance of other doctors in my Directorate.

4.4 I have extensive experience in acting as an independent expert in Court proceedings. This has involved in-depth interviews, detailed note-taking, and analysis of volumes of notes and records before weighing up information and reaching conclusions based on all the information available. I am accustomed to asking for additional information when I believe that is needed before I may form an informed, balanced, and fair opinion.

the doctors involved showed good insight into the issue and a willingness to accept and address the issue.

6.3 I have been provided with the following detail from the Medical HR Manager, Mrs Zoe Parks:- (Her email in full to me May 2022)

To the best of my knowledge, I have you down for the following (6 cases). There were also a few other investigations that I know you were involved with, but they weren't managed/investigated under MHPS as such, such as the Dr AS queries into training in O&G DHH.

1. Dr XX 2021 ******** CI: N Chada CM: ******* HR ***** NED
2. Dr XX 2019 GMC CI: **** CM: N Chada HR ***** Bank Locum so referred
3. DR XX 2016 ******** CI: N Chada CM: ****** HR ***** NED:
4. Dr XX 2013 assigned CI: N Chada CM ***** HR ****** NED
5. Dr XX 2013 assigned CI: N Chada CM ***** HR ***** NED
6. Dr XX 2013 assigned CI: N Chada CM: ****** HR ****** NED

7. If you were not aware of or had not previously implemented or applied MHPS and/or the Trust Guidelines, what was your understanding of how you should address concerns relating to the performance of clinicians?

7.1 Not applicable.

8. Outline how you understood the role of Case Investigator was to relate to and engage with the following individuals under the MHPS Framework and the Trust Guidelines:

- **I. Clinical Manager;**
- **II. Case Manager;**
- **III. Chief Executive;**
- **IV. Medical Director;**

clinicians who explained how the referrals into the specialty/theatre lists/waiting lists should operate.

17.4 It was clear to me through the investigation that managers had tried to address issues with Mr O'Brien in the past and had been thwarted in doing so. "Work arounds" had been set up by managers and even admin staff to try and ensure the system remained as safe as possible in the absence of Mr O'Brien carrying out the triage work, dictating on clinics and keeping notes at home. Admin staff tried to ensure notes were returned as needed. At investigation, it seemed to me that Mr O'Brien is "an old school" consultant surgeon who had been supported by a personal secretary for many years and who had worked under a system he had essentially set up until increasing demand, more consultants and a review of the service and processes meant he was no longer able to continue to operate as a sole practitioner and needed to work as part of a team. I believe Mr O'Brien had difficulties adapting but failed to adequately bring to peoples' notice the things that he wasn't doing. He continued to work in the way that he always had, for example, by taking notes home with him and not always dictating following a clinical contact. These were out-dated practices which were not consistent with GMC Guidance, nor Trust policy.

17.5 I understand Mr O'Brien was advised about the outcome of the investigation on 1st October 2018, following the Case Manager's review of the investigation report.

Additional Comments

18.1 It would be helpful for Case Investigators to receive feedback from the Case Manager, indicating whether the investigation had addressed the issues. At a later stage, it would also be helpful if the Case Investigator was advised about the Case Manager's Determination (as this is a learning opportunity and a form of feedback).

18.2 My experience of this process is one of concern. These investigations are voluntary roles undertaken along with clinical and management roles rather than instead of those roles. Significant time, often personal time, is entailed. It is often undertaken due to a sense of wanting to improve the quality of patient care, a sense of responsibility and to some extent a sense of '*quid pro quo'* i.e., if there is a similar investigation required within your own Directorate, another clinician will volunteer to carry out an independent investigation.

Unfortunately, with Case Investigators, Case Managers, and SAI Chairs facing the prospect of being called to a Coroner's Court or Public Inquiry, it seems likely these roles are going to have to be formalized, as it would be difficult to imagine people would continue to volunteer. There is a significant amount of time involvement in these processes which is time taken away from frontline services, at a time when Trusts are under so much pressure. Answering these 17 questions alone has taken many hours of reviewing notes and records and away from other work. That is not to say we don't strive to improve and to learn, but how we do that more efficiently along with addressing increasing clinical demand is the conundrum.

18.3 In providing my answers above I have not gone into the detail which is contained in the investigation report itself which I understand is already available to the Inquiry Team, nor the detail provided in the witness statements, which are lengthy and detailed. (The Inquiry Team has also been provided with all the witness statements.) Whilst I believe a number of different people knew there were issues with Mr O'Brien's practice, I formed the impression different people knew different things at different times, and the pressures on workload, waiting lists and changes of personnel meant that no-one (in my opinion) appeared to be aware of the full extent of the issues. Once the extent of the issues became more apparent it does seem the Trust management system attempted to address those issues with Mr O'Brien, and my impression was that he thwarted them by making complaints, hinting at legal action and trying to deflect/distract. At interview he was arrogant at times, and I believe there were subtle attempts to intimidate, for example, by bringing along a relative who was a [redacted] and sending an email enquiring about my qualifications to lead such an investigation, whether I had revalidated, was up-to-date with my CPD, etc. (I believe the email was sent to Medical Director or Dr Khan, which I think was after the investigation was completed.)

Personal information redacted by USI

18.4 I understand Mr O'Brien was allowed to return to work under supervision and with monitoring. I was copied into some emails during the process of the investigation indicating that the supervision and monitoring was progressing reasonably well, though I note other managers had indicated when they had raised issues with Mr O'Brien in the past in an informal way his practice would often improve for a period but then slip back. I am unaware of how he progressed on his return as I was not advised of that. (I believe emails of progress

Urology Services Inquiry

6. The Inquiry is interested in your experience of handling concerns regarding any staff member. Prior to your appointment as MHPS Case Manager in respect of the case of Mr. Aidan O'Brien, specify whether you ever have had occasion to implement or apply MHPS and/or the Trust Guidelines in order to address performance concerns and outline the steps taken.

6.1 As Associate Medical Director (AMD) in Children & Young People Directorate (CYPD) from 2013 to 2018, I had managed medical staff performance concerns. This was carried out as per the Trust policy of September 2010, mentioned above.

6.2 Prior to this MHPS investigation, I had no previous experience of implementing or applying formal MHPS investigations.

6.3 My line manager, Dr Richard Wright, was aware of this as I informed him during our discussion for Mr O'Brien's MHPS Case Manager nomination in December 2016 & Jan 2017. He asked me to complete upcoming MHPS training in March 2017.

6.4 I did complete MHPS training on 7 and 8th March 2017. I also reviewed the MHPS framework document and Trust Guidelines in detail. This included those parts in respect of the roles and responsibilities of Case Investigator and Case Manager.

7. Outline how you understood the role of Case Manager was to relate to and engage with the following individuals under the MHPS Framework and the Trust Guidelines:

I. Clinical Manager;
II. Case Investigator;
III. Chief Executive;
IV. Medical Director;
V. Designated Board member,
VI. The clinician who is the subject of the investigation; and
VII. Any other relevant person under the MHPS framework and the Trust Guidelines, including any external person(s) or bodies.

7.1 I carried out MHPS Case Manager role as per the MHPS framework and Trust Guidelines. The MHPS Framework describes the Case Manager's role as follows at Section I:

A. So, this had started with my discussion with the Medical Director, when he approached me for MHPS Case Manager's role. I have indicated that I have no previous experience or training in this regard, therefore Dr. Wright asked me to go for the March training, which is the next training coming up. I did attend that training and I found it useful in the regard of general understanding of the MHPS Framework various roles. But the training was a workshop training specifically for case investigators. 10:38 10:39

I did reflect on that afterwards and subsequent to that as well. So, that training was directed towards the roles and responsibilities and the actions for a case investigator. Although I must say the training was very useful to me to understand the wider framework, how it should work, but the training -- I understood that there's another training after that for a case, or something for case investigator, but this training was mainly related to case investigator's training. I did gain knowledge and understanding of MHPS investigations and the current framework which was at that time. However, I felt that as the training was directed to case investigator, I felt that I did not receive what I was hoping or intending to do. I did discuss this afterwards and I've reflected on since then as well. 10:39 10:39 10:40

24 Q. When you think about it now -- let me ask you first: Have you had a subsequent MHPS role, whether in your current location or in the Southern Trust?

NHS
National Clinical Assessment Service

CERTIFICATE OF ATTENDANCE

It is hereby certified that

Dr Ahmed Khan

attended

Case investigator training workshop

for Southern Health and Social Care Trust

delivered by NCAS

on Tuesday 07 – Wednesday 08 March 2017

This workshop provides up to 12 hours towards your CPD

Workshop objectives

- *Explore how concerns about a doctor's practice arise and identify the most common factors affecting performance*
- *Explain why the decision to investigate is made and suggest other options to resolve performance concerns*
- *Describe roles and responsibilities of those involved in investigations*
- *Plan for an investigation which meets national requirements*
- *Describe the principles of robust and meaningful terms of reference and know how to work within them*
- *Collect, review and weight evidence*
- *Conduct an investigative interview using a structured approach, including the PEACE model*
- *Recognise the key skills and attributes of a case investigator*
- *Recognise their own limits of competence and access sources of support and expertise*
- *Reference relevant national/local standards*
- *Write an investigation report with conclusions*
- *Describe the potential legal challenges to an investigation*

24.2 However, on reflection I believe that I could maybe have been more proactive in dealing with challenges in the MHPS investigation. I believe there are some mitigating factors:

a. I think most important factor was that I had no previous experience of conducting such a complex MHPS investigations as a Case Manager. I reviewed all the relevant Guidelines and the MHPS framework document. However, with no previous experience I wasn't fully equipped to carry out such a complex MHPS case investigation. I received MHPS training after the investigation had commenced.

b. I also believe that having no dedicated / protected time for the Case Manager role in my job plan was also an important factor. Initially, it was meant to be for only a couple of months but ended up taking much longer. I was carrying out a very busy clinical and management job in Children's directorate at the same time. After my appointment as Acting Medical Director, I was very mindful of my competing demands as senior management team and Trust Board member and its responsibilities. Therefore, I requested to step down from the Case Manager role. However, this wasn't accepted by the Oversight Committee. (Email attached). **This can be located at Attachment folder S21 31 of 2022- Attachment 69 (a) and 69 (b).**

c. After the formal MHPS process started in January 2017, clarity of roles and responsibilities between Oversight Committee and Case Manager was lacking when I saw some decisions were taken by the Committee prior to coming to me as a case manager. An example was replacing case investigator role. As the Medical Director (Dr Richard Wright) was my line manager and in the Committee, I took a step back.
d. The information I received initially about the case was inadequate and inconsistent.
e. The case investigation evolved into a case of a more complex nature with more and more unexpected findings emerging.
f. The resources allocated to carry out such a complex investigation were inadequate.

24.3 However I believe these factors did not damage the quality of the end product (my Case Manager's Determination). They largely just caused the process to be slower than I think it ought to have been.

A. No.

25 Q. How useful do you think training is; how important is it for people taking on roles such as the role you took on? And have you any reflections to offer the Inquiry about how medical managers - because it is typically medical managers who take on these roles - how should they be prepared by way of training or familiarity with the processes? How should that be done if the Inquiry were thinking about making recommendations around that? 10:41

A. I think we need to understand the different process which we are going to train people. In case of MHPS, the training should be part of a suite of other things. The training was very useful but I don't believe that only going to a training will equip you to go through a complex, or even simple, case manager's or case investigator's role. 10:41

Training, in a way, is also very important but I think that developing skills, developing peers, developing competencies, and developing the expertise in this role requires more than just training. Training is one part of the expertise but there should be further elements to this whole, I say, a suite of tools available to people who are going to do the MHPS role. 10:42

No doubt training is very important, and the right training for the right time. Like, doing a training three or four years ago and if you are asked to do someone now, it is hard to remember or retain the

knowledge. So it's the ongoing training, it's the ongoing peership, it's the ongoing support, it is the ongoing elements of expertise development. And not necessarily a large pool of people because we know from clinical practice, the more you do something, you'll get more and more expert in that way. So it is one of those things.

I don't know whether I answered your question but that's what my view was, and still is. 10:43

26 Q. Thank you. That's helpful.

If we can drill down into that a little bit further. You talked about training being important but you also talked about the need to develop competencies. What are you thinking about in particular? So, for example, the Case Manager, you will recall, had a role, a significant role in terms of receiving the investigation report. Then the next step was to receive a statement from Mr. O'Brien, outlining, in his case, his concerns about the process. Then, you had to make a determination which contained three steps or three recommendations. Is there any particular competency or competence required around that that should be developed for case managers for the future that you thought might have been lacking in your case?

A. I think it's also important to have the background knowledge and expertise, clinical expertise in that particular area. Not necessarily specific in that

particular area, but an understanding of how the clinical, you know, clinical domains were developed and delivered would be useful having that competency within that kind of case training suite or tools.

27 Q. So in direct answer to my question, is there anything in particular about that part of the process where you as Case Manager have to do work around the investigation report and make determinations? 10:45

A. Yes.

28 Q. Do you think the bit that's missing in your case is a lack of direct knowledge of the area; is that the problem? 10:45

A. I don't see a problem there but I think that would be a useful add-on for a competency point of view, to have a greater understanding of the whole system or the service, or how the initial service was developed and delivered -- supposed to deliver. But I believe the understanding of GMC Good Medical Practice is the core principle which is available and which should be part of this development or expertise development tool. A lot of those performance or conduct-related issues are late to the GMC Good Medical Practice guidance. 10:46 10:46

I believe I implemented, I addressed those. But having a greater knowledge of that particular team or services would be useful. 10:46

29 Q. You've told us in your witness statement -- this is page 40 of your bundle, and WIT-31704 of ours. At paragraph 7.1, you say:

typing needed, some of the typing I did myself as I made changes and added information, and I am aware the assistant I had from HR did a lot of work, as well as a significant amount of typing herself. This seems a very inefficient use of our time.

15.2 Mr O'Brien repeatedly complained about delays in the process. These were caused by the sheer volume of information to be gathered, the difficulty with getting timeslots for witnesses, delays in witnesses returning their signed statements, competing demands on my time as a clinician and also the significant delays incurred as a result of Mr O'Brien's own availability (Personal Information redacted by the USI absence, clinical demands, appraisal and not responding to emails in a timely fashion). We were mindful about pushing too strongly when Mr O'Brien did not respond as we had been informed he had been unwell in the previous year.

15.3 I would offer much the same comments about the Trust Guidelines when using the informal process; although those timeframes are not quite the same and my experience is that use of the informal process doesn't seem to cause the same amount of angst in doctors under investigation.

15.4 Generally, I believe the processes and findings on this occasion were robust, balanced (note our adoption of ToR 5), and led to clear conclusions which then generated and informed a clear action plan.

16. Consider and outline the extent to which you feel you can effectively discharge your role as Case Manager under MHPS and the Trust Guidelines in the extant systems within the Trust and what, if anything, could be done to strengthen or enhance that role.

16.1 On this occasion I was not the Case Manager, but I feel having people allocated as Case Managers and Case Investigators as part of their job plan, i.e., protected time, would be helpful. This allows individuals to build up their skills and familiarize themselves with the processes, so they are not having to refer back to the MHPS Framework or Trust Guidelines as often. Specific administrative/secretarial time would also be helpful for both the clinical and non-clinical/HR investigators.

explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?

70.1 My reflection in response to this Question is again based on knowledge, information and evidence experience obtained through the MHPS investigation.

70.2 Personally as Case Manager, I tried my best to fulfil my duties as best I could. On reflection I could maybe have been more proactive in dealing with the non-engagement of Mr O'Brien during the MHPS formal investigation which started in January 2017, especially when he wasn't engaging between January and March 2018. In my view, there were some mitigating factors, listed below. However, I believe these factors did not damage the quality of the end product (my Case Manager's determination). They largely just caused the formal MHPS investigation process to be slower than I think it ought to have been.

a. In my view, most important factor was that I had no previous experience of conducting such a complex formal MHPS investigation as a Case Manager. I reviewed all the relevant Guidelines and the MHPS framework document. However, with no previous experience, I wasn't fully equipped to carry out such a complex case investigation. I received MHPS training after the investigation had commenced.

b. I also believe that having no dedicated / protected time for the Case Manager role in my job plan was also an important factor. Initially, it was meant to be for only a couple of months but ended up taking much longer. I was carrying out a very busy clinical and management job at the same time. Then I was appointed as the Acting Medical Director role in April 2018 after going through recruitment and selection process in previous couple of months.

c. The resources allocated to carry out such a complex investigation were inadequate.

70.3 I also refer in particular to the following part of my MHPS Determination in answer to Question 70:

> "4.7. Investigation findings:
> *"Concerns about Mr O'Brien's practice were known to senior managers within the Trust in March 2016 when a letter was issued to Mr O'Brien regarding these concerns. The extent of the concerns was not known. No action plan was put in place to address the concerns. It was found that a range of managers, senior managers and Directors within the Acute Service Directorate were aware of concerns regarding*

through the process. Maybe one of the learnings should be that the Case Manager and the Case Investigator should be briefed in a more formal way, providing the information not only through verbal information but having a more formal structure that a Case Manager, Case Investigator, and others in that particular role, should receive.

55 Q. Just one final question before the break, Dr. Khan. Dr. Wright described this as a "tricky case". Perhaps all MHPS cases are complex and tricky. You were new to the world of MHPS, no experience and no training, as you described, albeit you were familiar with the documents. Did you feel that you had any option but to accept the brief from the Medical Director or could you have refused? 11:46 11:46 11:47

A. On reflection, it's actually I could have refused, yes. I could have said no, but I felt that I needed to -- at that point in time I needed to discuss more with Dr. Wright to understand better, and as a medical manager in the Trust, I have roles and responsibilities as part of my medical governance roles. My main purpose of my medical governance was in the CYP, in the Children's Directorate, but I was also part of the Trust part of the system, so I felt that I needed to be part of understanding more and knowing more and then taking it from there. 11:47 11:47

Obviously, in hindsight, I could have refused. Should I have? I don't know. I would have liked a better

supported environment and training and time, and protected time. But that was my thinking behind that at that point in time.

MR. WOLFE KC: Very well. Is now a suitable time for a break? 11:48

CHAIR: Yes. We'll come back again at 12.05, ladies and gentlemen.

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS: 12:05

56 Q. MR. WOLFE KC: Hello again, Dr. Khan. Are we loud and clear?

A. Yes, yes. Thank you.

57 Q. Just before the break you were reflecting on the fact that based on your experience, a greater formality and 12:06 a greater level of detail, in your view, should accompany the briefing of the Case Manager at the commencement of an MHPS investigation. I can see from your statement that you recall having perhaps two meetings with Dr. Wright during January, but still and 12:06 all, you, upon reflection, seems to be dissatisfied, knowing what you know now, about the briefing that you received.

A. I suppose at that point in time, I had no further knowledge of what I have gained since, and at that 12:07 point in time I felt that -- I perceived that I was getting all adequate information, but in hindsight, with the information available to me now, there's a much greater knowledge I acquired, you know, now rather

Again, the delay in the process, was it simply down to resources between you and Mrs. Hynds to get them in a fit state to be disclosed to the witness in the first place for agreement and then out, or were there other factors at play? 14:31

A. I am not aware of other factors. As I explained, the process was Mrs. Hynds would type it up the statement, she would send it to me, I would compare it to my notes, I would make changes, I sent it back to her. All of that was being done without, for example, admin 14:31 support. You know, Mrs. Hynds, I'm aware, was typing these herself, which I think I highlighted in my Section 21 notice, that here was a very senior person within the Trust who was spending evenings typing up things, which I felt wasn't a good use of either her 14:31 time or my time.

Perhaps what wasn't helped was Mrs. Hynds doing it, sending it to me, me adding bits to it because that, of course, causes delays with every person that needs to 14:31 sort of look at it, and then it went back to the person and then they had to check it and send it back with any amendments. So, it was a slow process. I absolutely accept that at least some of those delays were down to me and some of those delays were down to lack of 14:32 administrative support.

129 Q. Would you agree that the longer you get away from the date of the witness interview, the more difficult it is, at least for the witness, to try to remember and

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RESPONSE TO STAGE 1 GRIEVANCE

MR A O'BRIEN
CONSULTANT UROLOGIST (Retired)

November 2018 (additional submission July 2020)

26 October 2020

STAGE 1 GRIEVANCE PANEL
Dr Aisling Diamond, Deputy Medical Director, SHSCT
Shirley Young, HR Associate, HSC Leadership Centre (Chair)

CONTENTS

1 BACKGROUND

1.1 Mr O'Brien raised a Grievance on 27 November 2018 supplemented by written papers/evidence. In advance of the Stage 1 grievance hearing, he made an additional written submission on 23 July 2020 relating to post-November 2018 events and additional information available to him regarding the matters in his November 2018 submission.

1.2 Dr Aisling Diamond and Shirley Young were asked to form a Stage 1 grievance panel under the Trust's Grievance Procedure. Mr O'Brien had retired by the time the grievance was heard on two occasions, 30 July and 7 August 2020.

1.3 Given the volume of papers, information presented and the need to speak to a range of employees referenced, the panel sought, and Mr O'Brien agreed to, an initial extension of the usual response time limits. It was agreed that the time limit for the panel's formal response be extended by three weeks until Friday 28 August 2020.

1.4 As a consequence of diary availability and the challenges noted at 1.3 above, Mrs Young wrote to Mr O'Brien on 25 August 2020, changing the time limit for the panel response to Friday 18 September 2020. This deadline was subsequently altered on two further occasions before the deadline for this report of Monday, 26 October 2020.

1.5 The matters raised in this grievance have been extensive and complex and they cover a significant timeframe and therefore the panel's formal response is in report format rather than the usual letter style.

1.6 <u>Summary of Stage 1 Grievance</u>

1.6.1 Mr O'Brien set his concerns in the following summary provided at the outset of his written submissions:

- *"the acts and omissions of senior managers within the SHSCT re handling of concerns about my administrative practices. I believe that the actions and failures of the Trust amount to breaches of Trust Policies and Procedures and a breach of my contract of employment* ***(*****Section 2 of this response*****)***

- *Additionally, I am formally lodging a grievance against the decision dated 1 October 2018 of the Case Manager to classify the case as a case of misconduct"* **(Section 3 of this response)**

- In July 2020, he added other matters, namely, *"delayed handling of my grievance", "additional concerns (i) events before so December 2016, (ii) An Unfocused Trawl, (iii) Private Patients ", Duty of clinical care update"* **(Section 4 of this response)**

1.7 This response will deal with each in turn.

2 ***"The acts and omissions of senior managers within the SHSCT re handling of concerns about my administrative practices. I believe that the actions and failures of the Trust amount to breaches of Trust Policies and Procedures and a breach of my contract of employment."***

2.1 To achieve an of understanding of the detail and chronology of Mr O'Brien's concerns we have organised our response in this section as follows[1]:

- March 2016 to December 2017 **(Section 2.2)**
- January 2017 to June 2018 **(Section 2.3)**
- July 2018 to November 2018 **(section 2.4)**

2.2 **MARCH 2016 TO DECEMBER 2016**

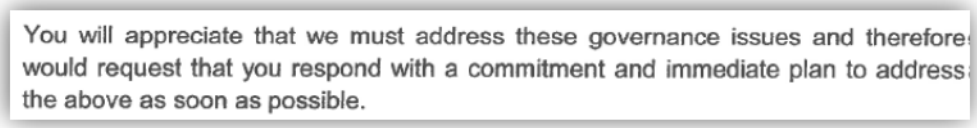
2.2.1 This time frame reflects the period between a formal letter to Mr O'Brien on 23 March 2016 and the decision to launch of the formal Maintaining High Professional Standards[2] (MHPS) investigation in December 2016.

2.2.2 **The facts established are set out at 2.2.3 to 2.2.23 below**

2.2.3 Mr Mackle, then Associate Medical Director, held a meeting with Mr O'Brien on 23 March 2016. Mr Mackle was accompanied by Martina Corrigan, Head of ENT & Urology services. A letter summarising the issues from the meeting was given to Mr O'Brien signed by Mr Mackle and Ms Trouton, Assistant Director of Acute Services (Appendix 1).

2.2.4 Mr Mackle and Mrs Corrigan are of the view that Mr O'Brien ought not to have been in any doubt that the reason for meeting him and, supplementing it with a letter, was to seek a response from Mr O'Brien to the concerns raised and, for his part, he would provide comment on the issues raised from his own perspective.

2.2.5 The letter communicated that action from Mr O'Brien was required in all aspects of the letter and not just about patient notes. The following is an extract from the letter of 23 March 2016 (Appendix 1):


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

2.2.6 There is no evidence of any response with a commitment of plan or any comment from Mr O'Brien between March 2016 and the Oversight

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[1]These differ from how Mr O'Brien organised and presented his information but in the panel's opinion it reflects how it organized its decision making.

[2] *Maintaining High Professional Standards in the Modern HPSS A framework for the handling of concerns about doctors and dentists in the HPSS* (Department of Health, Social Services & Public Safety - November 2005

Committee meeting on 13 September 2016. Neither is there any evidence of active follow-up from managers who had the authority to do so.

2.2.7 Mr Mackle stepped down from his role as Associate Medical Director on 30 April 2016. It was not until 13 September 2016 that the concerns about Mr O'Brien were a subject of a meeting of the Oversight Committee (see notes at Appendix 2) and were now escalated from direct line management. A decision was made at this meeting that an informal MHPS investigation should be launched.

2.2.8 Mr O'Brien expressed concern at his grievance that proper MHPS provisions had not been followed when Mr Mackle and Mrs Corrigan met him in March 2016. He says in his November 2018 submission:

> The letter is not described as a formal letter. It does not refer to the Trust Guidelines. It does not state on the face of the letter that it was issued pursuant to any Trust policy or procedure. It does not refer in any way to any suggestion of misconduct or even to a performance issue. Neither expressly nor impliedly can it be interpreted as a formal warning, or any form of disciplinary sanction. Nor could misconduct or lack of performance be inferred from the letter. In fact, the letter starts by stating, "*We are fully aware and appreciate all the hard work, dedication and time spent during the course of your week as Consultant Urologist*".

> The Trust Guidelines describe how concerns about a Practitioner should be handled. Paragraph 1.5 provides that:
>
> 1.5 This Guidance, in accordance with the MHPS framework, establishes clear processes for how the Southern Health & Social Care Trust will handle concerns about it's doctors and dentists, to minimise potential risk to patients, practitioners, clinical teams and the organisation. Whatever the source of the concern, the response will be the same, i.e. to:
>
> a) Ascertain quickly what has happened and why
> b) Determine whether there is a continuing risk
> c) Decide whether immediate action is needed to remove the source of the risk
> d) Establish actions to address the underlying problem

> If the letter of 23rd March 2016 is raising a concern about my performance as opposed to a concern about management, then that concern falls squarely within the definition above. **Yet the Trust Guidelines were completely ignored.**

2.2.9 Mr O'Brien also logged his concern about the Trust's response to National Clinical Assessment Service (NCAS)[3] advice and input in September 2016 (Appendix 3). He considered that the Trust's information to Dr Fitzpatrick to be inaccurate and these inaccuracies informed Dr Fitzpatrick's response.

[3] The NHS National Clinical assessment Service is at the time of writing became known as NHS Resolution – Practitioner Performance Advice. For the purposes of this response, we have retained the name NCAS throughout.

2.2.10 Ms Gishkori (then Director of Acute Services) was part of the Oversight Committee. Following the meeting on 13 September 2016, Ms Gishkori asked Dr Wright to amend the plan so that her clinical management team could have the opportunity to put in an alternative plan of their choice in place (Appendix 2 Notes of Oversight Committee 13 September 2016 and Appendix 4 email trail Miss Gishkori to Dr Wright):

On 15 Sep 2016, at 14:40, Gishkori, Esther <Esther.Gishkori@southerntrust.hscni.net> wrote:

Dear Richard and Vivienne,
Following our oversight committee on Tuesday 13th September I had a meeting with Charlie McAllister and Ronan Carroll, my AMD and AD for surgery.
I mentioned the case that was brought to the oversight meeting in relation to Mr O'Brien and the plan of action.

Actually, Charlie and Colin Weir already have plans to deal with the urology backlog in general and Mr O'Brien's performance was of course, part of that.
Now that they both work locally with him, they have plenty of ideas to try out and since they are both relatively new into post, I would like try their strategy first.

I am therefore respectfully requesting that the local team be given 3 more calendar months to resolve the issues raised in relation to Mr O'Brien's performance.

2.2.11 Mr Colin Weir (who took up the role of Clinical Director in June 2016) developed a plan with Dr McAllister and set the details out in an email of 16 September 2016 (full email trail at Appendix 5). The following is an extract sent by Mr Weir to Dr McAllister:

Dear Dr McCallister

Further to discussions I propose that I as CD and you as AMD implement the following action plan in relation to outstanding issues in respect of Mr O'Brien

1. That I (initially) have a series of face to face meetings with Mr O'Brien and aim to have resolution or plan for resolution in next 3 months. That is by mid December. I propose the first meeting would involve you me and Mr O'Brien
2. To implement a clear plan to clear triage backlog.
3. Make arrangements to validate the review backlog and adapt clinic new to review ratios to reduce this
4. All correspondence to GPs and copies for patient centre /ECR to be done at time of consultation
5. All patient notes to be return from home without exception
6. These meetings will report back regularly to Dr McCallister as AMD and he will be involved in some further meeting to assist me and provide support when needed
7. Throughout the process we want to encourage full engagement and have Mr O'Brien understand that if we achieve these aims through these processes that will satisfy the Trust and no further actions would be taken
8. That monitoring would continue to ensure there is no drift with an understanding that if this happened further investigations would take place.

2.2.12 The next meeting of the Oversight Committee was on 12 October 2016 (notes are contained at Appendix 6). The following extract is relevant:

Mr A O'Brien

Mrs Gishkori reported that Mr O'Brien was going for Personal information redacted by the USI and was likely to be off for a considerable period. It was noted that Mr O'Brien had not been told of the concerns following the previous Oversight Committee. It was also noted that a plan was in place to deal with the range of backlogs within Mr O'Briens practice during his absence.

Mrs Gishkori gave an assurance that, when Mr O'Brien returned from his period of sick leave, that the administrative practices identified by the Oversight Committee would be formally discussed with him, to ensure there was an appropriate change in behaviour. It was agreed that this would be kept under review by the Oversight Committee.

2.2.13 By September 2016, Mr O'Brien is correct that no one had spoken to him about the intentions of any new plan from Mr Weir and Dr McAllister, supported by Ms Gishkori.

2.2.14 It is a fact therefore that, since March 2016, there had been no practical inputs to respond to the concerns from any manager or Mr O'Brien. This means that Dr Wright, Medical Director, and the Oversight Committee, by 12 October 2016, had no assurance that matters were progressing in any planned way or that there was no ongoing risk. The committee had intended that these circumstances would be reviewed at its October 2016 meeting.

2.2.15 It is correct that Mr O'Brien made arrangements with Ms Corrigan about the return of files from his home.

2.2.16 It is also a fact that, at the time of the meeting on 12 October 2016, Mr O'Brien Personal information redacted by the USI and would be on sick leave for a period thereafter.

2.2.17 The Oversight Committee decided to keep the matters relating to Mr O'Brien under review. Its next meeting was held on 22 December 2016 (notes attached at Appendix 7).

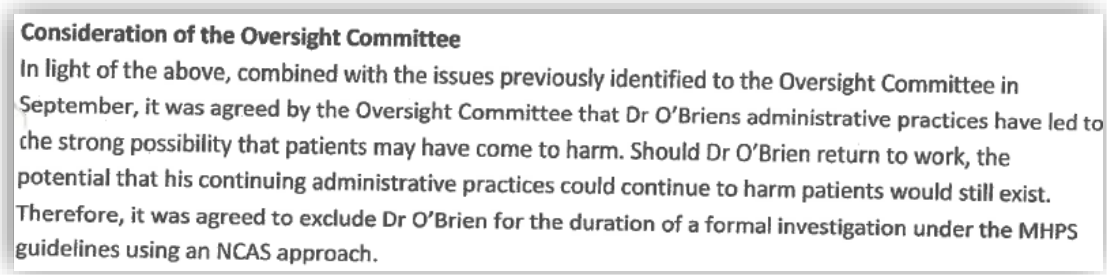
2.2.18 At this meeting, the following extract is relevant:

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

2.2.19 The new fact at this meeting on 22 December 2016 in relation to Mr O'Brien was that there was a Serious Adverse Incident (SAI). The committee was also provided with further update on more detail of

alleged administrative deficiencies – patient notes allegedly being held at Mr O'Brien's home and a number of undictated clinics (see notes at Appendix 7).

2.2.20 On consideration of these updates, the Oversight Committee made the following decision on 22 December 2016 (Appendix 7):



Consideration of the Oversight Committee

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

2.2.21 Mr O'Brien drew the grievance panel's attention to discrepancies in the notes of this meeting. These were that (i) the notes referred to a "formal" MHPS process being in place in September 2016 and (ii) that the decision on 22 December 2016 planned a meeting with Mr O'Brien on 30 December 2016.

2.2.22 The reference in the notes of 22 December 2016 is incorrect when it states "*formal*" - the notes of 13 September 2016 clearly state that an "*informal"* process was in place (see Appendix 2). Mrs Toal, Director of HR, who attended the Oversight Committee meetings confirmed that an informal process was in place and the note in December is an error. The author of the notes, Mr Gibson, also acknowledges this as an error.

2.2.23 Mr O'Brien's told us that the meeting planned with Dr Wright on 3 January 2017 was brought forward at this request to 30 December 2016.

2.2.24 **The panel findings on issue at 2.2 are set out in 2.2.23 to 2.2.46 below**.

2.2.25 There was no evidence before the panel that Mr O'Brien responded to or engaged in the concerns raised by Mr Mackle in March 2016 and summarized in his and Ms Trouton's letter of 23 March 2016 (Appendix 1)

2.2.26 Mr O'Brien expressed a view at the outset of his grievance hearing that it was disproportionate to move from the March 2016 meeting with Mr Mackle to formal MHPS processes in December 2016. This is not correct and there were attempts to move the concerns forward. These were delayed within the Directorate (2.2.10 to 2.2.20 above). We accept that Mr O'Brien was not aware of them at the time.

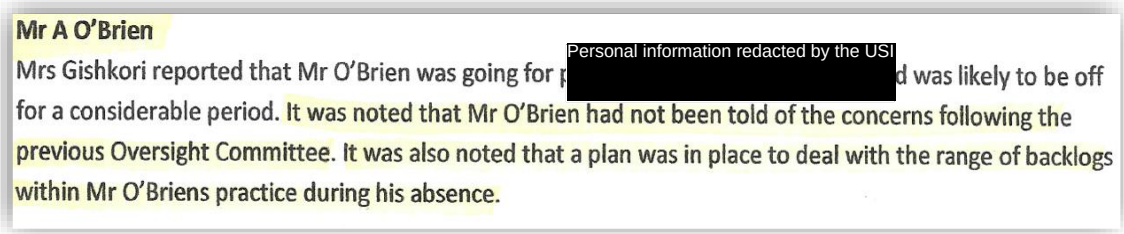
2.2.27 In relation to Mr Weir's input, Mr O'Brien suggests that any delay in speaking to him was because Mr Weir had been told (possibly by Mr O'Carroll) that he should not speak with Mr O'Brien. The possibility of this "instruction" only exists in the context of a decision to move to a formal investigation in December 2016 when it would have been inappropriate for Mr Weir to discuss the process with Mr O'Brien outside of his assigned role of Case Investigator. It does not explain any absence of contact by Mr Weir as Mr O'Brien's Clinical Director before then.

2.2.28 Mr Mackle clearly stated in March 2016 that there were matters of concern about Mr O'Brien's practice. It was, in our opinion, in Mr O'Brien's interests, to participate in examining this matter or refuting it for the record.

2.2.29 Mr O'Brien also stated there was an agreed plan with Mrs Corrigan relating to his return of files. This is correct but, in our opinion, this was an agreement about the process of returning charts that ought not to have been at Mr O'Brien's home. This is separate from any investigation into how and why the files were at this home and his explanation of that. The fact that some files were returned did not replace the need to seek Mr O'Brien's response to them being at his home in the first place.

2.2.30 Based on the emails at 2.2.10 and 2.2.11 above (and at Appendices 4 and 5), it is the panel's view that Dr Wright and the Oversight Committee had a reasonable basis for assurance in September 2016 that Ms Gishkori and her team would have actions in place on which progress could be reported at the next meeting of the Oversight Committee in October 2016.

2.2.31 However, this did not prove to be the case. Miss Gishkori updated the Oversight Committee on 12 October 2016 that no communication had taken place with Mr O'Brien:



Mr A O'Brien

Mrs Gishkori reported that Mr O'Brien was going for p[redacted]d was likely to be off for a considerable period. It was noted that Mr O'Brien had not been told of the concerns following the previous Oversight Committee. It was also noted that a plan was in place to deal with the range of backlogs within Mr O'Briens practice during his absence.

Personal information redacted by the USI

2.2.32 By December 2016, nine months had passed since Mr Mackle's intervention in March 2016. There were now significant matters of context:

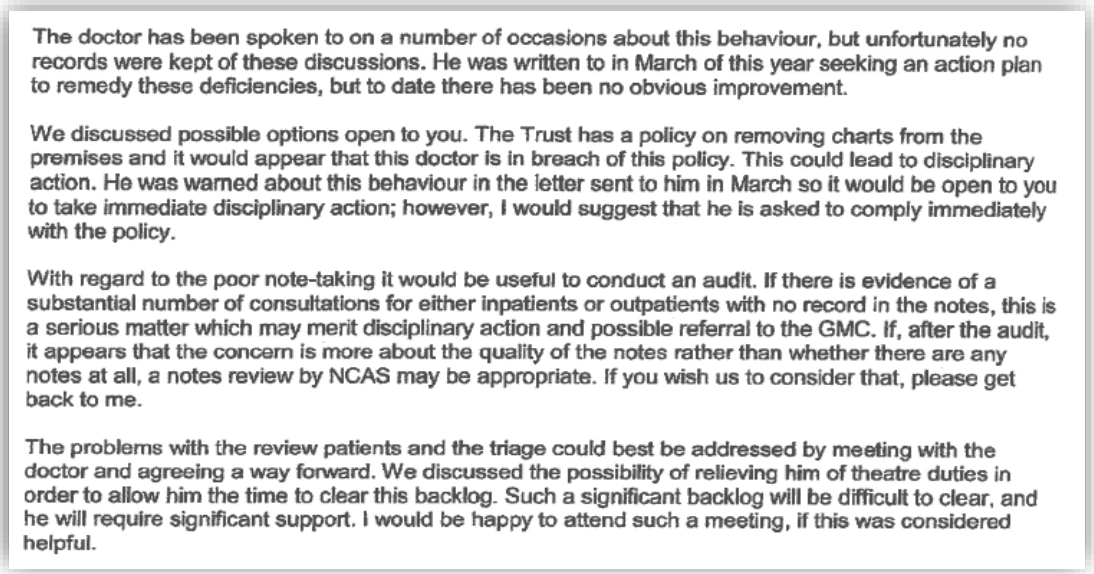
- the absence of assurances about progress made to manage and attend to the concerns
- the Serious Adverse Incident
- the information provided on the quantum of the alleged performance matters.

It is our opinion that Dr Wright, Medical Director, and the Oversight Committee were entitled to seek and escalate the required assurances. In the absence of active compliance by any party with earlier Oversight Committee plans in September and October 2016 in response to concerns going back to March 2016, we find that it is reasonable and by this stage, proportionate, that this matter was escalated to a formal MHPS investigation.

2.2.33 With regard to Mr O'Brien's comments on the advice from NCAS and its context in Trust decision-making, we established the following:

- NCAS wrote to the Trust on 13 September 2016 following a telephone discussion with Mr Gibson about Mr O'Brien on 7 September 2016 (Appendix 3). The Oversight Committee met on 13 September 2016 and there is no factual evidence from the notes whether the NCAS letter was presented or discussed at the meeting or Mr Gibson's summary of it.

- An extract from Dr Fitzpatrick's letter states:



The doctor has been spoken to on a number of occasions about this behaviour, but unfortunately no records were kept of these discussions. He was written to in March of this year seeking an action plan to remedy these deficiencies, but to date there has been no obvious improvement.

We discussed possible options open to you. The Trust has a policy on removing charts from the premises and it would appear that this doctor is in breach of this policy. This could lead to disciplinary action. He was warned about this behaviour in the letter sent to him in March so it would be open to you to take immediate disciplinary action; however, I would suggest that he is asked to comply immediately with the policy.

With regard to the poor note-taking it would be useful to conduct an audit. If there is evidence of a substantial number of consultations for either inpatients or outpatients with no record in the notes, this is a serious matter which may merit disciplinary action and possible referral to the GMC. If, after the audit, it appears that the concern is more about the quality of the notes rather than whether there are any notes at all, a notes review by NCAS may be appropriate. If you wish us to consider that, please get back to me.

The problems with the review patients and the triage could best be addressed by meeting with the doctor and agreeing a way forward. We discussed the possibility of relieving him of theatre duties in order to allow him the time to clear this backlog. Such a significant backlog will be difficult to clear, and he will require significant support. I would be happy to attend such a meeting, if this was considered helpful.

2.2.34 Mr O'Brien suggested that this advice from NCAS is not appropriate because it is factually incorrect, i.e. he says that no such action plan existed with which he had to comply. It is correct that Mr O'Brien was not "*warned*" on 23 March 2018, but he was made aware of the concerns about the charts and was asked to demonstrate his commitment and participate in a plan. If we accept that Dr Fitzpatrick believed Mr O'Brien

to have been "warned" then his advice in that context being that the Trust could "take immediately disciplinary action" in relation to the charts at home that advice may have been correct. The Trust did not take any immediate disciplinary action. Therefore, there is no detriment in practice to Mr O'Brien and we have no evidence that Dr Fitzpatrick was misled.

2.2.35 The implication is that Dr Fitzpatrick was wrongly informed on purpose. This relates to the matters initially discussed at 2.2.3 to 2.2.5 above and to the letter of 23 March 2016 at Appendix 1.

2.2.36 To set this in context we refer again to Mr Mackle and Ms Trouton's letter of 23 March 2016 in which they also stated:

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

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

2.2.37 It is not correct that Mr O'Brien did not know that he had to respond. He did not do so. It is our opinion that the NCAS advice was delivered in the context of the issues facing the Trust. The use of the word "warned" in Dr Fitzpatrick's letter is misleading as there was no official warning in place but as stated above, Mr O'Brien was aware of the criticisms of him that needed a response.

2.2.38 With regard to Mr O'Brien's comments on policies and procedures, it is our opinion that the MHPS process is the appropriate mechanism to address matters like this about a doctor's alleged performance especially where no actions planned earlier had been implemented.

2.2.39 Mr O'Brien expressed a view in his grievance that there were viable alternatives to MHPS processes during 2016[4]. This was the case in March, but by October 2016 nothing had been implemented. It was not Mr O'Brien's fault, that matters were not progressed at this point by the clinical team. They were not progressed. This lead credibly to Dr Wright's decision on 22 December 2016 to move matters into a formal MHPS process.

[4] Section 2.3.2 (page 8) of Mr O'Brien's November 2018 submission

2.2.40 Mr O'Brien is correct about errors in the notes of the Oversight Committee meeting of 22 December 2016 (see 2.2.21 to 2.2.23 above). It is our view that the suggestion that the meeting notes were not formally written up until later has credibility. On balance, we consider it to have been the case that the notes, were not written up immediately, given the Christmas and New Year breaks. They were, in our opinion likely to have been written up in the current typed format much later.

2.2.41 It is our opinion that neither the errors nor the date the notes were written did anything but reflect the outcome of the meeting and the decision to progress to a formal MHPS investigation. Dr Wright, by the time of 22 December 2016, was then minded to formalise the Trust response regarding the alleged concerns about Mr O'Brien. He could only reasonably have escalated this from an informal stage already in place so the reference to "formal" is indeed an error.

2.2.42 Mr O'Brien told us that the meeting with Dr Wright to discuss the decision to move to the formal MHPS process was initially arranged for 3 January 2017 and it was brought forward to 30 December 2016 at Mr O'Brien's request. It is factually correct that on 28 December 2016, Mrs Toal wrote to Ms Hainey in HR asking her to accompany Dr Wright at a meeting with Mr O'Brien "this Friday" (30 December 2016). We cannot say with certainty whether a January 2017 date had already been discussed direct with Mr O'Brien and he had subsequently sought to change it by 28 December 2016 when Mrs Toal wrote her email. Either way, we see no significant issue to our findings here of impact on Mr O'Brien other than it may have been he who instigated the meeting being brought forward. We agree that it was better to do so rather than meet on his first day back at work.

2.2.43 The Trust Guidelines state that a role of the Oversight Committee is to "monitor progress"[5]. It is reasonable that, having not being assured of informal progress at its September and October 2016 meetings and then the December 2016 meeting, and with the potential of additional concerns arising from a Serious Adverse Incident, the Committee endorsed a formal approach with immediate effect.

2.2.44 It is concerning that the December 2016 notes did not reflect earlier "informal" action correctly in retrospect. In the context of our comment above at 2.2.43 about the legitimacy and reasonableness of progressing the concerns formally, it is clear from Dr Wright's actions following the meeting that invoking a formal process was the clear plan.

[5] Section 2.5 *Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance* (September 2010)

2.2.45 Dr Wright's roles as Medical Director and General Medical Council Responsible Officer include significant responsibilities to the public about a practitioner's fitness to practise which should not be underestimated. This is interlinked with his role in the MHPS Framework to deal with performance concerns.

2.2.46 We note the level of non-compliance with the Oversight Committee's plans by managers/clinicians and also Mr O'Brien's non-engagement or his motivation to enquire about the concerns raised with him, even to dispute them. We have no evidence of his input in this regard. **It is our decision that by the time matters were discussed on 22 December 2016 at the Oversight Committee, the opportunity for a viable informal approach no longer existed and the Committee endorsed the decision to address them formally under the MHPS Framework. This was a reasonable response in accordance with processes and the grievance is not upheld.**

2.3 JANUARY 2017 TO JUNE 2018

2.3.1 This timeframe reflects the period covering the formal MHPS investigation until it reported on 21 June 2018. It also relates to Mr O'Brien's submission that there were variations to Trust policies and procedure to the extent that his contract of employment was breached.[6]

2.3.2 **The facts established are set out at 2.3.3 to 2.3.14 below**:

2.3.3 It is Mr O'Brien's contention that policies and procedures were not applied correctly in his case and this was a breach of his contract on the part of the Trust.

2.3.4 As well as his contract of employment, he also referred to:

- *Maintaining High Professional Standards in the Modern HPSS A framework for the handling of concerns about doctors and dentists in the HPSS* (Department of Health, Social Services & Public Safety - November 2005 *(referred to as MHPS Framework or MHPS in this response)*

- *Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance* – September 2010 *(referred to Trust guidelines in this response)*

2.3.5 We are in no doubt that the MHPS Framework is the overarching document and contractual process that applies to handling concerns about doctors employed in Health & Social Care (HSC) in Northern

[6] Section 2 heading on page 3 of Mr O'Brien's November 2016 submission

Ireland. It is our opinion that it cannot be set aside nor an alternative put in place because to do so would be outside of national terms and conditions of service.

2.3.6 Having read and considered the Trust Guidelines, our opinion is that it describes the operational processes within which the MHPS Framework is applied. It is not an alternative to the MHPS Framework nor is it a substitute for the primary process to attend to concerns about doctors.

2.3.7 Mr O'Brien is correct that there are gaps in the Trust's compliance with the requirements of these processes.

2.3.8 In relation to the stated timescales, MHPS sets out very precise requirements:

- *"the Case Investigator should, other than in exceptional circumstances, complete the investigation within 4 weeks of appointment and submit their report to the Case Manager within a further 5 working days*[7]*"*

2.3.9 From the date of the Case Conference on 26 January 2017 which confirmed that there was a case to answer, to the date of submission of Dr Chada's (Case Investigator) report on 12 June 2018 and then issued to him on 21 June 2018, 73 weeks had passed.

2.3.10 We therefore examined this timeline and any explanations for the passage of time. A timeline summary for the formal investigation provided by the investigators is included at Appendix 8. We also shared this document with Mr O'Brien and considered his comments on it.

2.3.11 To assist us in understanding the grievance aspects relating to procedural delay of the MHPS investigation itself, we also set out a calendar for 2017 and up to June 2018 (Appendices 9 and 10).

2.3.12 Mr O'Brien referred to other matters. At page 4 of his November 2018 grievance submission he said that "… *the Trust was always aware that the volume of work was overwhelming. It is clear from the witness statements provided in the investigation my administrative backlog was known to Trust managers for a very considerable periods of time*". This is the case and the backlog in Urology was known.

2.3.13 In his grievance, Mr O'Brien also expressed his concern that excessive time was spent in "*scoping*" the investigation and its terms of reference. He also said that there is a lack of clarity on what "*scoping*" is

[7] Paragraph 37 on page 10 of MHPS

2.3.14 Mr O'Brien further expressed his concern to us that on the one hand, the investigation was delayed significantly but when it came to his required response, the Trust was disinclined to extend any flexibility on the timeline for his responses.

2.3.15 **The panel findings on issues at 2.3 are set out in 2.3.17 to 2.3.44 below**

2.3.16 Having stated that MHPS Framework is the underlying contractual process, we are of the view that whatever practical challenges there are in its operation, its overarching intention is to resolve matters in a timely way, even before the Framework in invoked. It is our view that Mr O'Brien's lack of engagement and absence of evidence of him working with his employer before the formal MHPS investigation commenced contributed significantly to the decisions that later escalated the process to a formal MHPS context. With professional and meaningful engagement input from Mr O'Brien it is plausible that events may never had needed to be escalated and all the later delays in the investigation subsequently avoided.

2.3.17 The initial plans in March 2016 were not implemented by any clinical manager. It is credible that, when Mr Mackle ceased to be Clinical Director, that progression of the concerns raised with Mr O'Brien were not prioritised after Mr Mackle ceased his role as Clinical Director. Mr Haynes became the new Associate Medical Director, and Mr Colin Weir became the new Clinical Director in June 2016. Mr Weir intended to design a new local approach by September 2016 (2.2.11 above). There is no evidence that, as the Directorate representative at the Oversight Committee, Ms Gishkori had taken steps to check the status of Mr Mackle's intervention before she attended the 13 September 2016 meeting of the Oversight Committee or ensure that responsive action was taken to the later plan she proposed to Dr Wright as an alternative in September 2016 (2.2.10 above). This allowed Mr O'Brien's non-engagement to go unchecked and give rise further delay

2.3.18 Mr O'Brien's suggested that the letter to him of 23 March 2016 did not require his attention. We do not consider this to be the case as the letter's closing remark (Appendix 1), clearly describes the action required of Mr O'Brien. He presented no evidence of his response to the request made of him and therefore progress was stalled:

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

2.3.19 Mr O'Brien also states that this letter of 23 March 2016 fell outside the required Trust Guidelines.

> If the letter of 23rd March 2016 is raising a concern about my performance as opposed to a concern about management, then that concern falls squarely within the definition above. **Yet the Trust Guidelines were completely ignored.**

2.3.20 We do not accept this. From the notes of the meeting of the Oversight Committee an "*informa*l" MHPS approach was only commenced in September 2016, not before. It is our opinion that in March 2016, Mr Mackle's intention was to draw Mr O'Brien's attention to alleged performance issues and this was in advance of entering an MHPS process. This does not make the letter itself informal and we can understand, from our consideration of the later delays, that Mr Mackle may have considered the letter to be best followed up in writing at this time.

2.3.21 We did not understand the term "scoping" that Mr O'Brien told us the Trust said that it was carrying out before the terms of reference were issued. A "*Screening Process*" is referenced in the Trust Guidelines at its Appendix 1 on page 8 of the document. This may have been what was meant by "scoping" but we cannot be clear. In any event the time taken was lengthy, irrespective of definition.

2.3.22 Mr O'Brien commented in his grievance on the letter of 23 March 2016 (see 2.2.8 - the first extract) saying that "*it does not refer in any way to a suggestion of misconduct or even to a performance issue*".

> The letter is not described as a formal letter. It does not refer to the Trust Guidelines. It does not state on the face of the letter that it was issued pursuant to any Trust policy or procedure. It does not refer in any way to any suggestion of misconduct or even to a performance issue. Neither expressly nor impliedly can it be interpreted as a formal warning, or any form of disciplinary sanction. Nor could misconduct or lack of performance be inferred from the letter. In fact, the letter starts by stating, "*We are fully aware and appreciate all the hard work, dedication and time spent during the course of your week as Consultant Urologist*".

2.3.23 This comment is unfounded as the letter indicates in the second sentence in the extract, from the 23 March 2016 letter, below that there is an issue:

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

The letter goes on to describe these and give examples (Appendix 1).

2.3.24 Mr O'Brien stated that concerns should be raised with a practitioner's clinical manager and he is correct[8]. Mr Mackle fell into this category as Associate Medical Director.

2.3.25 Mr O'Brien is also correct that there are no notes of earlier interventions with any other clinical manager before the meeting with Mr Mackle on 23 March 2016. However, is not unusual in practice that managers of all professions choose to express early concerns before they escalate them and decide that no note is necessary and that this is proportionate at this point. This is a judgment call. On balance, and in the context of everything we have examined in this grievance process, it is our view that it is credible that Mr Mackle may have been aware of previous discussions about these matters and there was no evidence of attention to them by any party, so he have decided to hold the meeting.

2.3.26 On balance, we do not consider it likely that Mr Mackle chose to have this meeting and issue a letter as a first response within the department and it was credibly an escalation of earlier unrecorded concerns. We consider that such an approach would have been fair to Mr O'Brien in the first instance. However, after 23 March 2016, Mr Mackle had ensured that Mr O'Brien could not indicate his unawareness of the alleged concerns and that there remained an opportunity to resolve these.

2.3.27 When MHPS is invoked it is a clear process and it states that when even deciding if an informal process should be applied it says:

- *"… it is necessary to decide whether an informal approach can address the problem or whether a formal investigation is needed. This is a difficult decision and should not be taken alone but in consultation with the Medical Director and Director of HR, taking advice from NCAS or Occupational Health Service (OHS) where necessary)* (MHPS paragraph 15 page 10)

2.3.28 In March 2016, it is our finding that Mr Mackle discussed this matter outside of the MHPS Framework and matters had not yet got to the stage of being discussed within the context of the MHPS extract above. There is no detriment to Mr O'Brien in doing this. He could reasonably be said to have neglected to take advantage of this opportunity to engage in early resolution or provide actual assurances that there was no basis to the concerns by becoming involved in active dialogue with a genuine view to this resolution.

2.3.29 Mr O'Brien stated at page 8[9] of his November 2018 submission that "*MHPS recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather*

[8] Trust Guidelines section 2.2.
[9] Second paragraph at top of page 8 of Mr O'Brien's November 2018 submission

than solely through formal action". The implication is that in not doing so, The Trust has breached his contract.

2.3.30 We do not find this to be the case. First, this assumes that the matters were clinical in nature, and there is no common ground on this matter. Dr Khan, Case Manger under MHPS, considers this to be a matter of conduct unrelated to clinical skill (this is covered in Section 3 of this report). Secondly, any resolution, clinical, or otherwise under MHPS assumes a principle of co-operation. It is our view that Mr O'Brien was persistent in his non-engagement in any process that suggested any potential for shortcoming in his role. He only engaged when he had concerns about the Trust and in this regard, he expects timely responses from them that were not reciprocated by him. Mutuality is key. In there being no common ground and, in the absence of Mr O'Brien's acknowledgement that there was the potential for an issue to be addressed from the Trust's perspective, it is not solely a failure or breach on the Trust's part that any "*remedial action*" could succeed in the one-way process that existed.

2.3.31 We noted from Mr O'Brien's submission in his November 2018 submission[10] that his workload pressures were known (to the Trust) and we inferred that he meant this backlog to be mitigation of the position in which he found himself. Our findings on this are:

- Mitigation of allegations and findings in an investigation which leads to a disciplinary process, is for that formal process and only for a disciplinary panel to consider

- In our opinion, mitigation will be only relevant where allegations are factually correct and serves to provide an explanation and context.

- None of these above is relevant to the grievance process and we cannot comment on whether it may have featured or not in a disciplinary hearing that never happened. If it had taken place and Mr O'Brien was subsequently dissatisfied with the outcome and mitigation was not considered in his view, that would be appropriately raised in a formal appeal within the disciplinary process. It is not something that this grievance panel can decide upon.

2.3.32 The MHPS Framework sets out specific timescales for the Formal investigation process i.e. *"The Case Managers should, other than in exceptional circumstances, complete the investigation within 4 weeks of appointment and submit their report to the Case Manager within a further 5 working days."* In our calendars at Appendices 9 and 10, we have set out information collated from the investigators and from Mr O'Brien in his written submissions, at the grievance hearing and in his response to seeing the panel comments sent to us. The key dates on which issues are of most significant dispute to Mr O'Brien,

[10] Page 4 section 2.3 of his November 2018 submission Mr O'Brien states in reference to his workload, "*This was always known to the Trust and the Trust was always aware that the volume of work was overwhelming*."

(after he had seen the investigators' timeline) are set out in the table below **(NB the next section relates to the timeframe for the formal MHPS investigation only that is relevant to this Section, 2.3):**

DATES	MR O'BRIEN'S COMMENTS	INVESTIGATORS'/GRIEVANCE PANEL'S COMMENTS
A. January to March 2017	*"It took approximately 10 weeks before the Terms of Reference were even provided to Mr O'Brien. This delay is unconscionable"*	There was a significant delay in providing the Terms of Reference to Mr O'Brien.
B. April, May & June 2017	"*there is no explanation provided as to why the Case Investigator took 3 months to interview all of these witnesses. It does not feel reasonable …"*	*Dr Chada said in response "… three months were required to interview people given I had a busy full-time clinical job and had duties and responsibilities in my tole as Associate Medical Director." She does point out that that they attempted to meet with Mr O'Brien having heard from witnesses but their statements had not been returned, "but having better understood the issues which we wished to raise with Mr O'Brien"*
	"Mr O'Brien did not receive any of the statements made by these witnesses by the time of his first interview on 3 August 2017…. The complete list was only provided to Mr O'Brien on 28 September 2017"	
	"Mr O'Brien did not meet once with Dr Chada to discuss the investigation even though it is stated in MHPS to be best practice for the Case Investigator to meet with the practitioner first."	This is not a requirement.

DATES	MR O'BRIEN'S COMMENTS	INVESTIGATORS'/GRIEVANCE PANEL'S COMMENTS
C. 14 June 2017, 19 June 2017 & 5 July 2017	"*We are concerned that these entries give the impression that Mr O'Brien was in some respects causing delay to the investigation … It proved impossible to schedule the meeting in late June to 1 July as scheduling commitments had already been made and it was agreed to schedule the meeting for 31 July and then subsequently 3 August 2017."*	Investigators pointed out that Mr O'Brien said in his own email of 19 June 2017 (00.33 hrs) that "I do not know how important that it is that I meet with Dr Chada around that time, rather than later" (29 and 30 June 2017) Investigators were able to be flexible and agreed to meet on Mr O'Brien's suggested date of Saturday, 1 July 2017. However, in his email of 19 June 2017 (15.05 hrs), Mr O'Brien said "*I believe it would be better to defer meeting until end of July 2017, and so would prefer not to have to cancel appointments, clinics etc … Therefore, I propose that we could meet Dr Chada on any day during the week beginning Monday 31 July 2017."*
D. 3 August 2017	"*Mr O'Brien had none of the evidence that the investigator was referring to and really only had the terms of reference and a summary of the initial concerns to respond to. The fact that this important evidence had not been provided 8 months after the beginning after the beginning of this investigate (*sic*) was astonishing …"* *"in order to mitigate the effects of this, it was necessary to arrange a second meeting."*	This is correct and is referenced in **A.** and **B**. above. The panel agreed to the second meeting.

DATES	MR O'BRIEN'S COMMENTS	INVESTIGATORS'/GRIEVANCE PANEL'S COMMENTS
E. 6 November 2017	*"The draft of the first statement [11] had been provided to Mr O'Brien on 28 October 2017 and Mr O'Brien had expressed concerns about the accuracy of these notes and wished to make amendments."* *"During the meeting, Mr O'Brien did advise that November and December were going to be very busy periods at work and he was going through the completion of his appraisal. It was agreed that the additional matters from the meeting of 6 November 2017 would be addressed in the new year."*	Evidence from the timeline shared by the investigators and (Appendix 8) demonstrates that this is correct. They agreed that he would not have to participate in November and December 2017.
F. 15 February to 2 April 2018	"*There was no further communication with Mr O'Brien until 15 February 2018. The entries[12] again to give the impression that Mr O'Brien was causing delay to the investigation, it is not recorded that Ms Hynds only provided the draft of the second statement of 6 November 2017 on 4 March 2018."* *"Mr O'Brien stated on 22 February 2018 that he would not be able to provide his commentary until 31 March 2018. Ms Hynds responded by insisting on receiving the remarks by 9 March 2018. …This was impossible given Mr O'Brien's heavy commitments at work… He endeavoured throughout March 2018 to complete his commentary and ultimately the commentary was provided on 2 April 2018 following the Easter weekend."*	From the timelines discussed in relation to **E.** above and below. There were more than just Mr O'Brien's comments on a statement to be provided. This timescale is correct and not disputed. During this period, Mr O'Brien missed further extensions of the deadline on five further occasions (see comment at **F**. below and calendar at Appendix 10)

[11] Refers to the meeting held on 3 August 2017
[12] "*entries*" means the comments made by investigators on their investigation timeline

DATES	MR O'BRIEN'S COMMENTS	INVESTIGATORS'/GRIEVANCE PANEL'S COMMENTS
G. Other remarks from Mr O'Brien	*"There is significant imbalance in the way that time is provided to the investigators on the one hand and Mr O'Brien on the other. Statements from witnesses in March to June 2017 were not provided to Mr O'Brien until October and November 2017. This delay is not considered noteworthy by the investigators. However, where Mr O'Brien required extra time, this became a subject of criticism."*	See **F.** above and our comment in **F.** below.
	"It is also worth noting that the Investigator's report was not in fact completed for almost another three months when finally provided on 21 June 2018. Mr O'Brien then provided his full response by 10 July 2018 having been given a 24-hour extension. Then there was almost another three-month delay until the Case Manager provided his determination on 1 October 2018."	This is factually correct and not disputed. See section 2.4 which covers this period.

2.3.33 The investigators provided us with emails having been sent Mr O'Brien's comments of 25 September 2018. These ae in Mr O'Brien's possession as they were emails to him and he responded to them. It is our intention to eradicate the sense of imbalance between the parties' perspectives and we have set out our findings on each of the above points as follows:

A. The Terms of Reference can only be formally finalised when the preliminary enquiries have been completed and the case conference held (in this case it was held on 26 January 2017). It was therefore almost seven weeks, not ten, before Mr O'Brien was provided with these on 16 March 2017. However, this is too long and we would expect that some early consideration of these could have taken place in preparation and thereby finalised much more quickly. There has been much confusion about preliminary drafts of terms of reference (a draft had been prepared for Dr Wright's information for the December 2016 meeting), screening and scoping. None of which explains the delay on an input that is clearly the responsibility of the Trust. We do not find evidence whereby we could safely conclude that this was motivated by some sense of purposeful dishonesty and was unscrupulous as is suggested by Mr O'Brien's contention that it was "*unconscionable*". This is his view but it is not our finding.

B. We accept Dr Chada's explanation that this investigation had to be managed within her job plan and her roles. It is credible that in trying to seek diary availability with Mrs Hynds and then each of the 13 witnesses was challenging. It is not that unlike what Mr O'Brien said about his commitments preventing him from moving onwards. The difference from Dr Chada's perspective is that we have evidence of active progression on her part despite diary availability. Although, regrettably, over a period of 13 weeks, there is evidence that Dr Chada did set aside time and did meet all 13 witnesses by 5 June 2017.

While we find the overall period to do this took much longer than it ought to have, it cannot be categorised as impacting negatively on the investigation. The witnesses were essential to the investigation and there were actions happening over the period, albeit at a frequency that was not ideal where all the parties could have protected time from their jobs. This is not possible while maintaining services.

C. Investigators made attempts to meet Mr O'Brien in late June. While not attributing "blame" to Mr O'Brien, it was he who was unable to comply with the dates suggested. We understand that, like Dr Chada, these are related to work priorities. At one point, Mr O'Brien offered to meet on Saturday, 1 July 2017. Then in view of his work activity and the unavailability to his son (who accompanies him), he finally offered 31 July 2017. It is likely that Mr O'Brien's job plan was not made up entirely of Direct Clinical Care activities throughout July 2018 and we noted that he offered no alternative date in July, only 31 July 2017.

We observed that, immediately Mr O'Brien suggested 1 July 2017, a Saturday, and the investigators facilitated it, Mr O'Brien cancelled it saying, "*it would be better to defer the meeting to later in July."* We are concerned that Mr O'Brien was not demonstrating the sense of urgency that he now complains was lacking by the investigators.

D. See responses in **A**. and **B.** above.

E. Mr O'Brien asked for the process to be delayed for 2 months in November and December 2017 and we acknowledge that the investigators agreed with this proposal. However, the next actions sat also with Mr O'Brien (he wished to make comments on statements and his own inputs). Regrettably in his comment above these actions would *"be addressed in the new year".* Mr O'Brien suggests that all the remaining actions were on the part of the Trust, but he did have actions i.e. comments on witness statements. He was reminded of this on 22 February 2018 and as well as expressing some confusion on his actions, he stated *"I have not had time to attend to the process since November 2017".*

It suggests that Mr O'Brien considers that he has considerable authority to manage the timeframe of the MHPS investigation himself which is not the case. It is our opinion that both parties share responsibilities for <u>progression</u>.

Having said that, we fully accept that the pace required in such a complex investigation needs to be set by the investigators. However, date provision and availability need to be reciprocated and it was not until 2 April 2018 that Mr O'Brien submitted the outstanding inputs.

It is our finding that Mr O'Brien was not inclined to progress and he controlled this by his inaction. We observe with the benefit of hindsight now in 2020, that there ought to have been a more assertive management of Mr O'Brien even thought he would have been unlikely to have welcomed that. If he considered he "*had no time*" and valued faster progression of the matter with the certainty he expressed at his grievance, he ought to have asked if space could be created to allow him to progress his inputs.

Regrettably in this section we saw a similar pattern to the wasted time frame from 23 March 2016 onwards, i.e. Mr O'Brien appears to withdraw and then takes the view that he had no role in that delay.

F. Mr O'Brien appears to suggest that there were no actions from him in the period up until February 2018. This is not the case (see **E.** above and in the table). Having requested, and the panel agreeing, to exclude November and December 2017 for any actions from him, there was no curiosity from Mr O'Brien about how he could progress without a draft of his statement which he then said was essential to his comments. It appears to us that he lost interest in the investigation during this time and it was only when Mrs Hynds reminded him about outstanding matters on his part that he expressed that he had "*misunderstood the arrangements and commitments … and wondering why there had been such a long delay."*

In considering this grievance in its entirety, we do not find the lack of understanding on Mr O'Brien's part to be credible.

By February 2018, the required inputs were Mr O'Brien's i.e. to expedite his comments back to the Trust and to do this by 9 March 2018. Mr O'Brien was not able to meet this deadline because of work commitments. Mrs Hynds extended the deadline to 16 March 2018 and, on no receipt of comments on 16 March 2018, extended it to 26 March 2018. When this deadline was also missed by Mr O'Brien, it was extended to 29 March 2018 and finally to 30 March 2018. Mr O'Brien submitted his comment on 2 April 2018. These were available to the investigators on 4 April following the Easter Bank Holiday break.

Mr O'Brien stated at **F**. in the table above that this delay was because of him not being provided with his draft statement until 4 March 2018. We do not accept that Mr O'Brien was unable to reflect on matters raised at the meeting on 6 November and earlier, on 3 August 2017. While we do not need access to the investigation report and notes of meetings with Mr O'Brien (we cannot re-investigate the formal MHPS investigation itself), we do not find it credible that there were no matters put to him at

the meeting on which he needed to reflect and comment on. This is because he had sought time to do so. We do not accept that his response was solely dependent on him seeing how his statement was reflected to him in writing at the later date.

G. It is correct that from submitting his factual response to the draft report on 10 July 2018 to Dr Khan, the Case Manager, Dr Khan's decision on the report was not completed until 28 September 2018.

Our comments in relation to this timescale are made in Section 2.4 below (where we deal with this period until Mr O'Brien lodged this Grievance on 27 November 2018.

2.3.34 In our analysis of the facts relating to the timescale of the investigation itself, it took 350 working[13] days to complete. We then considered what accounted for the passage of time beyond what may have been considered reasonable at the outset of the investigation. In the way that it is not automatically appropriate to categorise all contribution to the extended timescale on Mr O'Brien's part as a "delay", it is also not appropriate to define all time on the part of investigators as a "delay" either. Both parties will have had to spend necessary time in their own analysis and that has to be understood as a necessity.

2.3.35 In this regard, our attempt to quantify and understand the passage of time in this case is not intended to pejorative, it is purely factual. Our view on the parties' contributions is set out separately from 2.3.36 below. It is essential in any investigation that there will be a certain amount of time that inevitably passes between scheduled interventions, for example, to read and comment on documents, set up meetings with witnesses, write up notes and draft documents. The blocks of time in the 350 working days that could not have been reasonably predicted or expected in this case are as follows:

- An investigation meeting scheduled for 28 June 2017 was changed at Mr O'Brien's request. A new date of 1 July 2017 was agreed but was immediately changed to 31 July 2017. This date was again, at Mr O'Brien's request, moved to 3 August 2017. This period accounted for 25 working days (7% of the 350 working days).

- The first formal MHPS meeting with Mr O'Brien was held on 3 August 2017 and it was 65 days later, on 3 November 2017, that the second meeting was held (18%)

- Mr O'Brien requested that he be allowed on concentrate on his workload and prepare for his appraisal in November and December 2017. From the date of his meeting with investigators on 6 November

[13] All weekends and bank/statutory holidays have been removed.

2017 (when he requested this) until end of December 2018, 76 working days were unused (21%).

- To make his response to matters on 6 November 2018 as he indicated he wished to do, from January 2018 until his response on 2 April 2018, a further 63 days had passed (18%)

- From receipt of the information from Mr O'Brien on 2 April 2018 until the Case Manager issued her report on 21 June 2018, there are 55 working days (15%)

2.3.36 These figures are concerning and we do not suggest that some of these could have definitely been shortened to one or two weeks. However, 79% of the time of the investigation was waiting for the next event to take place. It is our opinion, with the benefit of hindsight, that the setting up of the second meeting with Mr O'Brien ought to have been accelerated. It is also our opinion that Mr O'Brien's changes to dates and non-submission of responses was tolerated beyond what now looks reasonable. We understand that request for more time like these are commonly facilitated to avoid any unintended unfairness to Mr O'Brien in this case. But such facilitation did not have the intended effect of minimising any sense of unfairness and now in this grievance it has contributed to the extension of the timeframe and subsequent criticism of the Trust. This will always be a dilemma and matter of judgment for the Trust on a case by case basis because there is potential criticism either way. From our perspective, having seen significant lack of active engagement from Mr O'Brien from March 2016, more pressure on him to respond may have been appropriate.

2.3.37 We note that having conceded to three extensions to a deadline from 9 March 2018 otherwise the Case Investigator would proceed. She did not ignore his submission on 2 April 2018. Although late and she could have ignored it from a technical perspective, she did not.

2.3.38 It is our finding therefore that while there were periods of time that the Trust should have minimized, they did afford considerable leeway to Mr O'Brien.

2.3.39 On his receipt of the MHPS report on 21 June 2018, Mr O'Brien had to comment on the document and the facts. He sought more time to do so and the Trust did not willingly afford more additional time. It was an already protracted matter and a few days would not have had significant impact. However, they may have been mindful of his missing deadlines in the past and were disinclined to give more than a short extension.

2.3.40 Returning to the original catalyst for these processes, by December 2016, matters had lain in abeyance since March 2016, with no one, including Mr O'Brien, responding actively to the concerns raised about him. Mr O'Brien, as well as the Trust, had an interest in these matters

being closed one way or the other. At the point where this grievance was heard this year, Mr O'Brien continued to express a view that there is no basis for the allegations and he remains confident of that. However, from the Trust's perspective these matters could not be set aside just because of the passage of time. Mr O'Brien ought also to have attended to them and presented his evidence in the structured context of the conduct panel arising from the MHPS investigation which, by the time of the grievance, was the procedural way forward.

2.3.41 Mr O'Brien chose to present evidence to us at his grievance hearing that not only had the allegations no basis, in his view, the MHPS investigation report was flawed. This is outside of the remit of a grievance panel. The correct place for such evidence and challenge of the MHPS report is at the conduct panel hearing that was planned. Mr O'Brien presented much information to us and a high level of dispute of the content of the investigation in a forum that cannot appropriately deal with them. We explained that this was likely to be the case when we spoke to him at the grievance hearing. On balance, we consider that in not participating in a disciplinary process, Mr O'Brien has delayed proper attention to the matters and resolve them in line with the processes set out in the national terms and conditions and contractual arrangements. We are also critical of the Trust where they did not inform Mr O'Brien regularly about delays and revised timescales on their part.

2.3.42 Mr O'Brien has an entitlement to raise a grievance where he has a dispute with his employer. We note, however, the need for reciprocity in an employment contract and thereby Mr O'Brien has a responsibility to engage with and participate in his employer's use of formal processes too. This is the basis on which MHPS is intended to operate. Therefore, while we find delays existed in the investigation on the part of the Trust, when considered in their totality, they did not dispense with the expectation that Mr O'Brien ought to have complied with Trust processes at the outset In March 2016 and then during and when the lengthy investigation was completed in June 2018.

2.3.43 **Mr O'Brien's grievance about the duration of the investigation is not upheld. It does breach the 4 weeks for the investigation and the further 5 days for submitting the report. However, we consider that the "*exceptional circumstances*" do exist. While not excusing all delays in the process, on balance, there is a level of credible explanation for some of them. It does not in our view reach the threshold of a breach of his contract.**

2.4 JULY 2018 TO NOVEMBER 2018

2.4.1 **The facts established are set out at 2.4.2 to 2.4.4 below**

2.4.2 This timeframe reflects the period from Mr O'Brien's comments on the Case Investigator's formal MHPS report made on 10 July 2018, to the Case Manager's decision of 28 September 2018 and until Mr O'Brien lodged his grievance dated 27 November 2018 (20 weeks)

2.4.3 In section 2.3.33 above in the table at section G, we note Mr O'Brien's comments:

Mr O'Brien then provided his full response[14] by 10 July 2018 having been given a 24-hour extension. Then there was almost another three-month delay until the Case Manager provided his determination on 1 October 2018."

2.4.4 In his grievance Mr O'Brien set out his concerns about the delay in setting up his grievance and receiving documents he sought from the Trust.

2.4.5 **The panel findings on issue at 2.4 are set out in 2.4.5 to 2.4.7 below**

2.4.6 In speaking to Dr Khan, Case Manager, we do consider that he clearly reflected on the report and the MHPS options. However, we find that the 21 weeks he took to do so unnecessarily protracted the process. After such a lengthy investigation, Dr Khan's response where no exchanges with Mr O'Brien were required, should have been expedited. It required Dr Khan's analysis and reflection on the facts in the report and how it fitted with MHPS decision-making. **The timescale is not explained sufficiently but Mr O'Brien's grievance is not upheld to the extent that it breached his contract of employment**.

2.4.7 From Mr O'Brien's receipt of the Case Investigators decision on 28 September 2018 until he lodged his Grievance on 28 November 2018, the period is not overly long and he appears to have used the time to prepare his lengthy submission. This is not relevant to the grievance

[14] to the Case Investigator's MHPS report received on 21 June 2018

3 *"I am formally lodging a grievance against the decision dated 1 October 2018 of the Case Manager to classify the case as a case of misconduct."*

3.1 **The facts established are set out in 3.2 below**

3.2 The MHPS Framework states that there is a range of decisions open to the Case Manager, in this case, Dr Khan, when he has examined the report. These are set out at paragraph 38 page 12 of the Framework:

38. The report should give the Case Manager sufficient information to make a decision on whether:

- no further action is needed;
- restrictions on practice or exclusion from work should be considered;
- there is a case of misconduct that should be put to a conduct panel;
- there are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer;
- there are concerns about the practitioner's clinical performance which require further formal consideration by NCAS ;
- there are serious concerns that fall into the criteria for referral to the GMC or GDC;
- there are intractable problems and the matter should be put before a clinical performance panel.

3.3 **The panel findings on issue 3 are set out at 3.4 to 3.6 below**.

3.4 We spoke to Dr Khan as part of the grievance process and we also read his Case Manager's Report. We find that Dr Khan's response at that time was in line with the MHPS Framework requirements in 3.1 above and we are satisfied that he gave due consideration to the information available to him.

3.5 We are also satisfied that Dr Khan gave due consideration to whether a conduct or clinical approach was appropriate. At the time that he made this decision, it was reasonable for him to conclude that the matters before him were not concerns about Mr O'Brien's clinical skill or aptitude and a conduct approach was appropriate.

3.6 **This aspect of Mr O'Brien's grievance is not upheld.**

4 In July 2020, Mr O'Brien added other matters, namely, "*Delayed Handling of my Grievance", "Additional Concerns (i) events before 30 December 2016, (ii) an unfocused trawl, (iii) private patients", and Duty of clinical care update*"

4.1 Delayed Handling of my Grievance

4.1.1 **The facts established are set out in 4.1.2 to 4.1.4 below.**

4.1.2 Mr O'Brien's grievance is dated 27 November 2018 and the grievance hearing (day one) was held on 30 July 2020. This process took 103 weeks. We considered the period from November 2019 to April 2020 (say 25 weeks) when, because of industrial action and then the early days of the Covid-19 pandemic, much of the usual HR activity was set aside. However, even setting these events aside which significantly distracted from normal business, it still took approximately 78 weeks to arrange this grievance and we needed to examine this timeframe.

4.1.3 The Grievance Procedure states that the Trust will "*arrange for a grievance panel to hear the grievance normally within 20 working days or as soon as reasonably practicable. If it is not possible to hold the hearing within 20 working days the employee must be provided with an explanation for the delay by the Human Resources Department."*

4.1.4 In looking at the facts of this we considered the correspondence between Mr O'Brien and the Trust in his quest for additional information.

4.1.5 **The panel findings on issue 4.1. are set out at 4.1.6 to 4.1.17 below**.

4.1.6 There is no requirement in the grievance process, once invoked by the employee, to supply him/her with ongoing information. It is enough that they set out their concerns and it is then for the panel to seek out all evidence. While it is useful for the employee to provide some of the information in his own possession, he/she is not expected to do the research and trawl for other information. This is provided for in the Grievance Procedure, *"the Grievance Panel may also additional information/clarification in the pursuit of resolution of the grievance."*[15]

4.1.7 Unusually, for a grievance, Mr O'Brien told us that he had *"set out proposed actions that would allow the grievance process to commence with a first meeting …"*[16]. It is our understanding that it is the Trust who sets out the timetable and manages the process.

[15] Paragraph 6b of the Grievance Procedure
[16] Contained in Mr O'Brien's supplementary comments to the panel on 25 September 2020

4.1.8 Mrs Toal, Director of Human Resources, acknowledged receipt of Mr O'Brien's grievance on 14 December 2018 and in it she referred to *"arrangements being finalised to consider your grievance".* She also referred to information sought earlier by Mr O'Brien and that the Trust would endeavour to release it to him by 21 December 2018 and, if that were not possible, she would update him.

4.1.9 Further communication continued for some time:

- The Trust provided some documents by 22 December 2018 and sought an extension to provide the remaining papers by 11 January 2019

- Mr O'Brien and Mrs Toal exchanged further correspondence between 12 March 2019 and October 2019 when information was delivered to Mr O'Brien's secretary.

4.1.10 Our finding is, having examined correspondence, that the requests for more information by Mr O'Brien were considered by the Trust to be a condition of his attendance at his own grievance. In his letter to Mrs Toal of 12 March 2019 he says (when he requests further information for the Medical Protection Society - MPS:

> *"Following its receipt, you will be advised whether any further information is to be requested, and/or whether the grievance is to be amended."*

4.1.11 On 3 June 2019 Mr O'Brien wrote to Mrs Toal on 3 June 2019. In the first paragraph he refers to information connected to his grievance "*has still not been provided".* In Mrs Toal's response of 3 June 2019 (Appendix 12), she states *"once this information has been provided to you, I will be commencing your grievance process immediately to avoid further undue delay. Any additional requests for information or amendment to your grievance can be done so as it is progressed.".*

4.1.12 We have no evidence to indicate that Mr O'Brien did not agree that it was the case that his attendance at a grievance was conditional upon his receipt of information as set out, nor have we evidence that he corrected this if he did not agree.

4.1.13 We have no evidence to indicate that Mr O'Brien sought assurances about his grievance for the avoidance of any doubt that he may have had after the correspondence from Mrs Toal on 3 June 2019. We have experienced in this grievance Mr O'Brien's attention to dates and correspondence and we do not consider it likely that he believed that the Trust was the party that had not progressed the matter.

4.1.14 It is our opinion that the process stalled. Mr O'Brien sought extensive information and the Trust understood that until he no longer had outstanding information requests, he was not prepared to attend his grievance.

4.1.15 As before it is our opinion that after Mr O'Brien was provided information on 30 October 2019, the industrial action faced by all HSC employers and subsequently the Covid-19 pandemic while not related directly to Mr O'Brien's case, had the effect of all HSC HR departments having to redirect attention urgently to matters beyond normal business.

4.1.16 Finally, in this section, Mr O'Brien contended that a decision by the Medical Director to refer him to the General Medical Council (GMC) was related to him advising the Trust that he had instructed legal representation. Mr O'Brien provided no evidence on this beyond timing alone. It is therefore not possible for us to conclude safely on that basis that he is correct.

4.1.17 While there are significant delays in setting up Mr O'Brien's grievance, we have been able to explain them, at least to some extent, by examining the correspondence. We inferred from Mr O'Brien's submissions that this was deliberate on the part of the Trust and we do not find this to be the case. Unlike most other grievances, Mr O'Brien's had the attention of the Director of HR and she personally attended to much of the responses to him. **This aspect of the grievance is not upheld**.

4.2 Additional Concerns

(i) Events before 30 December 2016

4.2.1 All matters on which we wish to comment are included in section 2.2.

(ii) An unfocused trawl

4.2.2 Mr O'Brien pointed out that included in Dr Lynn's (NCAS) letter to Dr Wright of 29 December 2016, "*the investigation should not be an unfocused trawl".* **(Appendix 11)**

4.2.3 It is not possible nor is it appropriate for a grievance panel to reinvestigate the matters contained in the formal MHPS investigation. This includes seeking whether the matters considered by the investigators were relevant or not. This would have required some investigation on our part and judgment of the matter to decide whether the inclusion of any item was appropriate. While we would have preferred to attend to and address all matters raised by Mr O'Brien, it is beyond our remit in this matter. This is only appropriate in the context of the disciplinary hearing that was anticipated and Mr O'Brien

presenting his evidence there and his view that he has no case to answer.

(iii) Private Patients

4.2.4 Again, it is not possible nor is it appropriate for a grievance panel to reinvestigate the matters subject to the formal MHPS investigation. By doing otherwise in relation to private patients would have required re-investigation on our part and we cannot substitute the MHPS and disciplinary processes with our analysis or judgment on this. This is only appropriate in the context of the disciplinary hearing that was anticipated and Mr O'Brien presenting his evidence and his view that he has no case to answer in this regard

4.2.5 **In relation to the items in 4.2 (i) and (ii), these are beyond the panel's remit.**

4.3 Duty of Clinical Care

4.3.1 On examination of these matters, these are outside of the remit of a grievance panel because they raise concerns of a clinical nature.

4.3.2 For this reason, these will be passed on by Dr Diamond to the Trust's Medical Director, Dr O'Kane, to alert her formally to them and to decide on what, if any, next steps may be required.

5 Data Protection

5.1.1 Although not set out as a separate matter in his grievance, Mr O'Brien described some confidential matters that had been included in information sent to him that was in breach of Data Protection and confidentiality requirements. On examination, this appeared to be the case.

5.1.2 There are separate formal processes to deal with such alleged breaches and the panel forwarded details of these to the Trust so that they could be addressed within those policy requirements and dealt with, if required.

6 SUMMARY CONCLUSIONS

6.1 **Overall, we do not find Mr O'Brien's grievance upheld**.

6.2 Mr O'Brien referenced the MHPS Framework on many occasions in his submissions and at the grievance hearing. We consider that there were issues on the part of the Trust and Mr O'Brien himself that compromised the effective operation of the Framework the way it was intended. However, even though the Trust moved beyond timescales to the extent that they were, in effect, set aside, Mr O'Brien did not actively participate in an early resolution at the outset. This may have obviated the need to the subsequent investigation.

6.3 In the period after 23 March 2016 when Mr O'Brien did not respond, we are aware that it was not his fault that he did not know about the plans suggested by Ms Gishkori in September 2016. However, none of this takes away from the responsibilities of the Medical Director to have concerns examined and the time for informal resolution had passed by 22 December 2016.

6.4 As stated above, the delays in adhering to the timeframes in MHPS, while challenging and, from experience, seldom adhered to, the duration on this occasion was a concern. We also consider that the timeframe from submitting his grievance to it being heard was the subject of delay. We have explained in the sections above how we have taken account of some on the factors contributing to the timescales.

6.5 It is also our view that there were examples where Mr O'Brien's apparent focus solely on his own perspective contributed to the challenges facing his employer in attending to their concerns at an earlier stage which in turn created the escalating context that he faced. These delays, and the context in which they existed, did not mean that his contract was breached.

6.6 This also links to the fact that Mr O'Brien summarised the overall detriment to him by the time he got to his planned retirement i.e. not being able to stay beyond retirement because HR issues were remained without conclusion. This again is factually correct but our finding is also set in the context of his choices as set out in 6.2 above.

6.7 The correct way of addressing his views or veracity of the matters set out in the MHPS investigation report after Dr Khan decided it should go to a conduct panel, was for Mr O'Brien to participate. In line with the procedures he then could present his own evidence to a panel to support his view and have it fully considered. Mr O'Brien did not do this, he sought a grievance instead, some of which we were unable to consider because it was relevant to the purpose of the conduct panel and we could not re-investigate the MHPS investigation.

6.8 We find that, had Mr O'Brien met his obligations to engage meaningfully from March 2016, there was a chance of resolution and support to him, if it was required, outside of the formal MHPS process that ensued.

6.9 In relation to the concerns about Mr O'Brien which were the catalyst for this whole process, there are three key facts:

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

6.10 In examining these, it was, in our opinion, reasonable that Dr Wright was not assured of a viable alternative to the formal MHPS process in December 2016. All earlier intended interventions outside of the formal MHPS process had failed to deliver progress, let alone closure.

6.11 Overall, we inferred a suggestion that the actions and, in other cases, lack thereof, were deliberate and designed to cause distress to Mr O'Brien. We did not find evidence to support that level of allegation. However, we do appreciate that any formal employment process brings an inevitable anxiety to the parties.

***** END *****

D. The making of the determination by the Case Manager.

17.5 I received the Case Investigator's Report at the end of June 2018.

17.6 In April 2018 I had been appointed as Acting Medical Director, which was an extremely busy job with significant outstanding work due to the previous Medical Director (Dr Richard Wright) having been off Personal information redacted by USI for a period of time before I took up the acting role.

17.7 I had no dedicated / protected time in my Job Plan for this MHPS work from the start of this case in the beginning of January 2017. I already had a busy clinical and management role in Children & young people directorate. However, after my appointment as the acting Medical Director, I became extremely busy with senior management team and the trust board related duties.

17.8 Like many people, I had planned annual leave in July 2018.

17.9 I discussed these challenges with my line manager, the Chief Executive (Mr Shane Devlin) and Director of HR (Mrs Vivienne Toal) and the possibility of replacing my Case Manager role. I also provided the name of a senior Associate Medical Director as a possible replacement. However, such a change wasn't approved by the Oversight Committee.
See my email communication to Mrs Toal, regarding possible replacement of case manager's role. **This can be located at Attachment folder S21 31 of 2022- Attachment 64.**

17.10 Due to the very complex nature of this MHPS investigation (with the very detailed investigation report), it took me a significant amount of time to thoroughly review all of the statements and details of the investigation.

17.11 I then had number of meetings to seek advice from the Chief Executive, Director of HR, and the NCAS Adviser.

17.12 Then I started drafting my report with careful consideration of the options, as per the MHPS framework.

From: Khan, Ahmed
Sent: 07 June 2018 17:16
To: Toal, Vivienne
Subject: Re; MHPS Case

Viv, As discussed recently, have you received any legal advise regarding case manager role for AOB MHPS case with my current responsibilities . I am not comfortable having both roles therefore have discussed with Dr Tariq (AMD cancer care) & he would be happy to take case manager role for this case. I know he was also trained last year with me. What do you think?
Regards,
Ahmed

From: Khan, Ahmed
Sent: 12 June 2018 18:06
To: Toal, Vivienne
Cc: Devlin, Shane
Subject: Re; MHPS Case

Vivienne, I discussed this with Shane today, we agreed that its best if I come out of case manger's role and delegate to someone else. I have spoken to Dr Tariq (AMD for cancer services) & considering delegating this role to him. Talk soon.

Regards,
Ahmed

RESPONSE TO REPORT OF FORMAL INVESTIGATION

I am writing this report in response to the report of formal investigation from Dr Neta Chada. My response is structured in parallel to the Dr Chada's report. In responding to the report, I have considered to set the reasons for the investigation in an historical context. Thereafter, I have commented upon the investigative process and the report itself. Lastly, I respond directly to the five terms of reference.

Historical Context

I graduated in Medicine from the Queen's University of Belfast in 1978. After basic, postgraduate surgical training in Northern Ireland, including a year as Demonstrator in Anatomy, and during which time I had spent some time in every surgical specialty, except for Urology, I applied for a post as a Registrar in Urology at Belfast City Hospital in 1984. During my tenure in that post from August 1984, I became increasingly impressed with Urology as a surgical specialty for a number of reasons: the greater ability to apply objective diagnostic tools to assessment of urinary tract pathology, such as renography and urodynamic studies; the rapidly increasing role of endoscopic and minimally invasive surgery, and most importantly at that time, the varied spectrum of malignancies of the urinary tract. I became increasingly interested in new diagnostic tools in the assessment of bladder carcinoma, such as nuclear image analysis and DNA flow cytometry.

As DNA flow cytometry was unavailable in Northern Ireland at that time, I applied for and was appointed to the post of Registrar in Urology at St. James' Hospital, Dublin in July 1985, followed by a Research Fellowship at the Meath Hospital, Dublin, in 1986. I was appointed a Senior Registrar in 1988, and completed Higher Surgical Training in Urology on 30 June 1991. During that training, I was particularly aware that it pertained exclusively to adult Urology. As a consequence, I applied for and was appointed Senior Registrar in Paediatric Urology at the Royal Hospital for Sick Children in Bristol, taking up that post on 01 September 1991.

In May 1991, I received a phone call from Mr. Ivan Stirling, (now retired) Consultant Vascular Surgeon at Craigavon Area Hospital, to advise that Mr. W. Graham, Consultant Surgeon at Craigavon Area Hospital, was due to retire on 30 June 1991. He was a general surgeon who had developed an interest in urological surgery. Mr. Stirling advised me that there had been some discussion among colleagues as to whether he should be replaced by a general surgeon or by a urologist, and sought my view. I immediately advised that he should be replaced by a general surgeon and by a urologist. Some days later, I was invited to meet with him, his consultant colleagues and with the Chief Executive, Mr. John Templeton, over lunch. It was during that meeting that they appreciated that I had a two month hiatus prior to taking up the post in Bristol. I was asked whether I would spend some time during that two month period as a Locum Consultant at Craigavon Area Hospital, as Mr. Graham had 77 patients on his waiting list for elective admission for prostatic resection (TURP). After a one week break, I came to Craigavon Area Hospital, performing 77 TURPs, and a left ureteric reimplantation for ureteric stenosis, in seven weeks.

On Wednesday 28 August 1991, I was invited once again to meet with the Chief Executive and the remaining three Consultant General Surgeons, Mr. John O'Neill, Mr. Osmond Mulligan and Mr.

Ivan Stirling. I was earnestly requested to remain as a Locum Consultant Urologist with the intent that I would be appointed to a substantive post when approval was granted. However, as I passionately believed in the importance of a period of training in Paediatric Urological Training, I declined. However, the Chief Executive then advised me that obtaining approval would require a long battle, and which he was not prepared to embark upon, without my promise to apply for the post, if successful. I pledged to apply for the post, without fully understanding how it could possibly require such a battle to gain approval.

The only specialist urological service in Northern Ireland at that time was provided by the Department of Urology at Belfast City Hospital, led by five consultant urologists. I did anticipate that there would be strong resistance from that Department to the appointment of a Consultant Urological Surgeon, and indeed there was. I did not anticipate at all that the greater battle would be with the Director of Public Health at the South Health and Social Services Board, and who did not believe that there would be enough work for one consultant, and at a time when Northern Ireland had the least adequate urological services in the 34 EBU countries and in the 42 OECD countries!

In any case, the struggle was successful, the battle was won. I was appointed by competitive interview on 11 June 1992, and took up post 26 years ago, on Monday 06 July 1992. Mr. Graham had indeed been replaced by a urologist and by a general surgeon, Mr. Eamon Mackle, who had taken up post earlier in 1992.

On taking up post, I was provided with four inpatient beds in Ward 2 South, one inpatient operating session per week, one outpatient clinic per week, and the assistance of half a Registrar, Mr. Shamim Khan, who was then embarking upon the third year of a four year work visa in the UK. It was only after some time that I came to appreciate the reason for struggle to gain approval for the appointment in the first place, followed by such minimal provision of capacity on appointment. It was because in the minds of the majority of clinicians and managers, 'Urology' was spelt 'TURP'. However, during that first year, I had introduced ureteroscopic lithotripsy to Northern Ireland, performed the first and only radical prostatectomies in Northern Ireland, and on 15 December 1992, performed the first radical cystectomy and orthotopic bladder replacement in Ireland, and one of the first to be performed on a female in the UK. By 31 March 1993, the end of that first financial year, over 850 referrals had been received.

The first four years were most difficult, until the appointment of a second consultant urologist in 1996. During that four year period, I provided a continuous, 24/7, emergency urological service, except for one week when colleagues at Belfast City Hospital agreed to provide emergency cover while I attended the Annual Meeting of the American Urological Association. I did take off either two or three separate weeks from elective work each year, made possible by the continued assistance of Mr. Shamim Khan, who ensured that elective work continued, while I provided a continuous emergency service. I had also succeeded on obtaining Home Office approval for Mr. Shamim Khan to remain in the UK for one further year, from August 1994 until July 1995, as our Department's first Clinical Research Fellow.

That appointment was a necessity at that time as it had otherwise become impossible for a single consultant urologist to provide an adequate service to meet the increasing urological needs of the population of the then Southern Health and Social Services Board. By then I had secured four

inpatient operating sessions per week, and occupied 20 to 30 inpatient beds in Ward 2 South. We had begun to have outreach clinics in Armagh and Banbridge. We had urodynamic and flexible cystoscopy sessions, while still providing a continuous emergency service. It was also only made possible by the founding of CURE (Craigavon Urological Research and Education) by Mrs. Roberta Brownlee and myself in 1994. That enabled CURE to fund all of the costs of research while the Trust agreed to provide the salary of the Fellow as he provided clinical sessions in addition to undertaking research. Mr. Khan's research enabled him to be appointed a Senior Registrar in Dublin in 1995. He was appointed a Consultant Urological Surgeon at Guy's Hospital, London, in July 1999, was awarded an OBE in 2007, and was appointed Professor of Urology at King's College School of Medicine in 2017. Mrs. Brownlee progressed on several fronts, not least becoming Chair of the Southern Health and Social Care Trust Board in March 2011.

During subsequent years and much hard work, including numerous collections, charity lunches and Gala Dinners with guest speakers, including Lord Eames, Lord Trimble and Sir Kenneth Bloomfield, CURE had raised approximately £250,000, used to fund research by some five trainees, leading to their higher degrees. Our Ward Manager, Mrs. Eileen O'Hagan, since deceased, was a founding member of the British Association of Urological Nursing (BAUN). CURE still jointly sponsors with BAUN its annual keynote lecture given by an eminent international speaker, the Eileen O'Hagan Memorial Lecture. Through its collaboration with the Faculty of Health Sciences of the University of Ulster, CURE promoted the joint appointment of Mr. Jerome Marley as Lecturer Practitioner in Urological Nursing in 1998. Since then, through on site and distance learning, numerous urological nurses from around the world have been able to study academically accredited, urological nursing modules as part of their primary and higher nursing degrees. Mr. Marley was a founding member of the European Association of Urological Nurses in Brussels in 2000. In 2006, we launched the International Journal of Urological Nursing, with Mr. Jerome Marley as its first Editor in Chief. The Journal is the official organ of all national associations of urological nursing throughout the world, apart from the Society of Urological Nurses of America, which has its own Journal. I have to confess that it has been one of my proudest days was when I presented to Mr. John Templeton the first edition of the Journal on his last day as Chief Executive of Craigavon Area Hospital Group Trust.

The second Consultant Urologist, Mr. Wahid Baluch regrettably left his post at Craigavon Area Hospital in 1998, but was replaced by the appointment of Mr. Michael Young, who took up post in May 1998. By then, I had secured the approval of the Trust, with the support of the Southern Health and Social Services Board, for the establishment of first (and still only) on site, extracorporeal shock wave lithotripter (ESWL). During 1997, I had visited a number of leading on site ESWL centres in Belgium and Germany, and concluded that we should have the multipurpose Dornier Lithotripter in a setting adjacent to theatres, with anaesthetic facilities if required, but one also amenable to ambulatory access. With some resistance from other interests, I secured the current location of the Stone Treatment Centre which had been vacated by CSSD. On his appointment, I charged Mr. Young with the task of designing its interior. On his appointment, I had my first holiday with my family, outside of Northern Ireland Personal Information redacted by USI appointment in 1992.

The Urological Department at Craigavon Area Hospital had been remarkably successful in its first decade, and was widely recognised throughout Northern Ireland for being so. However, that success was achieved at the cost of much personal sacrifice for me and for my family, and also particularly for Mrs. Eileen O'Hagan, our Ward Manager, and whose death at the age of Personal Information redacted by USI

in 2001 was, in hindsight, perhaps a harbinger of more difficult times to come. It is often said that everyone can be done without. I would add that not everyone can be done without as well. There is no doubt that the success of our Department led to some envious resentment, the Chief Executive having received complaints and delegations alleging favouritism. I believe that charge led to a long delay in further, desperately needed development of the service. It was after a commissioned, external review of urological services by Professor Sam Mc Clinton of Aberdeen that the Trust could be impressed of the dire need for further, urgent development.
Mr. Mehmood Akhtar was appointed to a third Consultant Urologist post in July 2007, facilitating the introduction of laparoscopic renal surgery. However, in 2008, we were devastated to be advised that we had lost our single inpatient department in Ward 2 South, our patients being dispersed throughout three general surgical wards. Even though our inpatients were later concentrated in one ward, Ward 3 South, it remains my contention that inpatient care has never been of the high standard it had been previously. Then, in September 2010, radical pelvic surgery for bladder and prostatic carcinoma was centralised to Belfast City Hospital. I was strongly opposed to this centralisation, in the belief that patients would suffer and die as a consequence. I submitted a written proposal that radical prostatectomy continue to be performed in both Derry and Belfast, while radical cystectomy would continue to be performed in Craigavon and Belfast. Of course, the proposal was dismissed. Meanwhile, I believe that two patients died of bladder cancer due to their not having radical cystectomies performed when they could have been, and radical prostatectomies have not been performed at all anywhere in Northern Ireland for several years. Moreover, the loss of radical pelvic surgery at Craigavon Area Hospital contributed to the departure of Mr. Akhtar in April 2012.

Mr. Akhtar had established and chaired a weekly Urology MDM in April 2010. On his departure two years later, I was appointed Lead Clinician of the Southern Trust Urology Multidisciplinary Team and Chair of the Urology MDM, in April 2012. Concurrently, my colleague, Mr. Michael Young, and I became increasingly concerned by ever increasingly long, waiting lists for elective admission for surgery, with the consequential risks of death and morbidity for those patients. We therefore embarked upon extended operating days, Mr. Young operating until 7 pm each Tuesday and my operating until 8 pm each Wednesday. After arriving home at 9 pm, and having the meal of the day, I would then typically spend three to four hours previewing the 30 to 50 cases to be discussed at MDM which I chaired the following day, finishing at 02.00 to 03.00 am. After each MDM, all clinical summaries were corrected and amended if required, and all outcomes were reviewed and signed off, with Mrs. Vicky Graham, Cancer Tracker and Coordinator, finishing by 7 pm each Thursday evening. So doing enabled formatted letters to be generated from CaPPS and sent by post to each patient's GP each Friday morning. No time was allocated in job planning for extended operating sessions, or for the previewing or reviewing patients discussed at MDM which I chaired each week.

In late 2012, I was requested by consultant colleagues and by the secretariat of NICaN to consider taking on the role of Lead Clinician of NICaN's Clinical Reference Group in Urology. I agreed to do so, if no one else offered to do so. Regrettably, no one did do so. I was appointed to that post in January 2013. Being Lead Clinician of the Southern Trust's Urology MDT and Chair of its MDM in addition to being Lead Clinician of the Regional Clinical Reference Group was a heavy burden and consumed much time and energy, particularly during the two years leading up to National Peer Review of Urological Cancer Services, both by the Southern Trust and Regionally, in June 2015. I wrote the required Operational Policy for the Southern Trust's Urology MDT, holding monthly

meetings with multidisciplinary colleagues to discuss and seek consensus for its many parts. I commissioned ongoing audits of histopathological diagnosis of prostatic carcinoma. I addressed deficiencies in input by radiology and oncology, which compromised MDM quoracy, and which still does. More successfully, I received a weekly update of those patients who were at risk of breaching cancer target timelines, undertaking to review and/or operate on these patients myself, with the result that not one patient had breached a target timeline during the previous six months by the time the Southern Trust was peer reviewed in June 2015.
It is worthy of note that there were some failures in preparedness for Peer Review. Firstly, I had sought the agreement of my consultant colleagues to advanced triage of red flag referrals to facilitate and expedite their assessment, diagnosis and management with the required timelines. It was not possible to obtain that agreement as my colleagues asserted that there was not enough time, while being urologist of the week, to do so. Similarly, they declined to provide to the Cancer Tracker a clinical summary of each patient to be discussed as is required, insisting instead that they would ask the Tracker to list patients for discussion at MDM, providing a copy of a letter dictated to a GP or other referrer, the Tracker having to compose a clinical summary for CaPPS, and which is contrary to the regulations. Once again, they declined to do so because of time constraints. Lastly, I failed to obtain the agreement of my colleagues to compile a management plan for each patient, a copy to be given to each patient and a copy to be included in the chart. This too has been a requirement of the National Cancer Plan. I do have to agree that this requirement was, and remains, entirely unrealistic, as there was simply not enough time to do so, and certainly not enough time when my colleagues had already asserted that there was not enough time to undertake advanced triage or to provide clinical summaries.

Concurrently, I was responsible for ensuring that Northern Ireland's Regional Urological Cancer Services were prepared for National Peer Review by June 2015. This proved to be a significantly more complex process than preparing the Southern Trust for review. This entailed not only the Operational Policy for Regional MDM, it involved the composition of Clinical Management Guidelines for all aspects of referral pathways, investigations, diagnoses, management and review for all of the urological cancers. It entailed compliance with NICE and EAU Guidelines. It particularly included the identification of aspects of the patient pathways that could not be compliant with NICE or EAU Guidelines, either throughout Northern Ireland as a whole, or in areas within Northern Ireland. It included the commissioning of Operational Policies from Urological Surgeons, Clinical and Medical Oncologists, Pathologists, Radiologists, Clinical Nurse Specialists, Palliative Care Specialists and Nurse Practitioners. I believe that my work over a period of two years led to a successful Peer Review of Northern Ireland's Urological Cancer Services. During that time, I was also requested to join the National Peer Review Panel, being a member of the panel which reviewed the North West Urology MDT in June 2015.

Having completed the three year tenure as Lead Clinician of NICaN's Clinical Reference Group for Urology, I stepped down from that post in January 2016. I remained as Lead Clinician of the Southern Trust's Urology MDT until 31 December 2016, having completed National Peer Review updates in September 2015 and again in September 2016. With some substantial success, I addressed the chronic lack of input by Clinical Oncology to our MDM, and with much less success, the chronic inadequacy of radiological input to MDM, even though I met with the Medical Director for the first time in April 2016 to discuss the concerns of the MDT regarding this particular issue. Both these issues continue to pose an existential threat to the continuation of a Southern Trust Urology MDM.

The burden of the roles of Lead Clinician of the Southern Trust's Urology MDT, Chair of the Southern Trust's Urology MDM, Lead Clinician and Chair of NICaN's Clinical Reference Group in Urology from 2012 to 2016, and preparing both the Southern Trust and the Region for National Peer Review in June 2015 was considerable, particularly in terms of the time and energy required, both of which were additional to continuation of the usual and preceding, clinical commitments.

Since the departure of Mr. Akhtar in April 2012, the compliment of Consultant Urologists at Craigavon Area Hospital had increased to six. However, the operating capacity allocated to the Urological Service had not been correspondingly increased. Irrespective of the number of consultant urologists, and irrespective of operating capacity, the number of referrals continued to increase annually. One obvious consequence was that increased numbers of urologists were unable to provide operative management to increased numbers of patients referred, resulting in increasing numbers of patients waiting for ever longer periods of time for admission for surgery. The cohort of patients who suffered most severely were those acutely admitted in the first place. As there was no consultant staff available to operate on these patients when required, and no theatre capacity to facilitate their surgery, these patients were attended to after elective surgery had terminated, and by staff who had already completed an elective day, and in a manner which only temporised the acute condition, those patients then being discharged to a waiting list for readmission for definitive surgery, and at risk of acute readmission due to acute morbidity as a consequence.

After a long gestation period, the 'Urologist of the Week' was introduced in 2014. I have no doubt in asserting that the reason for the delayed introduction was the belief on the part of one or two of my colleagues that the Trust would not agree to funding its introduction as there would not be enough work to sustain it, and the reason for that belief was the failure to appreciate the distinction between 'Urologist of the Week' and 'Urologist on Call'. The latter would just have required the Consultant Urologist to be available when required and called upon by a Registrar. As a consequence, it was even proposed that we would have time to conduct an afternoon clinic each day when Urologist of the Week. It was as a consequence that it was agreed that we would be able to conduct triage when Urologist of the Week.

Even though I too agreed with the conduct of triage while being Urologist of the Week, I soon came to realise that there simply was not enough time to do so effectively and optimally whilst also delivering optimal, definitive and timely management to those patients who had been acutely admitted. I could not do so in addition to spending three to five hours conducting inpatient ward rounds with the registrar, assessing patients in the Emergency Department, advising regarding the management of acutely admitted patients elsewhere in Craigavon Area Hospital, Daisy Hill and South West Acute Hospitals, in addition to performing zero to six operations each day. It has been my belief and understanding that the primary purpose of Urologist of the Week is to optimally care for those patients acutely admitted to the above three hospitals due to urological pathology. To do this, the Urologist of the Week is required to undertake the duties described above and these are time consuming and it is therefore not possible to accommodate triage in addition to those duties without compromising the standard of care provided as Urologist of the Week, or compromising the standard of triage, or both.

In order for my colleagues to accommodate triage, it has been necessary for them to reduce the work done as Urologist of the week. For example, some do not come in to the hospital at all over the weekend. Some colleagues may not conduct a ward round during a particular day or days, letting the Registrar "get on with it." It has also recently been reported to me and other colleagues that one consultant did not do one ward round during an entire week on call. I have also observed some colleagues undertaking triage whilst the registrar "got on with it" in theatre. It has been the case that patients did not have their definitive operative management following their acute admissions, being discharged by the Urologist of the Week, only to be readmitted at a later date, suffering complication as a consequence. In outlining the above examples, it is not my intention to be critical of my colleagues but rather I am setting these out to explain that the demands of triage and the demands of the Urologist of the Week are not compatible and it has been my experience that having triage included in the workload of Urologist of the Week has compromised patient management and was therefore unsafe.

It is stated in the investigation report that I had argued for advanced triage to be employed as the method of triage by the department. It is important to point out that the reason why I believe this to be necessary is because the waiting times for first appointment for routine and urgent referrals are so lengthy that to allow that time to elapse without having directed some further investigations can lead to a compromised outcome. An example best illustrates the issue. Pers onal is a Personal Information redacted by the USI man who was routinely referred in December 2017 with symptoms indicative of bladder outlet obstruction. He did not have any Red Flag symptoms such as haematuria. He had normal renal function and a normal serum PSA level. Urinary microscopy and culture were both normal. I triaged that referral and concluded that it should remain categorised as Routine. However, in addition, I wrote to the patient to advise that I would request an ultrasound scan of his urinary tract. I also wrote to the GP requesting that he prescribe Tamsulosin for the patient. When ultrasound scanning was performed at Daisy Hill Hospital in January 2018, it did indeed confirm that the patient had an enlarged prostate gland probably causative of of bladder outlet obstruction. However, it also indicated that he probably had a bladder tumour. That impression was then further assessed and confirmed by flexible cystoscopy. The patient has since had multifocal, high grade, transitional cell carcinoma with carcinoma in situ resected. He is currently undergoing intravesical BCG therapy.

If I had not taken the time to request ultrasound scanning, writing to the GP and the patient in the process, and acting upon the report, this man may not have received an appointment until 2019. I have absolutely no doubt that only one of my colleagues may have requested a scan. The probability would have been that he would have still been awaiting a routine appointment. However, it probably would have taken me a minimum of 15 minutes to review his details on NIECR, request the scan and write to both GP and patient. We currently receive approximately 160 referrals per week. Even if triage time per patient were a mean of half the time spent on the referral of Perso nal, that represents 20 hours of work while Urologist of the Week. Yet, to date, there has been no predictable sessional PA time allocated to triage in any of our Job Plans. Moreover, in my comments relating to the SAI report concerning Patien t 10, in January 2017, I requested the Trust to address the issue of triage, determining who, when and in what manner it should be done. To date, there has been no response.

The year of 2016 proved to be difficult for several reasons. I had become increasing concerned by the morbidity, and risk of mortality, suffered by patients awaiting admission for surgery. I had

shared my concerns with colleagues and with the Head of Service on many occasions, at Departmental meetings during that year, as I had done during many years previously. I was so often advised that the waiting lists were a Trust issue, if only! It had been my experience that the Trust was either unaware of the waiting lists or times, and of the disparity between specialties, or were aware, but it was not an issue. For several years, I had not taken any leave for any reason on an operating day, or on any day when operating sessions were made available to me, when my colleagues did take leave. I continued with this practice during 2016 in an endeavour to mitigate so far as was possible the risk of harm to patients. I did so even though I was suffering increasingly from painful, Personal information redacted by the USI In addition, I had undertaken to defer Personal informati for as long as possible to enable me to provide backup support to Mr. Suresh, for whom we had been requested to provide such support when he was Urologist of the Week, and which some of my colleagues had declined to do. It was when Mr. Suresh confirmed to me that he was returning to a Consultant post in England in October 2016 that I decided that I should undergo Personal informa on 17 November 2016. Surgery went very well with the expected outcome until symptomatic deterioration one month later, due to urinary infection. Readmission for cystoscopy had been scheduled for 28 December 2016. However, I was able to cancel that appointment as symptoms had improved on antibiotic therapy.

The Investigation

I received a telephone call from the Medical Director's office, also on Wednesday 28 December 2016, to advise that the Medical Director wished to meet with me the following Tuesday, 03 January 2017 at 11.00 am. I advised that I would be unable to do so as I had a Day Surgical operating list that morning. However, I advised that I was happy to speak with him by telephone before then. I then was advised that the Medical Director was of the view that he required to meet with me in person, and offered to do so on Friday 30 December 2018. I enquired whether he was aware that I was on sick leave. I was advised that he did. I telephoned later to request an agenda, which was provided by email. Otherwise, I would have attended, unaccompanied, Personal Information redacted by the USI, while on sick leave.

The meeting was both shocking and devastating for both me and for my wife who accompanied me. It initiated the worst month in my life with serious consequences for my health. It initiated a period of trauma which still persists. Inter alia, I was advised of my immediate exclusion in accordance with the Southern Trust Guidelines for handling Concerns about Doctors and Dentists' Performance (September 2010) and Maintaining High Professional Standards in the Modern HPSS (November 2005). The exclusion was subsequently confirmed by the Medical Director in writing on 06 January 2017, when it was also confirmed that Dr. Khan had been appointed Case Manager, and Mr. Weir had been appointed Case Investigator. I was not advised of the appointment of a non - Executive member.

Cognisant of the stipulation in the Southern Trust Guidelines that the Investigation had to be completed within four weeks of the date of exclusion, and not having received any communication from the Case Investigator, I contacted Mr. Weir by telephone on 16 January 2017, when he advised me that he was equally cognisant of the significance of the four week period, but was alarmed to be advised by him that a meeting had been scheduled for him to meet with the HR Representative, appointed to assist him in the Investigation, on Thursday 26 January 2017, the

penultimate day of the four week period, and that no meeting with me was scheduled to take place until after that date.
On 17 January 2017, I wrote to the Medical Director to express my concerns regarding the conduct of the Investigation to date. I requested to be advised of the identity of the non – Executive member. I requested Minutes of the Meeting of the 30 December 2016. I requested to be advised of details of when I would meet with the Case Investigator. Lastly, I requested to be advised in more detail of the reasons and justifications for the immediate exclusion imposed on 30 December 2016, so that I could prepare to offer alternatives to exclusion when I would meet with the Case Investigator. (Appendix 1: Letter of 17 January 2017).

I received a Note of the Meeting of 30 December 2016 from and approved by the Medical Director, dated 18 January 2017.

I then received a telephone call from Mr. Weir on 19 January 2017 to advise that a meeting had been scheduled for Tuesday 24 January 2017 to discuss alternatives to immediate exclusion. I did not receive any detailed reasons or justifications for immediate exclusion from the Medical Director prior to the meeting. I returned a telephone call on 19 January 2017 to clarify whether the meeting of Tuesday 24 January 2017 required me to state my case. I was assured by Mr. Weir that it was not. I subsequently received a letter from Mr. Weir, dated 20 January 2016 (sic), advising of the time and venue of the meeting of Tuesday 24 January 2017, advising that he meeting would provide me with an opportunity to state my case and to propose alternatives to exclusion.

I then received a letter from Mr. Weir, dated 23 January 2017, requesting my knowledge of the hospital charts of 13 patients and which had been tracked out to me, and which had not been included in the charts that had been returned from my home. I provided a detailed account of each patient, including those who had never been a patient of the hospital at any time, or had never been a urological patient, or had been discharged from urological review 15 to 20 years previously. One patient whose chart was tracked out to me and whose chart was missing, I operated on six months later, in July 2017, her chart made available for her admission by Medical Records in the usual fashion.

I met with Mr. Weir and with Ms. Hynds, the HR Representative, accompanied by my son, Personal Information, on 24 January 2017. In addition to the three issues of concern already identified, I was advised of a fourth arising from a review of TURP patients, identifying nine patients who had been seen privately as outpatients, then had their procedure within the NHS, their waiting times being significantly less than for other patients.

The Oversight Group met on Thursday 26 January 2017, concluding that immediate exclusion be lifted with effect from Friday 27 January 2017, subject to advice from Occupational Health regarding fitness to return to work, and to agreed conditions relating to work practices. I was advised of that decision by Dr. Khan, by telephone, later that day. I received written confirmation of that decision, dated 06 February 2017. The conditions relating to my return to work were detailed at a further meeting with Dr. Khan and Ms. Hynds on Thursday 09 February 2017, and I returned to work in a phased manner later that month, as advised by Occupational Health.

On 06 February 2017, I received by email from Ms. Hynds, the Note of the Meeting of 24 January 2017 with Mr. Weir.

On 07 February 2018, I met with Mr. Wilkinson, non – Executive Director, to raise a number of Concerns Regarding the Investigation Process, (Appendix 2). The Case manager replied to those concerns by letter on 24 February 2017, (Appendix 3).

On 14 February 2017, I wrote to the Medical Director, detailing a number of errors and omissions in the Note of the Meeting of 30 December 2016, requesting that amendments be made, (Appendix 4).

On 01 March 2017, I received from Ms. Hynds an acknowledgement of the letter to the Medical Director, advising that she would arrange for an amended Note to be sent to me, taking into consideration my comments.

On 06 March 2017, a list of Questions to be Asked were provided to Mr. Wilkinson, non – Executive Director (Appendix 5).

On 16 March 2017, I was provided with the List of Witnesses to date (seven persons) and the Terms of Reference. The Terms of Reference should have been provided when it was decided to have a Formal Investigation, in accordance with NCAS Guidelines.

On 28 March 2017, I submitted to Ms. Hynds a list of Amendments to be made to the Note of the Meeting of 24 January 2017, requesting that she return a copy of the amended Note.
I received no response.

On 30 March 2017, the Medical Director replied to the Questions to be Asked, and which had been submitted on 06 March 2017 (Appendix 6). In response to Question 13, the Medical Director asserted that an initial verification of the issues by the Clinical Manager was not required, as the information was being collated by Mr. Carroll and Mrs. Hogan (sic).

On 19 April 2017, I sent to Ms. Hynds an email to remind her that I still awaited an amended Note of the Meeting of 30 December 2016.
I received no response.

On 14 June 2017, I received a letter from Dr. Chada, the Case Investigator, inviting me to meet with her on Wednesday 28 June 2017. Due to my having scheduled operating that day, and my son's unavailability to accompany me, I made myself available on Saturday 01 July 2017. However, that date did not suit Dr. Chada, and the meeting was eventually rescheduled for 03 August 2017 to avoid cancellation of scheduled clinical commitments and to facilitate Dr. Chada's leave, as outlined in email correspondence (Appendix 7).

On 29 July 2017, I was provided with a list of 61 outpatient clinics which the Case Investigator had been advised had not been dictated (Appendix 8).

On 30 July 2017, I wrote to D. Khan, Case Manager, detailing my concerns regarding the Investigation to date (Appendix 9).
I did not receive a response.

On 31 July 2018, I submitted to Ms. Hynds, by email, a request for a copy of the minutes of the meeting of the Oversight Group in December 2016, a copy of the correspondence / 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) and a list of the Witnesses and their Statements (Appendix 10).
I did not receive a response until 28 September 2017 when I was provided with a list of Witnesses and their Statements. I was not provided with any of the other requested documentation.

On 03 August 2017, I met with Dr. Chada and Ms. Hynds, accompanied by my son, who wished to advise that we would have considered it reasonable to expect that the Witness Statements would have been provided prior to the Meeting, to enable me to address and respond to them, but he was advised initially that he was not permitted to speak.

On 03 August 2017, I also submitted to Dr. Chada and Ms. Hynds, detailed documentation of all additional inpatient and day case operating during the years 2012 to 2016, and all additional outpatient clinics during 2012 to 2016, in addition to all additional time spent in the roles of Lead Clinician of Urology MDT and of Chair of Urology MDM from 2012 to 2016, (Appendix 11).
None of this documentation has been included in the Report of the Investigation.

At the meeting of 03 August 2017, I was provided with a list of 11 patients who had attended privately, had been added to the waiting list and had been admitted after a short time frame. I was surprised to find that another two TURP patients had been added to the list, as I was certain that only nine patients had been admitted for TURP during 2016, having previously attended privately. Upon review, it was evident that the new list provided on 03 August 2017 contained only three patients who had TURP performed during 2016, the remaining eight patients having other diagnostic or surgical procedures performed. I then reviewed all 46 patients who had TURP performed during 2016. This figure included the 9 patients who had previously attended privately and 37 who had not. The mean time on waiting list for the nine patients who had attended privately was 202 days whilst the mean time for the remaining 37 patients was 219 days. In fact, 5 (56%) of those who attended privately had waited more than 100 days while 14 (38%) of the remaining 37 patients had done so.

On 06 November 2017, I met for the second time with Dr. Chada and with Ms. Hynds to discuss the issue of the private patients. I submitted a detailed account of the management of each of the eleven patients. I also shared my conviction that an analysis of all the TURP patients of 2016 had not complied with the anecdotal allegation that those who had attended privately, had had their surgery performed after a significantly shorter period of time, and that this finding had laid those compiling the information for the Case Investigator to find patients who had had other procedures performed following prior private consultation, and who better fitted the allegation. Regrettably, I

have not since had the opportunity to undertake a similar comparative analysis for those patients and their procedures.

On 06 November 2017, I also provided a spreadsheet addressing the issue of Term of Reference 3, (Appendix 12). This clearly established that not all of the patients who had attended 51 clinics had not letters dictated, and not 61 clinics as the Case investigator had been advised by those collating the information. The total number of patients who had attended those 51 clinics had been 450 patients. Moreover, 261 patients had had letters dictated. These 261 patients were those who were more clinically urgent. This left a total of 189 patients who had not had letters dictated, and not 668 as had been advised by those who had informed the Case Investigator, and whose data the Medical Director found no need to validate. This detailed information submitted on 06 November 2017 was not included in the Report of the Investigation.

On 02 April 2018, I submitted an email to Ms. Hynds, attaching my comments concerning the proposed Respondent Statements of 03 August 2017 and of 06 November 2017, and my comments relating to the Statements of Witnesses, (Appendix 13). It was the earliest date that I could do so. Mindful that I had been advised that Dr. Chada had intended to begin writing the Report on 30 March 2018. I also reminded her that I still awaited amended Notes of the Meetings of 30 December 2016 and of 24 January 2018. I particularly requested that she would clarify whether it was intended to provide amended Notes, and if so, when I might expect to receive them.
I did not receive an acknowledgement or a response.

On 10 June 2018, I sent an email to Ms. Hynds, requesting an update on progress of the Investigation, and responses to the requests submitted previously, (Appendix 14). Having received her response, I determined that I would not enter into further communication. I was also most concerned to find that my comments relating to Witness Statements and to proposed Respondent Statements, submitted on 02 April 2018, may not have been duly considered in the Report which was not submitted to the Case Manager until 12 June 2018.

Investigation Report

The first comment regarding the Investigation Report is that it is entitled 'Investigation Report under the Maintaining High Professional Standards Framework'. There has been no reference whatsoever to the Southern Trust's Policy and Procedure for Handling Concerns about Doctors' and Dentists' Performance (September 2010). I have submitted my views previously concerning this issue. The Southern Trust's Policy and Procedure was obliged of it in response to the Maintaining High Professional Standards Framework. It is the Term and Condition of Employment.

In Section 1, the report states that 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. I believe that this is, by definition, and crucially, incorrect, and not just a matter of semantics. The model is a 'Consultant of the Week'. As I have already described, I believe the presence or absence of 'on-call' in the perceptions of participants has been critical to the feasibility of triage.

In Section 4, it is stated that Mr. Mackle and Mrs. Trouton met with Mr. O'Brien on 23 March 2016. This is incorrect, as it were Mr. Mackle and Mrs. Martina Corrigan who met with Mr. O'Brien. More importantly, it is stated that Mr. O'Brien was provided with a letter detailing concerns, and asking him to respond with an immediate plan to address the concerns. This is absolutely untrue. As stated previously, Mr. O'Brien asked what he was to do in response, the answer to which was a shrugged silence.

In Section 4, referring to the period April to October 2016, the Report states that considerations were ongoing about how best to manage the concerns raised with Mr. O'Brien and it was determined that formal action would not be considered as it was anticipated that the concerns could be resolved informally. In addition to failing to identify those who had done the consideration and determination, the Report does not include the allegation in a Witness Statement that those who were prepared to help in a supportive manner, had been instructed not to do so.

In Section 4, referring to the Meeting of 30 December 2018, the report states that Mr. O'Brien was placed on a 4 week immediate exclusion 'in line with the MHPS Framework to allow for further preliminary enquiries to be undertaken. This is of course incorrect as the instrument for doing so was the Southern Trust's Policy and Procedure for Handling Concerns about Doctors' and Dentists' Performance.

In Section 4, referring to 03 January 2017, it states that Mr. O'Brien met with Mrs. Martina Corrigan to return all case notes and all undicated outcomes. Mr. O'Brien had in fact returned all case notes on 02 January 2017 and met with Mrs. Corrigan on 09 January 2017 to return clinic outcomes.

In Section 6, the Report states that a large number of un-triaged referrals were subsequently located in an office drawer in Mr. O'Brien's office, by Mrs. Corrigan. In his review of those un-triaged referrals later upgrade to Red Flag status, Dr. Julian Johnston had been advised that the large number had been discovered there by Mrs. Corrigan. In fact, Mr. O'Brien had advised Mrs. Corrigan of their exact location.

In Section 6, Page 19, the Report listed eight patients to exemplify patients who had attended as outpatients without letters having been dictated:

1. Personal Information redacted by the USI: Patient seen 6 times and no letters on file for any attendances.

   Personal was a Personal Information redacted by the USI girl when she attended for the first time on 18 August 2015. I provided a hand written letter that day to the GP, detailing the diagnosed and prescribing Cephalexin, Oxybutynin and Desmopressin. I reviewed her on 18 January 2016 when I again provided a hand written letter to the GP requesting increases of dosage in her medication and advising of intended review. I reviewed her on 14 March 2016 when I dictated a letter to the GP advising of her arranged admission on 06 April 2016 for hydrostatic dilatation of her bladder. I did not provide a letter following her review in July 2016 but did do so following her virtual review on 16 October 2017. A letter was dictated following her last review on 20 November 2017, (Appendix 15).

Personal had three outpatient consultations for which no individual letters had been dictated, and two of which hand written letters had been provided to the GP.

2. Personal Information redacted by the USI: Letter done when patient was a private patient, no other letters on file.

   Personal was admitted for flexible cystoscopy and bladder biopsy on 04 September 2015. Discharge letter is on file. I subsequently advised the GP and the patient of the benign nature of the biopsy.

3. Personal Information redacted by the USI: Patient seen 14 times but no letters on file – not on a review list

   Personal is deceased. Last episode in 1998. No record of patient having been a urological patient.

4. Personal Information redacted by the USI: Patient seen on 19 September 2016, letter dictated on 28 February 2017.

   As above

5. Personal Information redacted by the USI: Patient attended on 19 June 2016 but note in chart says DNA (discharge to GP), this has not been done.

   Personal did not attend on 19 September 2016 and no further appointments were arranged for him

6. Personal Information redacted by the USI: Patient seen 11 April 2016, letter dictated on 22 February 2017

   As above.

7. Personal Information redacted by the USI: No urological entries in Chart or on PAS

   Has never been a urological patient

8. Personal Information redacted by the USI: No urology entries in Chart or on PAS

   Has never been a urological patient

In Section 8, page 31, the Report states that Mr. o'Brien's preference was that advanced triage should be done for red flag referrals only. This is untrue. As stated previously, I believe that it is even more important that advanced triage be conducted for urgent and routine referrals, if possible, in view of the waiting times for first appointments.

In Section 8, page 32, the Report states that Mr. Mackle reported that Mr. O'Brien had previously raised a complaint of bullying against Mr. Mackle in or around 2012. This is completely unture. Instead, I submitted a formal written grievance against Mr. Mackle when I discovered that he had

unilaterally advised Payroll to halve agreed, remunerative payments for additional clinical work. The grievance was upheld. I suspended further action as his [redacted]

In Section 8, page 36, the Report states that Mr. O'Brien acknowledged that there were 66 undictated clinic and no dictated outcomes for these. This is untrue. As stated above, the number of clinic incompletely dictated was 51, and the number of patients affected was 189. Even though this information had been submitted to the Case Investigator on 06 November 2017, the Report still includes the wrong information, and claims that I had agreed with it.

In Section 9, Page 45, the Report states that Mr. O'Brien has worked rigidly to the action plan out in place and has met all of requirements of the action plan on an on-going basis. However, this has been at considerable cost. IAs I have continued to find it impossible to complete triage while Urologist of the Week, I have had to take an Annual Leave Day on the Friday following completion of the Week to enable me to complete the week's triage. That has also resulted in a reduction in the number of cancer review clinics, normally conducted on Fridays.

Lastly, The Report states that Mr. O'Brien displayed some lack of insight and reflection into the potential seriousness of the above issues. This I would completely dispute this contention. I believe that this impression has been gained due to my disbelief at the lack of insight on the part of the Trust into the harm and risk of harm suffered by patients already on the longest waiting list. It has also been disappointing to read the Report, after 18 months of investigation, concluding that I did not agree with triage anyway.

Terms of Reference

1. Triage

I do accept that I was not undertaking triage of non-red-flag referrals. I have been clear since the outset of this investigation that I was not doing so because I found it impossible to do so. The background to that is explained above in detail.

I agree that triage is a vitally important process to ensure that patent management is initiated effectively and to ensure that patients are correctly categorised. It is my belief that some time with triage is necessary if the Consultant Urologist is to bring the value of his/her specialist expertise to the process and this means that triage becomes time consuming. I believe that it would be beneficial for the department to allocate sufficient time for the Consultants to complete triage effectively. I have raised this issue as part of my response to the SAI and I hope that the Trust will address the issue as soon as possible.

The investigation report states that the issue of concern relates to the fact that I failed to properly highlight to the Trust that I was not undertaking this aspect of the role. I accept that there are steps that I could have taken to more clearly state that I was not undertaking triage of routine or urgent referrals. I regret not having done so. That said, it is relevant to point out that senior management were aware of the fact that I was not completing Triage of non-red-flag referrals. This is demonstrated by the fact that everyone acknowledges that I repeatedly raised the fact that I found it impossible to complete triage, that they knew that triage was not being done and in fact a process was introduced to deal with the fact that it was not being done through the

implementation of the default system. I can quite honestly state that I believed that management knew that I was not completing triage.

The final point I wish to make about triage relates to the fact that I am completing triage since my return to work in February 2017. It is important that I point out that, in order to comply with management plan by returning triage within three days of urologist of the week, I have been taking a day off on annual leave following my week on call in order to use that Friday and the following weekend to complete triage. Therefore, whilst I am completing triage and I will continue to do so, it comes at a significant personal cost.

2. Patient Notes stored at Home

I accept that I had significant number of charts at my home. This was well known to the Trust. At the time of my meeting on the 30th December 2016, I had 288 sets of patients' notes at home which dated back to April 2015. 99 of these charts were for private patients. I accept that this could be considered not to be best practise. I have assured the trust that I have discontinued this practice and that I will not do this in the future.

3. Undictated Outcomes

I accept that it was sub-optimal practice to not have dictated letters on outpatient consultations in a timely manner. In particular, I recognize that this is important so that GP will be aware of the management plan.

I had endeavoured to ensure that the clinically urgent patients were dictated upon and had succeeded in doing so in the majority of cases. As stated above, the number of undictated outcomes was 189, markedly less than the 688 which was been informed to the case investigator. I had provided the documentation that sets this out. I am unaware of harm or risk of harm of any of the 189 patients who had not had letters dictated.

4. Private Patients

Initially, it was alleged that 9 TURP patients, who had previously attended privately, had had their operations after a significantly shorter period of time than the remaining TURP patients who had not attended privately. I have provided a thorough comparative analysis of TURP patients during 2016 which conclusively demonstrates that this was not the case. I have also provided a detailed explanation of the subsequent list of 11 patients who had attended privately. There has been no comparative analysis done as part of this investigation that indicates that there has been any preferential treatment to patients who have seen me privately. I have not given any preferential treatment to any patient because they have seen me privately.

5. The Role of Management

It is my belief that Management knew of the problems that I was having with these administrative practices for all of the reasons that are detailed above. Management did not take the opportunities to assist me and it is apparent from the witness statements that when some members of management indicated that they would wish to address these issues with me

informally, they were instructed not to do so. Additionally, when the issues were raised in the meeting of March 2016, I asked for some guidance on what I could do and I received no assistance. I believe that after 25 years of employment by the Trust and contribution that I have made to the development of urological services as described in the historical context section of this response, I would have considered it reasonable to expect that the Trust would have made efforts to deal with the concerns in a collegiate and supportive manner.

This did not happen.

Personal Information redacted by USI

[redacted]

Aidan O'Brien
10th July 2018

g. I then wrote a Letter to Mr O'Brien, informing him that the investigation had now concluded and I had received the Case Investigator's report. I also shared this report with Mr O'Brien and requested his comments regarding factual. **Evidence – Case manager's letter to Mr O'Brien – June 2018. This can be located at Attachment folder S21 31 of 2022- Attachment 13.**

During July & August 2018:

h. I was on planned Annual leave during July 2018.

i. Mr O'Brien's comments received in July & I sent him acknowledgement receipt of his comments to the Investigation report. **(Evidence: Letter from Case Manager to Mr O'Brien- 14 August 2018). This can be located at Attachment folder S21 31 of 2022- Attachment 14.**

During September 2018:

j. During August and September 2018, I deliberated on the Investigation report and the associated documents provided to me by the Case Investigator as part of the report.

k. I had discussions with the Chief Executive (Mr Shane Devlin) and the Director of Human Resources (Mrs Toal) regarding the report. I shared the Case Investigator's report with them. I informed them that factual accuracy has been considered by providing a chance to Mr O'Brien to comment on it. I also informed them that there are evidences to support all of the allegations with regards to Mr O'Brien.

l. I sought their advices. I do not exactly remember the details of our conversation however to best of my recollection they suggested that I should base my report and recommendations as per the evidence presented to me and in accordance with the MHPS framework and Trust Guidelines. I naturally followed this advice as it was consistent with my own approach in any event.

m. I also sought advice from Ms Grainne Lynn, Adviser with Practitioner Performance Advice (formally NCAS) **(Evidence: LETO+180921+Advice+letter+18665). This can be located at Attachment folder S21 31 of 2022- Attachment 15.**

n. Then I started to draft my Case Manager's Determination Report **(Evidence: 26/9/18- My email for meeting with CE & HR director). This can be located at Attachment folder S21 31 of 2022- Attachment 16.**

unlikely that in these circumstances the concerns about Dr. 18665 could be managed without formal action.

We also discussed while itself the issues did have clinical consequences for patients, as some of the concerns appear to be due to failure to follow policies and protocols and possibly also a breach of data protection law, these might be considered to be of conduct rather than capability". 15:15

Is this you advising Dr. Khan that these issues are appropriately regarded as matters of conduct as opposed to capability?

A. I thought so, yes.

471 Q. Could I just ask you to expand on your thinking there? I'll give you a bit of context in that subsequently a grievance is lodged with the Trust on the basis that the Trust have miscategorised this as a conduct issue, and that's from Mr. O'Brien. 15:15

Can you outline to me your thinking about why this was a conduct as opposed to what's termed there, as a capability issue? 15:16

A. Well, conduct is behaviour and capability is about can you do the job. I mean, I think the issues with Dr. O'Brien were a failure to follow processes, the processes the Trust had put in place. And they had clinical consequences for patients but it was because of his behaviour and conduct. You know, if a surgeon, 15:16

whilst I did not know what was happening at the Trust I concluded that they were not seeking advice from us and presumed that they were continuing with the MHPS process.

17. The next contact was from a new Medical Director, Dr Khan who emailed the Advice Service on 17 September 2018 asking for an immediate meeting or call. I was able to offer a call on 20 September.

18. A summary of my discussions with Dr Khan on 20 September 2018 appears in my advice letter dated 21 September 2018 which I now produce as **GL2**. We reopened our case and I recorded that the Trust investigation had been very delayed due to complexity and extent. I noted that since February 2017 the doctor had been working to an agreed action plan with on-going monitoring, so that any risks to patients had been identified and addressed. I did not see a copy of the action plan.

19. As Dr Khan explained that Dr O'Brien was seeing private patients at his home and did not have a private sector employer, I suggested that he should be asked to agree not to undertake any work in that area of practice and noted that he should not currently be working privately. I noted that Dr Khan intended to proceed with the case as a conduct matter under MHPS rather than one of capability. Dr Khan confirmed that the local GMC ELA (Employee Liaison Associate) was aware of the issues and I suggested that she should be updated.

20. I explained that Practitioner Performance Advice could offer support via the Professional Support and Remediation (PSR) team by drafting a robust action plan with input both from the practitioner and the Trust and subsequently I arranged for the forms to formally request PSR support to be sent to Dr Khan. This is a free service we can offer to assist Trusts. The forms were never returned.

21. The next contact was when Dr O'Brien himself contacted the Advice Service to express concerns about communications between the Trust and the Advice Service. I arranged to speak to Dr O'Brien on 4 October 2018 and then we spoke at greater length on 11 October 2018.

22. A summary of my discussions with Dr O'Brien on 04 and 11 October 2018 appear in my letter dated 17 October 2018 which I now produce as **GL3**. Dr O'Brien was worried that Trust had wrongly suggested he had been supported to address concerns, whilst his account was that whilst he was told about the concerns, he did

not receive any support or assistance in managing the difficulties (which he attributed to serious workload issues). He was concerned that he had not seen any correspondence with NCAS/The Advice Service prior to recent letters with Dr Khan.

23. On 18 October 2018, having sought Dr O Brien's consent, I let Dr Khan know I had been speaking to Dr O'Brien.

24. On 30 October Dr O'Brien called again (together with his son, Personal Information redacted by the USI) to discuss copy correspondence he had received between our service and the Trust. A summary of my discussions with Dr O'Brien on 30 October 2018 appear in my letter dated 31 October 2018 which I now produce as **GL4**. Dr O'Brien's letter in response, dated 1 November 2019 is produced as **GL5.** He shared his concerns about meetings of the Trust's Oversight Committee in 2016 and the scope of the more recent review.

25. On 31 October 2018 I was able to speak to Dr Khan and he subsequently emailed on 5 November 2018 (**GL6**) when we agreed a meeting with our involvement was unlikely to achieve anything further. A summary of our exchanges appears in my letter dated 6 November 2018 which I now produce as **GL7**.

26. I replied to Dr O'Brien on 9 November 2018 in a letter which I now produce as **GL8**.

27. I next followed up with the Trust with an email to Dr Khan on 2 January 2019 in which asked "I am just checking if this case has come to a conclusion and if so whether you are happy for Practitioner Performance Advice (formerly NCAS) to close its file on it." Dr Khan replied to explain that there was a now a formal grievance issue which had to be dealt with first. There was also a new Medical Director Maria O'Kane

28. I emailed Dr Khan again in February 2019 and he told me that they were still addressing the formal grievance. In June 2019 I emailed Dr Khan and Dr O' Kane, the new Medical Director, to ascertain whether the grievance had been brought to a conclusion and what had happened with regards to the conduct hearing. On 10 June 2019, I received a reply from Dr Khan setting out that the hearing was on hold pending the outcome of Dr O' Brien's grievance. In September 2019 I emailed Dr Khan and Dr O' Kane again for an update, and when I did not receive a reply our file was closed in February 2020. In the meantime Dr O' Brien had contacted us to check if there had been further correspondence with the Trust.

So, the report is submitted to you. It says:

"The Case Manager must give the practitioner the opportunity to comment, in writing, on the factual content of the report produced by the case investigator. Comments in writing from the practitioner, including any mitigation must normally be submitted to the Case Manager within 10 working days of the date of receipt". 12:16

Then it says: 12:17

"The report [that is the investigation report] should give the Case Manager sufficient information to make a decision on whether...", and then there's a list of options. 12:17

Now, can I try to gain an understanding of your thinking at this point? The role of Case Manager at this stage is what? Is it to read the investigation report in the light of the clinician's comments around fact finding and to reach a conclusion taking the two documents into account? 12:17

A. I suppose my understanding was the role of Case Manager at that point in time was not necessarily just looking at the investigation report which was provided by the Case Investigation Team but looking in the statements, all the appendices which were the statements from various witnesses statements, the case investigator 12:17

report, getting the factual accuracy statement by the doctor, in this case Mr. O'Brien, but also to discuss all that investigations with the relevant professionals. In my case I shared the investigation report with the Chief Executive, also with the Director of HR, and then I had a lengthy discussion with Mrs. Grainne Lynn from NCAS. So, my determination was coming from all that elements into coming together, and then I also consulted the GMC's Good Medical Practice and the MHPS Framework which gives me what options are available as a Case Manager. So, I had took all those elements in line together in order to compile my report. 12:18 12:18

66 Q. Can you remember whether you read the report and the appendices before you considered Mr. O'Brien's submission on fact finding? 12:19

A. I think I read the reports at the same time as I read Mr. O'Brien's statement. So it was around the same time I read both of those, and the statements as well.

67 Q. Yes. We can see, if we turn to AOB-01879, it's your core 878 - this is Mr. O'Brien's response to the formal investigation. Did you recognise this at the time, Dr. Khan, as falling within that part of the process that I've just read out as being a response to issues of fact finding? 12:19 12:20

A. So I received Mr. O'Brien's statement, which I read as the part of the investigation. And it was a detailed account of his involvement and understanding during previous years. Yes, I did.

68 Q. But this document here, as distinct from the statements he gave to Dr. Chada, did you realise that this document here was his challenge, if you like, or his analysis of the fact finding contained in Dr. Chada's report? 12:21

A. Yes, I appreciated the number of challenges or number of points he raised in that statement in relation to the report and also in relation to the historical context of his involvement during previous years. Yes.

69 Q. And I want to explore with you the extent to which you took into account the points that he was raising. Could I ask you that as a general question first off. He raises a number of points in this document. What was your approach to that? Where you saw, for example - and I'll give you some examples - were you saw that he was taking a different view of the facts to Dr. Chada, what did you see as being your responsibility or your methodology to try to bridge that gap, if there was a gap? 12:21 12:22

A. So, there were a number of variation or differences in both statements. I obviously shared the investigation report with the Chief Executive and the Director of HR and I was advised to take the evidence as provided by the Investigation Team, because they have gone through the whole investigation. I did appreciate it at that point in time Mr. O'Brien was making comments on various elements of the investigation. For instance, he was making comment about the dictations or the undictated clinic numbers and so on. So I took 12:22 12:22

(b) It was found that there was the potential for 783 patients to have been added to the incorrect waiting list. A look back exercise of all referrals by other Consultant Urologists determined that of the 783 un-triaged referrals, 24 would have been upgraded to red-flag status, meaning the timescales for assessment and implementation of their treatment plans was delayed. All un-triaged referrals were added to Trust waiting lists based on the GP referral assessment.

(c) It was found that all other Consultant Urologists undertook triage of all referrals in line with established practice.

(d) It was found that of the 24 upgraded patient referrals, 5 patients have a confirmed cancer diagnosis. All 5 patients have been significantly delayed commencing appropriate treatment plans.

2. (a) It was found that in January 2017 Mr O'Brien returned 307 sets of patient notes which had been stored at his home. Mr O'Brien accepts that there were in excess of 260 patient notes returned from his home in January 2017.

   (b) The notes dated as far back as November 2014. It was found that Mr O'Brien returned patient notes as requested and he asserts therefore there was no impact on patient care.

   (c) It was found that there are 13 sets of patient notes missing. The Case Investigator was satisfied these notes were not lost by Mr O'Brien.

3. (a) It was found that there were 66 undictated clinics by Mr O'Brien during the period 2015 and 2016. Mr O'Brien's accepts this.

   (b) It was accepted by Mr O'Brien that he did not dictate at the end of every care contact but rather dictated at the end of the full care episode. This is not the practice of any other Consultant Urologist. The requirements of the GMC is that all notes / dictation are contemporaneous.

   (c) There are significant waiting list times for routine Urology patients. It is therefore unclear as to the impact of delay in dictation as the patients would have had a significant wait for treatment. The delay however meant that the actual waiting lists were not accurate and the look back exercise to ensure all patients had a clear management plan in place was done at significant additional cost and time to the Trust.

6. It has been found that Mr O'Brien scheduled 9 of his private patient's sooner and outside of clinical priority in 2015 and 2016.

75 Q. Did you think it your obligation to go back to Dr. Chada and say, where is this appendix; why haven't you mentioned it; why have you apparently not taken it into account?

A. No, I don't -- I don't think I went back to Dr. Chada. 12:30

76 Q. I know you didn't, Dr. Khan. I'm asking did you see it as part of your obligation during this fact-finding aspect of your role?

A. I must say I did not think that it's my role now to go back to the investigation team for more information. 12:30 I did obviously share the investigation and discussed with the Chief Executive and Director of HR, and clearly I was advised that you have to take the evidence provided by the investigation team. That was my point and context for making the determination. But 12:30 I did not go back and challenge Dr. Chada or challenge the investigation team.

77 Q. Is it fair to say then that you didn't go back and look at Appendix 11 or try to get Appendix 11 and see whether it would have made any difference to your 12:31 determination?

A. No, I didn't go looking for Appendix 11 from this letter.

78 Q. Could I ask you about the issue of undictated clinics. If you go forward to core 889 and if we pull up 12:31 AOB-01890. He explains here that also on 6th November he provided a spreadsheet addressing the issue of term of reference 3, the dictated clinics issue. He said:

Again, do you simply follow the evidence and the findings of Dr. Chada's report rather than take into account any aspect of what Mr. O'Brien is saying to you?

A. I believe that we need to understand the bigger impact of these to the patients, both of the undictated letters and the private patients, and how it impacted upon the systems put in place, the waiting list, the theatre lift, and impact on other patients. I believe at that point in time as well, going back for both the undictated letters, no matter if it is 600 or 162, every patient counts. It is important to understand that, yes, it is less than what is reported in 600 or 642, but 150 or 160, every patient has a right to be trusted by the doctor. That's again by the GMC Good Medical Practice, that patients should be able to trust the doctors. In order for that to achieve, doctors must show the good medical practice as per the GMC Good Medical Practice guidance. That includes not only the compliance or the clinical ability, but also the safety and quality, the interaction, the communication, the team working, the partnership and the trust that other professionals put in place for us as doctors to provide our reports. 12:39 12:39 12:40 12:40

Going back to the point, yes, he was challenging the number 600 and he is suggesting he is probably 100 and something, but every patient is as important. It is not about the numbers. There are sufficient numbers to

suggest he was failing in providing all that information to the multi-disciplinary team, both in the hospital and in the community in the Primary Care Team. But it is also important to understand the impact it had for each individual patient.

81 Q. Sticking with your example of the numbers of undictated; we'll move to the private patients issue then. But surely in terms of an investigation which took into account the numbers of patients involved, there is a factual significance to how many patients were involved; would you agree, Dr. Khan? If Mr. O'Brien is saying and putting evidence before you which he says wasn't taken into account by the investigator, why didn't you reflect that in your report? 12:41 12:42

A. Yes, perhaps I could have added the reflection in my report. However, I was provided, I was presented a clear evidence of all those elements of the terms of reference in the investigation.

82 Q. But with respect, Dr. Khan, this is the stage of the process which you read and you understood that Mr. O'Brien has a right to challenge the facts. And in relation to the dictation issue, while you may have read it, you didn't include in your report any reference to the factual dispute or to the fact that Dr. Chada had seemingly received evidence with respect to this factual issue and apparently had not taken it into account. Why did you fail to take those basic steps? 12:42 12:42

A. I suppose I'm going back to the point of the evidence presented to me in the investigations. So, I took that investigation report information of the -- my determination. Perhaps it would be good if I included some of the elements which Mr. O'Brien has indicated. I still believe that it wouldn't have changed the outcome but it would be good to have included that, yes.

83 Q. Is it fair to say that this element of the process, allowing Mr. O'Brien to contribute in respect of the factual aspects was simply removed from the process by the approach that you took?

A. I believe that Mr. O'Brien received opportunity at the time of investigation as well. He provided information and he did respond to his statement to the investigation team. So he already was provided at the time of investigation. He did provide further information to me as well.

84 Q. This is a wholly different stage. You are the Case Manager, you're performing a different role to Dr. Chada. You are expected, by the process, to take into account his submission and if there are gaps in the investigator's factual analysis, are you not supposed to take some steps to address that?

A. Yes, I suppose I could have included his comments into my determination, that he did not agree to the numbers. It was reflected in the investigation. However, I believe that there was sufficient grounds, the sufficient numbers of undictated clinic letters on

o. The MHPS Case Manager's Determination was completed & released on 26th September 2018. I shared my case manager's report and recommendations with the Chief Executive and the Director of Human Resources. **(Evidence: email to 26/9/18 to Chief Executive (Mr Devlin) & HR Director (Mrs Toal)) This can be located at Attachment folder S21 31 of 2022- Attachment 17.**

p. I wrote to Mr O'Brien informing him that the Case Manager's Determination is ready and requested to meet him. **(Evidence: Letter from Case Manager to Mr A O'B 26th September 2018). This can be located at Attachment folder S21 31 of 2022- Attachment 18.**

During October 2018:

q. I had a meeting with Mr O'Brien on 1st of October where I shared my Determination Report with him.

r. I then wrote a letter to Mr O'Brien confirming our discussion at the report sharing meeting. **(Evidence: 3/10/ 18- Case Manager letter to Mr O'Brien) This can be located at Attachment folder S21 31 of 2022- Attachment 19.**

s. I sought assurance from the Acute Directorate regarding the Return to Work Action Plan from the Acute Directorate as there was some information regarding a possible departure from the Return to Work Plan by Mr O'Brien.

t. I Informed the Chief Executive and the Director of Human Resources of this possible deviation from the Return to Work Plan by Mr O'Brien.**(Evidence: My email to the Chief Executive & the Director of Human Resources) This can be located at Attachment folder S21 31 of 2022- Attachment 20.**

u. I received further information and reassurance from the Assistant Director (Ronan Carroll) in the Acute Directorate to the effect that no significant issues were found in relation to the Return to Work Plan & there were only 16 clinic consultation dictations awaiting completion from end of September 2018. **(Evidence: FW AOB notes and dictation1 (Ronan ,Siobhan & Ahmed Khan). This can be located at Attachment folder S21 31 of 2022- Attachment 21.**

v. Then I wrote to Mr O'Brien regarding his obligations under the Return to Work Plan.

w. My understanding was that my Case Manager role ceased at this point as the MHPS Case Manager's Determination Report with recommendations had been issued and shared with the Chief Executive and the Director of HR. My perception was that my involvement in this case onwards was as the Acting Medical Director, although I acknowledge on reflection that this was not perhaps clear to me and I believe it is

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

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

The action plan should be reviewed and monitored by Mr O'Brien's Clinical Director (CD) and operational Assistant Director (AD) within Acute Services, with escalation to the Associate Medical Director (AMD) and operational Director should any concerns arise. The CD and operational AD must provide the Trust with the necessary assurances about Mr O'Brien's practice on a regular basis. The action plan must address any issues with regards to patient related admin duties and there must be an accompanying agreed balanced job plan to include appropriate levels of administrative time and an enhanced appraisal programme.

b. An exclusion from work

There was no decision taken to exclude Mr O'Brien at the outset of the formal investigation process rather a decision was taken to implement and monitor an action plan in order to mitigate any risk to patients. Mr O'Brien has successfully worked to the agreed action plan during the course of the formal investigation. I therefore do not consider exclusion from work to be a necessary action now.

3. There is a case of misconduct that should be put to a conduct panel

The formal investigation has concluded there have been failures on the part of Mr O'Brien to adhere to known and agreed Trust practices and that there have also been failures by Mr O'Brien in respect of 'Good Medical Practice' as set out by the GMC.

Whilst I accept there are some wider, systemic failings that must be addressed by the Trust, I am of the view that this does not detract from Mr O'Brien's own individual professional responsibilities.

During te MHPS investigation it was found that potential and actual harm occurred to patients. It is clear from the report that this has been a consequence of Mr O'Brien's conduct rather than his clinical ability. I have sought advice from Practitioner

Performance Advice (NCAS) as part of this determination. At this point, I have determined that there is no requirement for formal consideration by Practitioner Performance Advice or referral to GMC. The Trust should conclude its own processes.

The conduct concerns by Mr O'Brien include:

- Failing to undertake non red flag triage, which was known to Mr O'Brien to be an agreed practice and expectation of the Trust. Therefore putting patients at potential harm. A separate SAI process is underway to consider the impact on patients.

- Failing to properly make it known to his line manager/s that he was not undertaking all triage. Mr O'Brien as a senior clinician had an obligation to ensure, this was properly known and understood by his line manager/s.

- Knowingly advantaging his private patients over HSC patients.

- Failing to undertake contemporaneous dictation of his clinical contacts with patients in line with GMC 'Good Medical Practice'.

- Failing to ensure the Trust had a full and clear understanding of the extent of his waiting lists, by ensuring all patients were properly added to waiting lists in chronological order.

Given the issues above, I have concluded that Mr O'Brien's failings must be put to a conduct panel hearing.

4. There are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer.

There are no evident concerns about Mr O'Brien's health. I do not consider this to be an appropriate option.

5. There are concerns about the practitioner's clinical performance which require further formal consideration by NCAS (now Practitioner Performance Advice)

Before coming to a conclusion in this regard, I sought advice from Practitioner Performance Advice.

The formal investigation report does not highlight any concerns about Mr O'Brien's clinical ability. The concerns highlighted throughout the investigation are wholly in respect of Mr O'Brien's administrative practices. The report highlights the impact of Mr O'Brien's failings in respect of his administrative practices which had the potential to cause harm to patients and which caused actual harm in 5 instances.

I am satisfied, taking into consideration advice from Practitioner Performance Advice (NCAS), that this option is not required.

6. There are serious concerns that fall into the criteria for referral to the GMC or GDC

I refer to my conclusion above. I am satisfied that the concerns do not require referral to the GMC at this time. Trust processes should conclude prior to any decision regarding referral to GMC.

7. There are intractable problems and the matter should be put before a clinical performance panel.

I refer to my conclusion under option 6. I am satisfied there are no concerns highlighted about Mr O'Brien's clinical ability.

6.0 Final Conclusions / Recommendations

This MHPS formal investigation focused on the administrative practice/s of Mr O'Brien. The investigation report presented to me focused centrally on the specific terms of reference set for the investigation. Within the report, as outlined above, there have been failings identified on the part of Mr O'Brien which require to be addressed by the Trust, through a Trust conduct panel and a formal action plan.

The investigation report also highlights issues regarding systemic failures by managers at all levels, both clinical and operational, within the Acute Services Directorate. The report identifies there were missed opportunities by managers to fully assess and address the deficiencies in practice of Mr O'Brien. No-one formally assessed the extent of the issues or properly identified the potential risks to patients.

Default processes were put in place to work around the deficiencies in practice rather than address them. I am therefore of the view there are wider issues of concern, to be considered and addressed. The findings of the report should not solely focus on one individual, Mr O'Brien.

In order for the Trust to understand fully the failings in this case, I recommend the Trust to carry out an independent review of the relevant administrative processes

with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. The review should look at the full system wide problems to understand and learn from the findings.

satisfied that this is to proceed as a Conduct Panel. I was also aware that a Conduct Panel, if required, this can be referred to the GMC. So, GMC referral was -- in my determination I said at that point in time the GMC referral wasn't required. I wasn't saying it's not required at all. Having that discussion with the GMC ELA, we discussed that and seems to be meeting the threshold, so he was referred.

113 Q. We'll look at that in just a moment. But the -- you then set out the conduct concerns by Mr. O'Brien. You say that they include the following. You don't mention in that list his retention of multiple patient notes at home. Did you decide that that was not worthy of a conduct hearing? 14:35 14:36

A. I suppose I put a number of elements there. I did not include all of them. But I included -- for example, as a summary of some of the elements which are there but in the report, if you look at previously in my report, I did indicate these are the failings in Mr. O'Brien's case and it was included previous to that. But this was a list of some of the elements which were already included in the report. 14:36 14:37

114 Q. Notably, if you look at the fourth bullet point, I took you up on the issue of how you had formulated your GMC concern around record-keeping and here you're - can I suggest to you - more precise about the actual alleged shortcoming of Mr. O'Brien, which was dictation, a contemporaneous dictation issue as opposed to record-keeping more generally; would you accept 14:37

inappropriate, in approaching Mr. O'Brien's family members to a number of staff. And they were -- they felt vulnerable in that way. So, it was important that this was to be addressed.

139 Q. Into the following year a decision was made to make a referral to the General Medical Council; was that your decision or was it Dr. O'Kane's decision? 15:12

A. Dr. O'Kane took over the Medical Director role in December. So, in December 2018 we were together. She was coming in as a substantive medical director. I was transitioning out, I was finishing my role. We had a period of 2018, December, when both were there. At that point in time, the MHPS report was shared with GMC ELA and it was discussed around the same time. The ELA has indicated that all that information appears to be meeting the threshold. Therefore, Dr. O'Kane was in the Medical Director's role and responsible officer role at that point in time, so she provided all that information and made a referral. I think it was in March or April 2019. 15:12 15:13 15:13

140 Q. You were despatched to communicate this to Mr. O'Brien?

A. That's correct, yes. So I was informed by Dr. O'Kane and I was advised to inform Mr. O'Brien about that.

141 Q. Was that in your role as case manager?

A. I presumed it was as my previous role as case manager. 15:13

142 Q. Just finally from my perspective. You've offered some reflections on the MHPS process generally and your role in it. One of the things you've said in your witness statement -- this is at page 903 of your bundle, not

From: OKane, Maria
To: GMC Fitness to Practise
Cc: Joanne Donnelly [redacted]
Subject: GMC Referral
Date: 02 April 2019 17:17:48
Attachments: [redacted]
Importance: High

Please find attached GMC Referral, Reference: GMC Number [redacted]

I have attached 2 appendices and 3 NCAS advice letters, all of which will also be sent with the full report via post.

I have been unable to attach my digital signature to the document, please advise if this is acceptable as proof of authorised submission from my own email account.

If you have any queries please come back to me.

Kind Regards,

Dr Maria O'Kane
Medical Director

Southern Health & Social Care Trust
Craigavon Area Hospital,
Trust Head Quarters,
Lurgan Road,
Craigavon

With specific reference to each of the determinations listed at (I) – (III) above address,

A. Who was responsible for the implementation of each of these actions?

21.1 My understanding was that, as the MHPS investigation had concluded with my recommendations shared with the Chief Executive and the Director of Human Resources therefore my role as Case Manager ceased in October 2018. My perception was that my involvement in this case onwards was as the Acting Medical Director, which also completed in Dec 2018. Although I acknowledge on reflection that this was not perhaps clear to me and I believe it is unclear in the MHPS framework and Guidelines as to when Case Manager's role will cease. I was also aware that the Oversight Committee (The Medical director, Director of HR & Director of Acute Services) is in place to follow up the progress of the implementation of the recommendations.

B. The implementation of an Action Plan with input from Practitioner Performance Advice, the Trust and Mr. O'Brien to provide assurance with monitoring provided by the Clinical Director;

21.2 My understanding was that the Clinical Director, along with the Head of Service and Assistant Director of Surgery and Elective Care, were to continue to provide assurance until a review of the current action plan was completed.

C. That Mr. O'Brien's failings be put to a conduct panel hearing; and

21.3 My understanding was that the Director of HR would implement this recommendation.

D. **That the Trust was to carry out an independent review of administrative practices within the Acute Directorate and appropriate escalation processes.**

21.4 My understanding was that this would be implemented by the Director of Acute Services and the Chief Executive.

F. To the best of your knowledge, outline what steps were taken to ensure that each of these actions were implemented; and

Practitioner Performance Advice (formerly NCAS)
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Irrelevant information redacted by the USI

17 October 2018

PRIVATE AND CONFIDENTIAL

Dr Aidan O'Brien
Consultant Urologist
Southern Health and Social Care Trust

Ref: Personal Information redacted by the USI **(Please quote in all correspondence)**

Dear Dr O'Brien,

Thank you for ringing me to discuss your case. We spoke by telephone on 1 and again, as scheduled, on 11 October 2018, and I am writing to summarise the issues which we discussed on these occasions. Please let me know if any of the information is incorrect

In summary, you are a senior consultant urologist and have been the subject of a long running investigation after allegations were made about your practise. This investigation has now concluded and the matter is to proceed to a hearing. I note that the investigative report, which identified issues which have led to the matter being put to a hearing, also identified previous failings in management of your case. You told me that you have grave concerns about many aspects of the process. Specifically, you allege that the Trust has misled Practitioner Performance Advice service (formerly NCAS) by implying that you were supported to address concerns in 2016. Whilst you were told about the concerns, you did not receive any support or assistance in managing the difficulties (which you attribute to serious workload issues). You reported that when you asked in 2016 how the issues could possibly be addressed, the manager shrugged his shoulders

You also told me that, despite repeated requests, you have not received any of letters prior to the recent communication with Dr Khan. You are considering legal options.

You are aware of your right to see information which is held about you and will likely submit a Subject Access Request (SAR) to Practitioner Performance Advice service. You know that I cannot act as your advocate and I advised that you seek advice from your

defence organisation or legal team so that you can consider how best to raise your concerns. We discussed it is open to you to raise a grievance in line with Trust policy, and to write to the Designated Board Member, Chair or Chief Executive about your concerns. I suggested that before you would take legal action or approach any outside bodies with your concerns, it would be prudent to ensure you have exhausted internal processes, and that your defence organisation considers that this action is appropriate and necessary in the circumstances.

As discussed, I will inform Dr Khan of our conversation, and the subject of it. You are welcome to share this letter with him if you wish.

I hope you found our conversation helpful.

Relevant regulations/guidance:

Yours sincerely,

Dr Grainne Lynn
Adviser
Practitioner Performance Advice

From: O'Brien, Aidan
Sent: 21 October 2018 16:16
To: Khan, Ahmed
Cc: Toal, Vivienne; Wilkinson, John
Subject: RE: Information Request

Dear Dr. Khan,

I am disappointed to have not yet received the information that I have previously requested.

I also write to advise you that I have since had the opportunity of discussing my concerns with Dr. Lynn of Practitioner Performance Advice (formerly NCAS).
I have been further concerned to be advised by her that there had been an earlier consultation with and communication from NCAS in September 2016, and about which I had not been advised.

Therefore, in addition to the information previously requested, I now request copies of all communications with and correspondence from NCAS pertaining to me during 2016.

As previously, if you are unable or unprepared to do so in a timely manner, I would be grateful if you would advise of the reason(s), and similarly advise me from whom the information may be obtained,

Aidan O'Brien

From: Khan, Ahmed
Sent: 03 October 2018 10:36
To: O'Brien, Aidan
Cc: Hynds, Siobhan
Subject: RE: Investigation

Dear Mr O'Brien, thank you. I have requested some information & will be in touch soon.

Regards,
Ahmed

Dr Ahmed Khan
Case Manger- MHPS

From: O'Brien, Aidan
Sent: 01 October 2018 22:27
To: Khan, Ahmed
Subject: Investigation

Dear Dr. Khan,

Further to our meeting today, and specifically with regard to information previously requested, I write to clarify that I wrote to Dr. Wright on 14 February 2017, detailing a number of errors and omissions in the Note of the Meeting of 30 December 2016, requesting that amendments be made. On 01 March 2017, I received from Siobhan Hynds an acknowledgement of receipt of my letter to Dr. Wright. She advised that she would arrange for an amended Note to be sent to me, taking into consideration my suggested amendments. No amended Note was sent to me. On 19 April 2017, I sent an email to Siobhan Hynds, advising that I still awaited an amended Note. I did not receive any

response, reply or amended Note. A further request was submitted on 31 July 2017. Again, I did not receive a response or an amended Note. An amended Note was included in the Investigator's report.

On 28 March 2017, I submitted to Siobhan Hynds a list of amendments to be made to the Note of the Meeting with her and with Mr. Weir, and which took place on 24 January 2017. I requested that she return a copy of the amended Note. I received no reply or response. On 31 July 2017, I again requested an amended Note of the Meeting, without response. The original Note of the Meeting was included in the Investigator's report, without amendments having been made.

On 31 July 2017, I submitted to Siobhan Hynds, by email, a request for a copy of the minutes of the meeting of the Oversight Group and which took place in December 2016. I have still not been provided with a copy of the minutes.

On 31 July 2017, I submitted to Siobhan Hynds, by email, a request for a copy of a record of communication and correspondence with NCAS in December 2016. I have still not been provided with a copy.

On 31 July 2017, I also requested a copy of the Southern Trust's Policy & Procedure on Triage, and which I had previously requested. I still have not been provided with a copy.

On 10 June 2018, I again sent an email to Siobhan Hynds requesting responses to the requests made previously, as detailed above. As before, I still await the information.

Therefore, I would be grateful, even at this late juncture, if you would have the requested information sent to me, and specifically, lest there be any doubt:

- A copy of the Record of Communication and / or Correspondence with NCAS in December 2016, and subsequently.
- A copy of the Minutes or Note of the Meeting of the Oversight Group in December 2016
- A copy of Southern Trust's Policy & Procedure for Triage

Most importantly, if you are unable or unprepared to provide me with these requested documents, or have them provided to me, in a timely manner, I would be grateful if you would advise me of the reasons why, and of whom I may request the information,

Aidan.

Comac, Jennifer

From: Khan, Ahmed
Sent: 05 November 2018 12:09
To: O'Brien, Aidan
Cc: Wilkinson, John; Hynds, Siobhan
Subject: RE: Information Request
Attachments: Letter from Case Manager re GMC report 301018.pdf; Case Manager Determination AO'B FINAL 280918 - Redacted.pdf

Importance: High

Dear Mr OBrien,

Thank you. I have requested advise in relation to your last email (below), will reply as soon as possible.

In the meantime please find attached letter & redacted copy of MHPS report for your information.

Regards,
Ahmed

Dr Ahmed Khan
Medical Director (Interim)
Case Manager -MHPS

From: O'Brien, Aidan
Sent: 02 November 2018 07:54
To: Khan, Ahmed
Cc: Wilkinson, John; Toal, Vivienne
Subject: RE: Information Request

Dear Dr Khan,

Thank you for your email of 23 October 2018.

I have taken note of the comments of Siobhan Hynds included in your email. I take issue with a number of the assertions contained therein. I will address those issues in a separate email in coming days.

I also note your enquiry as to my adherence to the Return to Work Plan. I will also address your enquiry in a separate email in coming days.

I do so as I wish to avail of this opportunity to advise you of my alarm to discover the nature of the activities and conduct of senior Trust management in 2016 related to concerns pertaining to my administrative practice. Having now received the Action Note emanating from the meeting of the Oversight Committee of the 22 December 2016, it is evident that there were earlier meetings of the Oversight Committee on 13 September 2016 and on 12 October 2016. It is stated that, at the meeting of 13 September 2016, the Oversight Committee had recommended a Formal Investigation at that time, and that subsequently a 'different approach was to be taken', as reported to the meeting of the Oversight Committee on 12 October 2016. I have never been made aware of these meetings, or of the decisions made at them, before receipt of your email, two years later. It would appear that none of these matters have been disclosed to the Investigation, or investigated by the Investigation, despite falling squarely within Term of Reference 5 of the Investigation.

It is now of the utmost importance that all correspondence and Minutes are shared as a matter of urgency. Accordingly, I request that you provide me with the following documents within seven days of the date hereof:

1. The Minutes of the meeting of the Oversight Committee of 13 September 2016
2. The Minutes of the meeting of the Oversight Committee of 12 October 2016

In addition, I request the following be provided to me within 14 days of the date hereof:

1. All minutes, notes or records pertaining to any and all meetings or case conferences of the Oversight Committee relating to my practice from 2015 to date.
2. All minutes, notes or records of the meeting held by Ms. Heather Trouton and the Medical Director on 11 January 2016 at 10.00 am, and to which Ms. Trouton referred in her unsigned, undated witness statement.
3. The correspondence from Mr. A. Glackin to Mr. R. Carroll and to Ms. E. Gishkori relating to my practice, and to which Mr. Carroll referred at Paragraph 9 of his witness statement of 17 August 2017.
4. The email sent from Mr. M. Haynes, received by Mr. R. Carroll and relating to concerns regarding my private practice, and to which Mr. Carroll referred at Paragraph 11 of his witness statement of 17 August 2017.
5. All correspondence about my practice sent between and amongst management in 2016.
6. All minutes, notes or records of any meetings or discussions by management regarding me and my practice in 2016.

Lastly, I request that you acknowledge receipt of this email, and confirm that the sought documentation will be provided within the time periods stated above, and further and in the alternative (if they cannot be provided) full and precise reasons why this is the case.

Yours Sincerely,

Aidan O'Brien.

From: Khan, Ahmed
Sent: 23 October 2018 16:57
To: O'Brien, Aidan
Cc: Wilkinson, John; Hynds, Siobhan
Subject: RE: Information Request

Dear Mr O'Brien,

Further to your request, please find comments from Ms Siobhan Hynds below and attached documents as requested. I have also attached copy of September 2016 NCAS correspondence.

- **In respect of the note of the meeting on 30 December 2016. This meeting was attended by Mr O'Brien, his wife, Dr Richard Wright and Lynne Hainey, HR Manager. The information I have from that early stage of the process outlines that a note of the meeting was produced and sent to Mr O'Brien at the time. Mr O'Brien wrote to Dr Wright outlining some factual errors with the note of the meeting from his perspective. These comments were considered and Dr Wright responded to Mr O'Brien with an amended note of the meeting. In correspondence to Mr O'Brien, Dr Wright outlined that he was content to amend some aspects of the note, others he felt were reflective of the meeting. As the note of the meeting remained under question by Mr O'Brien, as part of the Case Investigators report to you as the Case Manager, the note of the meeting from Dr Wright was appended to the report along with Mr O'Brien's comments to ensure both positions were known. Both documents are contained within the appendices of the Investigation Report. It has been previously clarified with Mr O'Brien, that the note of this meeting would not be further amended. Mr O'Brien's request for information was discussed with him and dealt with at the meeting of 3 August 2018. Mr O'Brien has been provided with all of the documents referred to above.**

- **In respect of the note of the meeting on 24 January 2017 – as per above, Colin Weir (then Case Investigator) was satisfied with the content of the note as an accurate reflection of the meeting with Mr O'Brien on 24 January. Mr O'Brien submitted his comments on the note. Both have been appended to the final**

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Irrelevant information redacted by the USI

27 July 2020

PRIVATE AND CONFIDENTIAL

Dr Aidan O'Brien
Personal Information redacted by USI

Ref: Personal Information redacted by the USI **(Please quote in all correspondence)**

Dear Dr O'Brien,

Thank you for speaking with me on the telephone on 16 July 2020. Your wife also participated in the discussion.

We had a long conversation in which you described the events which have occurred to you in recent years from your perspective. Grainne Lynn has summarised much of the story in her letter but there were a few points which I felt particularly relevant to me. In particular you told me that my initial advice given in September 2016 had not been shared with the decision-making group when they decided how to address issues which were raised at that time. I was disappointed to hear this.

You also pointed out that you had not been re-employed after retirement by the trust because of an ongoing process which had been delayed by the failure to hear your grievance. You pointed out that the human resources department were responsible for both the decision on your re-employment and the management of the grievance and disciplinary process. You told me that you would not have decided to take retirement had you known that you were not to be re-employed.

You and your wife met the very helpful suggestion that our organisation should have an early discussion with practitioners who have been referred to us. Whilst there are some practical difficulties with this I can see that it has benefits. In particular in your case, I suggested that had I spoken to you early in the process, I would probably have advised you to contact the MPS early. That may have been beneficial. I will discuss your suggestion with my colleagues at one of our regular meetings.

Finally I would like to once again emphasise the importance of looking after yourself. These processes can be difficult and upsetting and given that you are considering ceasing clinical practice I feel that you should focus on what you want from life and look forward. I suggested that you may wish to get your solicitor to arrange a meeting with the trust to see if a way forward can be agreed to the satisfaction of yourself and the trust. There are a range of support services available for doctors in such situations and I can recommend the BMA service (0330 123 1245) or the GMC investigation support service (0207 7383 6707).

Relevant regulations/guidance:

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

Either Grainne or I are happy to have a further discussion should you feel it helpful. Please contact Case Support on the phone line or email address above.

I hope the process has been helpful to you.

Yours sincerely,

Colin Fitzpatrick
Adviser
Practitioner Performance Advice

the MPS early".

That is if I had spoken to you early in the process, you would probably have advised this?

A. Yes. 08:47

64 Q. Would you accept this as a broadly correct proposition - you'll take a view from management, whether that's the Medical Director phoning you or, as in this case Mr. Gibson, and they will provide a diagnosis or account of the problem which could be analysed in 08:48 a wholly different way by the clinician concerned?

A. Yes, yes. They're going to give a completely different -- in almost every case they are going to give a different story to the clinician concerned. There were a few things when I spoke to Mr. O'Brien in 08:48 2020, I was a little bit surprised and shocked at. I mean, for example, the fact that he had never heard of my discussion with Simon Gibson was shocking to me. That was something over the years we realised was happening, these letters and the fact of our 08:48 involvement was not being shared with practitioners. If you look at Gráinne's final letter in this chain of letters, you'll have noticed that I think she does say we advise that this letter be shared with the practitioner, or words to that effect. Because 08:48 we started to add that as a standard phrase in our letters to try to make sure that the practitioners knew what was going on.

65 Q. Yes. I can see that it isn't in your 2016 letter, but

Gibson, Simon

From: Haynes, Mark <[redacted]>
Sent: 16 November 2018 13:56
To: Khan, Ahmed; Gibson, Simon
Subject: FW: AOB

Hi Ahmed / Simon

Are you aware of this? Surely this behaviour (phone calls from wife and his son / legal advisor to Mr Young, below with Mr Weir) shouldn't happen?

How can we (his colleagues) be protected?

Mark

From: Weir, Colin
Sent: 15 November 2018 11:34
To: Carroll, Ronan; Hynds, Siobhan
Cc: Young, Michael; Gishkori, Esther; Haynes, Mark
Subject: RE: AOB

Can I put on record that last Thurs 8th Nov Mr O'Brien met me in my office from 08:50 to 09:15hrs. He requested the meeting

The conversation centred around his investigation. I was supportive to him as a colleague, and Clinical Director and I thought that was to be the focus of the conversation

He did ask me about evidence I had given to the investigation relating to meeting with Dr McAllister when he was AMD and prior to the investigation. I wasn't expecting this and tried to answer briefly my recollection.

I now feel that

1. he should not have made this approach
2. his questioning and my responses could undermine the investigation and action plan
3. he put me in a difficult and awkward position
4. having met Mr Young and knowing his experiences: I cannot meet or discuss anything with Mr O'Brien anything other than day to day activities in his work as a Urologist.

Can we please be protected from this as I suspect evidence is being gathered from us and make the Medical Director aware?

Colin

From: Carroll, Ronan
Sent: 15 November 2018 10:04
To: Hynds, Siobhan
Cc: Young, Michael; Weir, Colin; Gishkori, Esther
Subject: AOB
Importance: High

Siobhan,
Mr Young has advised me this morning that he received phone calls from Mrs O'Brien (Saturday evening) and Michael O'Brien (Monday Evening). Both these phone calls centred on the Mr Aidan O'Brien's investigation.
Give me a ring if you require anything further

Cc: Hynds, Siobhan
Subject: Re: MHPS investigation

Dear Mr O'Brien

It has been brought to my attention that members of your family have been in contact with Trust employees to discuss the ongoing case you are involved in.

This is entirely inappropriate and must cease immediately.

I have informed staff not to engage with your family members if approached in such a way.

I would be grateful for your acknowledgement of this e-mail.

Yours sincerely,

Dr Ahmed Khan

Case Manager- MHPS
Medical Director (Interim)

Sent from my Samsung Galaxy smartphone.

progressed, by Dr Khan as case manager who was also holding the role of Medical Director for the Trust. To progress each action, engagement was required with a number of people regarding each specific action:

I. The implementation of the Action Plan

27.3 I was not involved in or party to any discussions regarding the action plan.

II. The conduct panel hearing

27.4 In follow up to the 1 October 2018 meeting, I sent a draft correspondence to Dr Khan on 30 October for sending to Mr O'Brien, to begin to secure suitable dates for a conduct panel hearing. I do not recall if Dr Khan asked me for this draft or if I sent it to him in order to move this action along. This action was the one out of the three that required to be progressed with input from HR.

27.5 Following legal advice in respect of the process, it was advised that a panel member with urology specialism would be required for the panel as the issues of concern were professional misconduct.

27.6 I sent a further updated draft e-mail to Dr Khan on 26 November 2018 ***(located at S21 47 of 2022 Attachments 10. Draft e-mail to Mr O'Brien)*** to advise:

> *"Dr Khan, The previous draft e-mail referred to the 14th December as a possible date for the hearing. As the external panel member cannot do this date, I think we have no alternative but to notify Mr O'Brien that a date before Christmas is not possible due to diary commitments of those involved. I think we should ask him for his availability for January to see what we can work to. Are you happy to send an e-mail on this basis?"*

27.7 Dr Khan sent this e-mail on 28 November 2018 to Mr O'Brien. On 2 December, Mr O'Brien lodged a formal grievance with the Trust (***located at Relevant to HR/Evidence after 4 November HR/Reference 77/20181203 - Email***

Hynds, Siobhan

From: Hynds, Siobhan [redacted]
Sent: 30 October 2018 16:51
To: Khan, Ahmed
Subject: Strictly Private & Confidential

Importance: High

Follow Up Flag: Follow up
Flag Status: Flagged

Dr Khan

Draft e-mail to AOB below:

Dear Mr O'Brien

Further to our meeting on 1 October 2018. As explained to you at the meeting, as Case Manager, I have determined the next step in the MHPS process is to proceed to a conduct panel.

I am trying to secure some dates for this purpose and I would be grateful if you could advise of your availability (and that of your representative) for the following dates:

Friday 23 November 2018
Wednesday 28 November 2018
Friday 14 December 2018

I anticipate we will need at least a full day for the hearing. This may happen over 2 dates.

You will receive further correspondence in respect of the conduct hearing, the conduct allegations along with a conduct report for presentation to the panel in due course, however at this stage I am trying only to secure dates.

I would be grateful for an early reply to this correspondence.

Regards,

Dr Ahmed Khan

27 November 2018

Dear Mr Devlin,

Re: Formal Grievance

The purpose of this correspondence is to put you on formal notice of my grievance and to activate the Grievance Procedure of the South Health & Social Care Trust.

1. Subject of Grievance

I am raising a grievance about the acts and omissions of Senior Managers within the South Health & Social Care Trust ["the Trust"] relating to the handling of concerns about my administrative practices. I believe that the actions and the failures of the Trust amount to breaches of Trust Policies and Procedures and a breach of my contract of employment.

Additionally, I am formally lodging a grievance against the decision dated 1st October 2018 of the Case Manager to classify the case as a case of misconduct.

I have attached a schedule of documents, which I refer to in the course of this correspondence.

2. Details of the Grievance

2.1 Introduction

I first became aware that the Trust was investigating concerns about my practice on 30th December 2016. [redacted] Personal Information redacted by the USI [redacted]. On 28th December 2016, whilst still on sick leave, I received a telephone call from the office of the Medical Director, informing me that the Medical Director wanted to meet with me, on 3rd January 2017. I advised that I could not meet on 3rd January 2017 as I had scheduled operating that morning, followed by a clinic in the afternoon. I suggested that I could speak to the Medical Director by telephone but I was informed that the meeting had to be in person. I asked whether the Medical Director appreciated that I was on sick leave. I was advised that he was aware. I then offered to meet with him on 30th December 2016. The date and time was agreed. As I remained curious of the reason for such a meeting to be convened whilst on sick leave, I requested by email an agenda. When provided by return, I was greatly concerned, particularly as it included the timing of my return to work, and the advice that I could be accompanied at the meeting, for support.

I attended the meeting on 30th December with my wife. Dr Wright (Medical Director) and Lynne Hainey (Senior Human Resources Advisor) were also in attendance. The minutes of this meeting, together with my corrections are attached to the Schedule of Documents at Tab 1 and

2 respectively. At the meeting, Dr Wright informed me that concerns had been raised with him as a result of an ongoing Serious Adverse Incident investigation ["SAI"]. Dr Wright stated that attempts had previously been made to resolve the concerns informally, with no success. I was informed that there were three areas of concern, *viz*; (i) the period of time taken to undertake triage, (ii) a backlog of undictated clinics, and (iii) patient notes being kept at my home. At the meeting, I was advised that a formal investigation would commence and that this would be in accordance with the "*Southern Health and Social Care Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance*" and with reference to "Maintaining High Professional Standards in the Modern HPSS". I was provided with copies of both documents.

I was also informed that I was being placed on immediate exclusion on full pay. I was informed that this decision had been taken by an Oversight Committee and that advice had been received by this Oversight Committee from NCAS prior to that meeting. I remained excluded until a decision on 26th January 2017 that exclusion was unnecessary. I returned to work on 20th February 2017 with a return to work plan. Since that time, I have continued to work under the shadow and stress of ongoing investigations.

The investigation was carried out by Dr Neta Chada and she provided a report on 21st June 2018. I provided a complete response to this report on 10th July 2018. The Case Manager, Dr Khan, provided his determination on 1st October 2018. He has recommended a referral to a conduct panel.

During the course of the investigation, I raised many concerns about the failures of the investigation process. Moreover, since I received the Case Manager's Determination, I have received further information from NCAS and, following enquiry, from the Trust that has caused me grave concern about how the Trust has handled these issues throughout 2016 to date. It is now clear to me that the Trust has mishandled these concerns since 2016, that the Trust has failed to follow its own policies and procedures, and that the Trust has committed material breaches of my contract of employment. Furthermore, it is clear that some members of the Trust Management have frustrated other members of management who had the intention of dealing with the concerns in an manner which would have been appropriate, and which would have been compliant with Trust Guidelines, MHPS Guidelines and NCAS advice. I am deeply concerned that the Trust has not been transparent and honest with the information that it has provided to NCAS. Furthermore, when I have made enquiries about matters related to actions and decisions taken by the Trust, the responses that have been provided, have lacked transparency and candour and have been fundamentally misleading.

I have set out below particulars of all these issues. It will become clear that there are documents that I am not in possession of, and which may shed light on issues relevant to this grievance. Below, I request the documents, of which I am aware, that I consider to be relevant. Upon receipt of those documents, I may need to amend this grievance and I reserve the right to do so.

I am now also making a request that my personal file be provided to me.

2.2 Relevant Contractual Terms and Conditions, Policies and Procedures.

I requested and received a copy of my contract dated 16th August 2006 from Mr Malcolm Clegg. Though I have been in continuous employment with the Trust since 6th July 1992, this contract is the current and relevant contract in application throughout the relevant events. I have attached a copy of my contract at Tab 3 of the Schedule of Documents. The relevant terms are outlined below.

> 3. General Mutual Obligations
> Whilst it is necessary to set out formal employment arrangements in this contract, we also recognise that you are a senior and professional employee who will usually work unsupervised and frequently have the responsibility for making important judgments and decisions. It is essential therefore that you and we work in a spirit of mutual trust and confidence. You and we agree to the following mutual obligations in order to achieve the best for patients and to ensure the efficient running of the service:
> - To co-operate with each other;
> - To maintain goodwill;
> - To carry out our respective obligations in agreeing and operating a Job Plan;
> - To carry out our respective obligations in accordance with appraisal arrangements;
> - To carry out our respective obligations in devising, reviewing, revising and following the organisation's policies, objectives, rules, working practices and protocols.

I believe that it is important to emphasise the mutual nature of the obligations that the Trust and I both have to achieve the best for patients. I recognize that I have an obligation to co-operate with the Trust and to carry out my obligations in respect of the relevant policies, objectives, rules, working practices and protocols. I have done this to the best of my ability for 26 years. However, it is central to this grievance that I am asserting that the Trust has manifestly failed to meet its obligations.

> 15 Policies and Procedures
> You are required to comply with our Policies and Procedures as may from time to time be in force.

> 17 Disciplinary Matters
> Wherever possible, any issues relating to conduct, competence and behaviour should be identified and resolved without recourse to formal procedures. However, should we consider that your conduct or behaviour may be in breach of Trust policies or that your professional competence has been called into question, we will resolve the matter through our disciplinary or capability procedures, subject to the appeal arrangements set out in those procedures.

> 32 Entire Terms
> This contract and the associated Terms and Conditions of Service contain the entire terms and conditions of your employment with us, such that all previous arrangements, practices and understandings between us (if any) are superseded and of no effect. Where any external term is incorporated by reference such incorporations is only to the extent so stated and not further or otherwise.

It is important to make clear that I am required to comply with Trust Policies and Procedures. Disciplinary procedures should only be used or invoked where it is considered that I am in breach of Trust policies or where my professional competence has been called into question.

The most relevant Trust Policy is entitled *Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance,* dated 23 September 2010 (hereafter referred to as the "Trust Guidelines". These guidelines were updated in October 2017. However, it is the 2010 guidelines that are relevant to the events of 2016 and the formal investigation. I will make extensive reference to the Trust Guidelines throughout this grievance. It is attached in the Schedule of Documents at Tab 4. It is this document and the processes established within it that form part of my contract of employment.

The document entitled *Maintaining High Professional Standards in Modern HPSS* issued by the English Department of Health, Social Services and Public Policy in November 2005 is **not** part of my contract. This is made clear by Clause 32 of my contract outlined above.

2.3 Events before 30th December 2016

I have provided an extensive historical context for the concerns about my administrative backlog to the Case Investigator, Dr Chada. This response is attached in the Schedule at Tab 5. I do not intend to repeat the full context in this correspondence. In summary, I have provided detail of the pressures that I was under for many years with waiting lists for both in-patient treatment and review, and how I was using available time to ease that backlog. There had been times when I fell behind in administrative work in the past and would have worked additionally to ease that backlog. **This was always known to the Trust and the Trust was always aware that the volume of work was overwhelming**. It is clear from the witness statements provided in the investigation that my administrative backlog was known to Trust managers for a very considerable period of time prior to 2016.

The problems became more acute owing to additional pressures that built up between 2012 and 2016. I was provided with 2 hours and 40 minutes of patient related, administration time per week in 2015 (Tab 6) and 2 hours per week in 2016 (Tab 7) in my job plan. I described in my response, the additional commitments required following appointment as Lead Clinician of the Southern Trust Urology Multidisciplinary Team and Chair of Urology MDM in April 2012, and as Lead Clinician of the Northern Ireland Cancer Network (NICaN) Clinical Reference Group in Urology in January 2013. These appointments were followed by a two year period of time when both the Southern Trust's and Northern Ireland's regional urological oncology services were preparing for National Peer Review in June 2015.

I was not provided with or allocated any time for any of these undertakings during the years 2012 to 2014. The most onerous and time consuming was previewing all cases to be discussed at MDM which I chaired every Thursday afternoon. This required three to four hours of work, which I typically had to undertake from 10 pm each Wednesday evening, having operated to 8 pm. To relieve the burden, I introduced a rotating chairmanship of MDM with two of my colleagues, beginning in November 2014. Thereafter, I was provided with an additional 3 hours to prepare for chairing MDM as were my two colleagues, from 2015 onwards.

However, no time was allocated in my job plan for the remaining commitments at all during the years 2012 to 2016. By the time that the Southern Trust MDT was subjected to National

Peer Review in June 2015, we did not have a single patient breaching a cancer timeline since the end of 2014. This had been achieved by my ensuring that all patients were reviewed and operated upon within the required timeline, either by their nominated consultant urologist, or by myself, if the nominated consultant was unavailable to do so. All of these commitments and undertakings required considerable administration, a fact of which Management was aware. I did raise with Mrs. Martina Corrigan, as Head of Service, on more than one occasion the prospect of having time allocated in my job plan to facilitate these commitments, but no time was allocated or other commitments reduced. Despite having done so, no remedial or supportive plan or action was put in place to alleviate me of this overwhelming burden, which then gave rise to an administrative backlog in terms of dictation of letters, and which became a subject of concern.

Additionally, I found it impossible to complete triage of all referrals whilst Urologist of the Week, a system that commenced in 2014. Again, Trust managers were aware of this, as I had advised them myself. I undertook all Red Flag triage but not the triage of urgent and routine referrals and several of the witnesses have described in their statements my stating that I could not do it. Ms Martina Corrigan stated "Mr O'Brien complained that he didn't have time to do triage because of his patient care or admin commitments." Mr Michael Young stated "I know Mr O'Brien finds triage arduous and he would often say he had difficulty completing triage on a timely basis." Mr Tony Glackin stated "Mr O'Brien frequently expressed a view that he did not have time to do triage and he flagged that he couldn't manage the situation"

In fact, for a period of approximately 4-6 months in 2014, Mr Young completed triage of referrals for me. This was approved by Management because of the my additional undertakings and commitments. This was a clear recognition that these additional commitments made it impossible for me to complete my administration. However, the commitments remained throughout 2015 and 2016, long after Mr Young had stopped completing my triage.

As a consequence of Management's awareness of triage not being completed by me, at a meeting of consultant urologists with all personnel from the Office of Cancer Services, the Appointments Office and Medical Records involved in the appointment of patients following referral, we were advised that a default system had been put in place to ensure that patients were appointed in chronological order within the category of urgency by which their referral had been submitted.

I also do believe that it is critically important to appreciate the contextual distinction between the triage of Red Flag referrals on the one hand, and Urgent and Routine referrals on the other. Referrals are designated Red Flag by the referrer when a malignancy has been detected or suspected or a significant risk factor of malignancy is present. Upon triage, unless there is good reason, the Red Flag status will be retained, and the patient's assessment and management will be processed in a timely manner, and ideally within the prescribed cancer timelines. An urgent referral may be due to a detected or suspected condition which could be an even greater threat to the patient's life or future health, but which will not be processed with the same alacrity, or within any specified timeline, as does a Red Flag referral. During these recent years, the waiting times for a first consultation for urgent and routine referrals has increased relentlessly, currently 74 weeks for an urgent referral and 146 weeks for a routine referral. The only way of mitigating risk consequential upon such long waiting times, is by arranging further investigations, initiating treatment, informing referrer and patient alike, essentially undertaking a virtual consultation. Doing so necessitates time. The only way of spending such time is to compromise upon the time required to provide optimal care of inpatients while urologist of the week, or

alternatively allow the patient to wait 1.5 years for an urgent consultation, or some combination of both, and which I believe and have argued is unsafe on both counts. In any case, we were not allocated any predictable time at all in our job plans for triage while urologists of the week, and the Southern Trust does not have a Policy and Procedure on Triage, even though it claimed in writing in 2017 that it did do so, and that I was not compliant with it.

It is the Trust's actions since the beginning of 2016 that are the subject of my grievance.

2.3.1: <u>The Letter dated 23rd March 2016</u>

The Trust only raised the concerns with me once and this was in March 2016. This was in a letter dated 23rd March 2016 signed by Eamon Mackle, Associate Medical Director, and Heather Trouton, Assistant Director, which is attached in the schedule of documents at Tab 8.

The origin of this letter appears to be a meeting held by Heather Trouton and Dr Richard Wright, Medical Director on 11th January 2016 at 10am. I do have any Minutes or other record of this meeting. However, Heather Trouton has provided a witness statement which is attached in the schedule of documents at Tab 9. At Paragraph 13 of her statement, she asserts she addressed the concerns with Dr Wright as he was a newly appointed Medical Director and that at that meeting on 11th January 2018, she outlined the concerns to him and that she "*took his advice so we formally addressed the issues via a letter*".

I attended at a short meeting on or around the 23rd March 2016 with Eamon Mackle and Martina Corrigan, Head of Service. They handed me the letter dated 23rd March 2016 at the meeting. The letter makes reference to four areas of concern;

a) Untriaged outpatient referral letters – it was stated there were 253 untriaged letters dating back to December 2014;

b) Current Review Backlog – it was stated there was a review backlog of 679 patients in addition to a cancer review waiting list of 286 patients;

c) Patient Centre Letters – the Letter stated that there was a concern about frustration that there was no record of consultations / discharges on Patient Centre; and

d) Patient Notes at home – the letter asked for notes kept in my home to be brought back to the hospital.

The letter is not described as a formal letter. It does not refer to the Trust Guidelines. It does not state on the face of the letter that it was issued pursuant to any Trust policy or procedure. It does not refer in any way to any suggestion of misconduct or even to a performance issue. Neither expressly nor impliedly can it be interpreted as a formal warning, or any form of disciplinary sanction. Nor could misconduct or lack of performance be inferred from the letter. In fact, the letter starts by stating, "*We are fully aware and appreciate all the hard work, dedication and time spent during the course of your week as Consultant Urologist*". The Trust was indeed fully aware of my workload and was aware that the problems of backlogs could not be related to any lack of effort on my part. I did not have the time to do all that was expected of me to do.

At the meeting, I read the letter and this reminded me of the workload pressures that I knew all too well. I asked Mr Mackle and Ms Corrigan, "*what am I supposed to do?*" **The only response I was given was by Mr Mackle who simply shrugged his shoulders.** Accordingly, I was, yet again, left to deal with the problems alone, and without any input, assistance, intervention, monitoring or supervision by line management or by the Trust. As Dr. Wright said at the meeting of 30 December 2016, "*We left it with you*".

The Trust Guidelines describe how concerns about a Practitioner should be handled. Paragraph 1.5 provides that:

> 1.5 This Guidance, in accordance with the MHPS framework, establishes clear processes for how the Southern Health & Social Care Trust will handle concerns about it's doctors and dentists, to minimise potential risk to patients, practitioners, clinical teams and the organisation. Whatever the source of the concern, the response will be the same, i.e. to:
>
> a) Ascertain quickly what has happened and why
> b) Determine whether there is a continuing risk
> c) Decide whether immediate action is needed to remove the source of the risk
> d) Establish actions to address the underlying problem

Therefore, the Trust Guidelines are designed to provide an overarching and clear process for addressing concerns such as those raised at the meeting of 11th January 2016 and outlined in the letter of 23rd March 2016. At Page 4 of the Trust Guidelines it is stated at Note 1:

> Examples of Concerns may include:- when any aspect of a practitioner's performance or conduct poses a threat or potential threat to patient safety, exposes services to financial or other substantial risks, undermines the reputation or efficiency of services in some significant way, are outside the acceptable practice guidelines and standards.

If the letter of 23rd March 2016 is raising a concern about my performance as opposed to a concern about management, then that concern falls squarely within the definition above. **Yet the Trust Guidelines were completely ignored**.

Firstly, Paragraph 2.2 states, "*Concerns should be raised with the practitioner's Clinical Manager*." My Clinical Manager at that time was Mr Sam Hall or Mr Robin Browne. To my knowledge, the Concerns were not raised with either of those two individuals. I am certain that no Concern/s were ever raised with me by either Mr Hall or Mr Browne.

The Concerns were instead raised with the Medical Director, Dr Wright. Paragraph 2.2 further provides that, "*if the initial report/ concern is made directly to the Medical Director, the Medical Director should accept and record the concern but not seek or receive any significant detail, rather refer the matter to the relevant Clinical Manager. Such concerns will then be subject to the normal process as stated in the remainder of this document*." Again, my Clinical Manager was not informed of these concerns, to the best of my knowledge.

Part 2 and Appendix 1 of the Trust Guidelines describes the process for screening Concerns. The Clinical Manager is to undertake this process. Clearly, that did not happen. It is not at all clear what did happen in the 10 weeks between 10th January 2016 and 23rd March 2016. However, there appears to have been some screening done by some individual or individuals at the direction of the Medical Director who identified the number of patients waiting in a

review backlog and cancer review backlog and the number of untriaged referral letters, since these details are included in the letter of 23rd March 2016.

Had the Trust Guidelines been followed, the process may have lead to an informal local action plan that would likely have resolved all of the issues. I believe that such a plan would have resolved all of the issues because I have been the subject of a return to work action plan since February 2017 and it has been confirmed that these issues are no longer of concern. Paragraph 2.7 provides guidance on a local action plan. It states "*MHPS recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather than solely through formal action".*

Even if the Medical Director had not followed the letter of the Trust Guidelines, the "*General Mutual Obligations*" of my contract of employment ought to have led the Medical Director to seek a collaborative approach. The Trust did not provide any assistance for me whatsoever. No supports were identified, no plan was drawn up.

In failing to follow the Trust Guidelines, the Trust has committed a breach of contract.

2.3.2 Attempts by Clinical Managers

As stated above, there was no follow up with me by the Trust to the letter of 23rd March 2016. Personally, I had been addressing the review backlog issue by taking on *additional* cancer clinics and I was also using any available theatre time to ease the operating waiting lists. My personal initiative was known to Trust management. I did make some headway with the Review Backlog and this was not raised as one of the concerns in December 2016. I have detailed this fully in my response at Tab 5.

Whilst no one spoke to me about the issues, it is clear that Management was considering the issue throughout the summer and autumn of 2016. By around April 2016, Mr Hall had retired and my new Clinical Director was Mr Colin Weir. I was reluctant to speak to any of the individuals who have given statements during the investigation whilst the investigation was ongoing. However, since the investigation has concluded, I have spoken to Mr Weir about a matter raised in his witness statement – which is attached to the schedule of documents at Tab 10.

Mr Weir describes activity in August and September 2016 after he was made aware of the concerns by Dr Charlie McAllister, Associate Medical Director for the Urology Service at that time. Mr Weir has confirmed to me that the concerns had been discussed at least once at the weekly meetings that he had with fellow clinical directors and Associate Medical Director. Both he and Dr McAllister were strongly of the opinion they should address these concerns with me in a constructive and supportive manner in order to see them resolved, *a fortiori* since they had given some thought as to how the backlogs could be addressed.

Mr Weir further described at Paragraph 7 of his statement that he met with Martina Corrigan, the Head of Service around the end of September 2016 and got further information about charts tracked to me, about being behind in triage of GP referrals, and the backlog that needed to be addressed. He was intent on dealing with the matter informally.

However, he was then informed the concerns were to be formally investigated by the Medical Director's office and that Dr Wright was looking at the issues. He describes how Mr Ronan Carroll, Assistant Director, Anaesthetics and Surgery, told him not to have a meeting with me to discuss the issues as they were going to be the subject of the formal investigation by the Medical Director's office. Mr Weir has confirmed to me that it was Mr Carroll who told him this.

Mr Weir is my Clinical Manager pursuant to the Trust Guidelines, and has been in this position since April 2016. Mr Weir is the individual to whom concerns about my performance should have been brought – as stated above. The Trust Guidelines also state that it is the Clinical Manager who should screen the issues to assess the seriousness of the issues. The Clinical Manager would then make a determination with a nominated HR Case Manager as to what action should be taken in response (see Paragraph 2.6. of Tab 4). This could include no action, informal remedial action, formal investigation or exclusion/ restriction (see Appendix 1, Page 8, of Tab 4). If the informal approach is considered appropriate, then consideration must be given to a local action plan which may involve the assistance of NCAS (see Appendix 1, Page 9 of Tab 4). The Clinical Manager would also monitor an action plan and provide feedback as required.

Mr Weir and Mr McAlister were the members of management best placed to assess any issues of concern about my performance. As Clinicians who were familiar with my practice and with my job plan, they were best placed to understand the pressures that I was facing, and to be able to put in place a plan to resolve any concerns.

The Trust has further breached the Trust Guidelines by their failure to allow Mr Weir in particular to take the lead in the handling of the concerns and making the determination as to what form of action should have been taken. I believe that whichever individual/s interfered in the Clinical Manager's assessment process and removed the matter to the Medical Director's Office, such person/s has/ have actively frustrated the operation of the Trust Guidelines. It is not clear to me on what authority this was done.

Furthermore, the Trust Guidelines provide that at the outset of the screening process, the Clinical Manager is required to inform me about the process (See Tab 4, Appendix 1, Page 8). Transparency is a recognized important part of these processes. **Not only did my Clinical Manager not inform me that he was assessing the concerns about my practice, he was in fact instructed not to do so by an Assistant Director, Ronan Carroll**.

2.3.3 Meetings of the Oversight Committee and Communications with NCAS in September/October 2016

On 23rd October 2018, I received an email from Dr Ahmed Kahn in his role as Case Manager (Attached in the Schedule of Documents at Tab 11). In this email, Dr Kahn provided me with a number of documents that I had been requesting for a long time. One document that I received attached to Dr Kahn's email was a letter from NCAS dated 13th September 2016, which is attached at Tab 12 of the Schedule of Documents. I had requested this document because I had a telephone call with Dr Grainne Lynne of NCAS on 11th October 2018, wherein she revealed to me that there had been a communication between NCAS and the Trust in September 2016. I had not been made aware of any of this activity until 11th October 2018.

The letter is from Dr Colin Fitzpatrick of NCAS and details a telephone call between Dr Fitzpatrick and Mr Simon Gibson, Assistant Director at the Medical Director's Office, which took place on 7th September 2016. Mr Gibson had advised Dr Fitzpatrick that;

a) I had a long backlog of review patients of about 700 review patients and that this was different from my consultant colleagues who had managed to clear their backlog. The comparison with my colleagues is inaccurate. I have a copy of the performance data from 13th October 2016 attached at Tab 13 of the Schedule of Documents. This shows that my review backlog was comparable to the backlog of Mr Young who is the only comparable colleague owing to his long years as a Consultant;

b) I was very slow to triage referrals. This is an inaccurate and misleading assertion as I did triage Red Flag referrals in a timely manner, but did not triage Urgent and Routine referrals for the reasons already explained and of which Management had been advised

c) I had been taking patient charts home;

d) My note taking has been reported as very poor and on occasions there are no records of consultations. This is a very serious assertion and a grave potentially actionable misrepresentation. There has not been a suggestion throughout this investigation that I have not taken notes. The concern about patient notes was related to the dictation of letters, often letters discharging patients from my care.

Mr Gibson claimed that I had been spoken to on a number of occasions about my behaviour but that no records were kept of these discussions. I have in fact *not* been spoken to on a number of occasions about my behaviour. The only communication I had was a letter on 23rd March 2016.

Despite the misleading information that Mr Gibson provided, Dr Fitzpatrick advised a supportive, remedial approach. In respect of Mr Gibson's assertion that I was guilty of poor note taking, Dr Fitzpatrick suggested that an audit could be undertaken into the notes and offered the assistance of NCAS in such an audit.

Dr Fitzpatrick also advised that the issues with Triage and the review backlog could best be addressed by meeting with me and agreeing a way forward. He suggested that I could be relieved of theatre duties to allow me to clear the backlog. Dr Fitzpatrick recognized that such a significant backlog would be difficult to clear and that I would require significant support. Dr Fitzpatrick also offered to attend this meeting.

Finally, Dr Fitzpatrick had noted that it would be likely that further input from NCAS would be required and he stated that he would keep a file open on the issues and review the matter in one month – setting a date of 7th October 2016. This review did not take place.

A second document that was attached to Dr Kahn's email is a copy of a record of the meeting of the Oversight Committee on 22nd December 2016 (attached in the Schedule of Documents at Tab 14). This was the first time that I had the opportunity to see this document despite having first requested it on 31st July 2017 by email to Ms Siobhan Hynds (see Tab 15). That fact, alone, comprises a breach of clause 3 of my contract of employment, which provides there should be mutual cooperation as between the Trust and me, and the maintenance of goodwill to ensure the efficient running of the Trust's service.

I wanted to see the Minutes of the Oversight Committee because I had been informed by the Medical Director, Dr Wright (at my first meeting with him about this issue on 30th December 2016) that it was at the meeting of the Oversight Committee in December 2016 that it had been decided to commence a formal investigation and to exclude me from work.

The contents of this record have been particularly disturbing. Whilst there are numerous parts of this record that I will refer to later in this grievance, at this point I am referring to one paragraph. It stated the following as a context for the meeting:

> "On the 13th September 2016, a range of concerns had been identified and considered by the Oversight Committee in relation to Dr O'Brien. A formal investigation was recommended, and advice sought and received from NCAS. It was subsequently identified that a different approach was to be taken, as reported to the Oversight Committee on 12th October.
>
> Dr O'Brien was scheduled to return to work on 2nd January following a period of sick leave, but an ongoing SAI identified further issues of concern".

I have requested the records of the meeting of 13th September 2016 and of the meeting of 12th October 2016. I have not yet been provided with those records.

I am raising the following complaints about these events in this Grievance.

Firstly, the decision to seek advice from NCAS should be taken by a responsible Clinical Manager who is screening the concerns pursuant to the Trust Guidelines at Paragraph 2.6. It is concerning if any manger within the Trust should contact NCAS and open a file related to concerns about a Practitioner without the Practitioner's knowledge and without any explicit authority. I am only aware of the Oversight Committee having met on 13th September 2016 at the earliest. There may well be earlier meetings of which I am not yet aware. I seek clarity on what was the authority pursuant to which Mr Gibson communicated with NCAS about my practice and my behaviour.

Secondly, as any contact with NCAS about my practice should be taken only pursuant to the Trust Guidelines, I should have been informed that a screening process was being undertaken. I was not informed that advice was sought from NCAS in September 2016 for more than two years after the advice was received

Thirdly, I believe that the description of the concerns provided to NCAS was seriously misleading. Mr Gibson described my review backlog as different to my colleagues, who have largely managed to clear their backlog. This is simply false and misleading. Of my four colleagues, only Mr Young is an appropriate comparator since the other three consultants are all more recent appointments. At around that time, Mr Young's review backlog was similar to mine and may have been longer (See Tab 13). Additionally, Mr Gibson was stating that I was not taking on patient consultations. **This is a very serious allegation and it is false. It is not the case and it has never been the case**. Mr Gibson also gave the impression that I had been spoken many times about these issues. **That is also simply untrue**. Mr Gibson also gave the impression that I had received a warning that I was in breach of a Trust Policy on having patient notes at home. This again is manifestly untrue. **I was not warned of a breach of Trust policy.**

Fourth, Mr Gibson received the advice from NCAS to take what could be described as an informal approach. However, the record of the meeting of the Oversight Committee on 22nd December 2016 states that at the meeting of the Oversight Committee on 13th September 2016, a recommendation was made to commence a formal investigation into my practice. This would imply that either the advice from NCAS was not communicated to the Oversight Committee or that the Committee simply ignored the advice.

Fifth, I was not informed about the recommendation that the Oversight Committee made on 13th September 2016. When that recommendation was made, the Trust Guidelines require that a Case Manager is appointed and that the Case Manager would inform me of the investigation in writing. (See Tab 4, Appendix 2)

Sixth, it is stated that a *"different approach"* was to be taken and this was communicated to the Oversight Committee on 12th October 2016. Again, this was not communicated to me.

In any case, **no approach was made to me in line with professional advice from NCAS. I was never approached for a meeting about the concerns to agree a way forward. No offer was made to relieve me theatre duties or any other duties to enable me to clear the backlog**. It is important to note, once again, that I was still working in September and October 2016 and did not in fact take leave for my operation until 15th November 2016. I was reviewing patients and operating on patients and trying to clear an administrative backlog with no assistance or support from the Trust.

Around September 2016, Mr Weir and Mr McAllister, my Clinical Director and Associate Medical Director, had both been minded to formulate a plan to assist me. At around the same time, an independent professional advisory service in NCAS had advised the Medical Director's office that a plan could be agreed for a way forward which could involve relieving me of duties to enable me to clear the backlog. Despite this, a determination was being made to launch a formal investigation into my practice and a determination was made not to communicate with me.

These actions are not the actions of a reasonable employer. They breach the mutual obligations at Clause 3 of my contract of employment (Tab 3) to cooperate with each other and to maintain goodwill as well as breaching Clause 17 which states that "*wherever possible, any issues relating to conduct, competence and behaviour should be identified and resolved without recourse to formal procedures*".

2.3.4. Breach of Agreed Action Plan

Throughout 2016, [redacted]. However, I had undertaken to delay [redacted] for as long as possible to provide support to a Consultant colleague, Mr Suresh. Mr Suresh was having difficulty with the operation of Urologist of the Week, and my other colleagues and I were requested by Management to provide backup support during his week on call. I was providing that support. Mr Suresh confirmed to me that he was returning to a post in England in October 2016 and it was at that point that I decided that I could undergo my [redacted] November 2016.

On 14th November 2016, I received an email from Ms Martina Corrigan, Head of Service, which is attached at Tab 16. The email related to a request for a chart that had been tracked out

to me. I provided the chart that was requested. I also relayed to Ms Corrigan the following at 4.09pm on 14th November 2016:

> "Martina,
>
> As I will be having my [redacted] Thursday morning, I expect to be home again over the weekend.
>
> I expect that I will be well enough to dictate correspondence concerning patients and have charts delivered to Noleen's office for typing.
>
> I would greatly appreciate if I could be afforded this opportunity to have all charts returned in this manner,
>
> Thank you,
>
> Aidan"

The "Noleen" referred to is my secretary, Ms Noleen Elliot. Ms Corrigan responded to this email 5.49pm on 14th November 2016, stating:

> "Aidan,
>
> I am more than happy with this plan, please let me know if there is anything I can do to assist.
>
> By any chance could {PATIENT CHART NAME & NUMBER} be left in as I have had governance looking for this chart as well.
>
> Wishing you all the best for Thursday, please take care
>
> Talk soon
>
> Kind Regards
>
> Martina"

I also confirmed that I had returned the chart whose name and number I have redacted. I left work the following day and I had my [redacted] I had spent the previous months between March 2016 and November 2016 trying to clear the review backlog, particularly as it related to cancer patients, in addition to all of my other commitments in 2016. I was doing so without support from management. I made the suggestion of that plan to Ms Corrigan unaware that senior managers within the Trust had for some time been taking action to commence formal investigations into my practice, or that an Oversight Committee had been established and had already decided two months previously to launch a Formal Investigation, or that the Trust Guidelines had been engaged, and breached.

Ms Corrigan was one of the two individuals who gave me the letter of 23rd March 2016 and I believe that it was reasonable to expect that I could communicate a plan of action to her. In her email response above, Ms Corrigan clearly accepted this plan of proposed action that I should

continue to work whilst I was off on sick leave [redacted]. This plan would have resolved most of the concerns about my administrative practice. I continued to work the following day and then I went on leave [redacted].

My plan was disrupted somewhat when I experienced [redacted] During this period, I was in a great deal of pain and discomfort. Yet, I continued to work at home. However, I responded well to antibiotic treatment and was able to cancel that readmission. Despite that disruption, I was able to reduce significantly the undictated letters by the time I received the invitation of a meeting with the Medical Director on 30th December 2016, by continuing to work from home during my prolonged recovery from [redacted]. In the investigation, the number of undictated letters was stated to be over 600. I doubt that it was ever that high and it has never been made clear to me where this number came from. However, by the time of my exclusion, the number was reduced to 189. I have provided the documentation to the Case Investigator which sets this out, and I have attached a copy in the schedule of documents at Tab 17.

When the Oversight Committee met on 22nd December 2016, they were clearly made aware that I was undertaking this dictation on my sick leave as it is stated in the record at Tab 14 that, "*It was noted as part of this investigation that Dr O'Brien has been undertaking dictation whilst he was on sick leave*".

Despite having knowledge of this agreed plan, the Oversight Committee decided to proceed with a formal investigation into these issues. In the Trust Guidelines at Tab 4, it is stated at Appendix 1 (page 9) that following the informal plan being agreed and implemented with the practitioner, the Clinical Manager monitors the plan and provides regular feedback to the Oversight Committee regarding compliance. It is in instances where the practitioner fails to engage in the informal process that management of the concern will move to the formal process.

Accordingly, the Trust has manifestly committed a further breach of procedure by moving to a formal process whilst I was fully engaged in an agreed action plan.

It is clear that the Trust Management had entirely abandoned any pretence of following the Trust Guidelines at this time. There is nothing in the documentation before me that NCAS was informed that I was compliant with an action plan approved by a Trust manager, and that such compliance continued a time when I was on sick leave and [redacted]

Even in circumstances where the Trust Guidelines were not invoked for whatever reason, it would remain an unreasonable course of action for management to break with a plan that I had agreed with an appropriate manager and with which I was complying. I had a reasonable expectation that I would be given time to address these concerns in this way.

The Trust's actions in this regard further breach Clause 3 of my Contract of Employment (Tab 3).

2.4 The Decision-making and Investigations at or around December 2016

From the time that I was made aware of the investigation into my practice at the meeting on 30th December 2016, I have been unclear about the origins of the investigation. However, my immediate concern was addressing the decision to exclude me and with my desire to get back to work.

On 11th January 2017, I received the formal notification of the formal investigation and exclusion from Dr Wright, which is dated 6th January 2017 (Tab 18). Apart from this notification, I heard nothing from the Trust for over two weeks. I returned all of the charts as requested and remained at home uncertain about what was happening. This experience was profoundly traumatic for me and for my family - as it continues to be. I telephoned Mr Weir, who was originally appointed as Case Investigator on 16th January 2017. Mr Weir had advised me that apart from being informed of his appointment as Case Investigator, he had not yet received any further information at that point. He was only due to meet with the appointed representative from Human Resources for the first time on 26th January 2017 and that no meeting was scheduled to take place with me until after that date. It was concerning to me that the Trust had had no intention of even meeting with me before the four weeks allowed for immediate exclusion. Furthermore, no non-executive director had been appointed at that stage, and to whom I could address my concerns. For that reason, I wrote to the Medical Director on 17th January 2017, to express my concerns about the process at that stage (Tab 19).

Following my telephone call with Mr Weir and my letter to Dr Wright, I received replies form both (Tab 20 and 21). A Non-Executive Director, Mr John Wilkinson, was appointed, and I was invited to a meeting with Mr Weir on 24th January 2017 to put forward alternatives to exclusion. I attended that meeting with my son, Mr Michael O'Brien. A minute of that meeting together with my corrections is attached at Tab 22. Following this meeting, a decision was made to lift the immediate exclusion on 26th January 2016.

With the exclusion lifted, I tried to seek answers about why the investigation had started in this manner and why I had been excluded. On 7th February 2017, I had a meeting with Mr Wilkinson and I gave him a document containing concerns and questions on these issues. This document is attached in the Schedule of Documents at Tab 23. Mr Wilkinson confirmed by letter, dated 13th February 2017, that he was passing these concerns to the Oversight Committee (Tab 24). I received a letter from Dr Khan on 24th February 2017 (Tab 25) which was ostensibly a reply to my list of concerns and questions. However, the correspondence did not answer many of the questions asked.

With so many questions remaining unanswered, I wrote a second list of questions on 6th March 2017 and sent them to Mr Wilkinson (Tab 26). I eventually received a response to this list of questions from Dr Wright on 30th March 2017 (Tab 27).

2.4.1 <u>The SAI Investigation</u>

The responses that I have received to date suggest that it was an investigation into a serious adverse incident (SAI) that brought about the escalation of the response from the Trust. Dr Wright in his letter of 30th March 2017, states that he was "verbally made aware of an ongoing SAI in December 2016, and that this SAI has raised concerns in relation to a Urology patient who may have had a poor clinical outcome due to the lengthy period of time taken to undertake triage."

This was an investigation into a patient who had a delayed diagnosis. Mr Glackin chaired the team who reviewed the SAI. He stated in his witness statement that "there were 3 key issues in this case. The SAI looked at problems with radiology reporting, the second was the failure to understand findings from the x-rays and the triage issue was the least of the 3 issues." The problem with the radiology reporting was found to be the primary contributing factor. The triage issue was the only issue that related to me. The team also reviewed the other 7 patients whose referrals were not triaged on the day when that patient's referral was received and stated that they had been seen by the urology team by the time of the review and "have not been known to have been exposed to significant harm." The SAI review team also noted that, whilst it was outside their remit, they were provided evidence that a significant number of letters within Urology are not being triaged by the minority of the team.

The suggestion that the SAI gave rise to the concerns that led to the decision to commence a formal investigation is implausible and in any case, unreasonable.

Firstly, it is a fact recorded in the minutes of the Oversight Committee of 22nd December 2016 that the recommendation had already been made by 13th September 2016 to commence a formal investigation. Indeed, NCAS had been consulted about this by 7th September 2016. The SAI investigation had not even begun at that time and therefore it is not credible to suggest that it was the SAI that brought about the escalation.

Secondly, in December 2016, the SAI investigation had not reached the stage of even approaching me about the issue around triage. It had not produced any report. It produced its first draft report on 10th January 2017. I submitted my requested response on 25 January 2017. The review team completed a final report on 15th March 2017. Dr Wright was only made aware "verbally" that there was an SAI in late December 2016. He goes on to state that this was communicated to him in the week commencing 19th December 2016 by Ms Esther Gishkori. It is not reasonable for a verbal communication about an incomplete investigation to have resulted in this decision by 22nd December 2016.

Thirdly, the Oversight Committee will have been aware that it is not the purpose of an SAI investigation to attribute blame to any practitioner but rather to conduct a Root-Cause Analysis of the problems. It could not have been reasonable to assume that this related to personal performance or conduct issue on my part.

Fourth, the SAI report is concerned with only one of the issues, triage. The other issues that were to form part of the decision to commence a formal investigation are entirely unrelated to this. Even if the SAI prompted a formal investigation into the issue of triage, it does not explain why the formal investigation covered undictated letters, particularly as I was working to an agreed plan from 14th November 2016 that was dealing with this issue.

In addition to the above, there are details provided to the Oversight Committee on 22nd December 2016 that could not have come from the SAI investigation. Firstly, it is stated by Mr Ronan Carroll that the un-triaged letters were from the period between July 2015 and October 2016. The un-triaged letter that was the subject of the SAI was not within this period and was from October 2014. It is also stated that the SAI identified an additional patient who may have had an unnecessary delay in treatment for the same reason. The SAI report did not identify or refer to any such a patient. and I am, to this day, unaware of the identity of this patient.

The decision to escalate this approach is all the more unreasonable when considered in the context of what is now known about the Trust management's decisions and the advice they received throughout 2016. Management had identified the concerns from the beginning of the year at the latest but they did not consider it necessary to even offer any support or put in place any plan to remedy or resolve their concerns, not even for the purpose of mitigating any perceived or real risk to patient safety. Instead it was left to me, even though they were aware of my additional commitments and undertakings which led to the concerns in the first instance. As Dr Khan stated in his letter to me of 24th February 2017, "it was expected that as an experienced and senior Consultant, this notification of concern to you was sufficient to ensure you took all necessary steps to address the concerns and rectify the identified problems."

When management were aware that Senior Clinical Managers wanted to provide help in August 2016, they did not change their approach. When NCAS identified that I would require considerable support and should be relieved of some duties to enable me to deal with the problems in September 2016, Management still did nothing. They did not even communicate with me to tell me that they had spoken to NCAS.

2.4.2 Decision on Exclusion

The Trust Guidelines at Appendix 5 state that the decision on immediate exclusion "should only be taken in exceptional circumstances and where there is [sic] no alternative ways of managing risks to patients and the public."

In his letter of 30th March 2017, Dr Wright stated that the decision to exclude me was made "to protect you from any further concerns being raised, to protect the interests of patients and to enable the scoping of information to be gathered as part of the investigative process."

When the Oversight Committee decided to commence a formal investigation on 13th September 2016, no exclusion was implemented. I now know that the decision to exclude me was made on 22nd December 2016 by the Oversight Committee and that this decision was not an immediate exclusion within the meaning of the Trust Guidelines, but was in fact a formal exclusion for the duration of the formal investigation. It appears that when Dr Wright spoke to NCAS on 28th December 2016, Dr. Lynn (as related in her letter dated 29th December 2016, attached at Tab 28) advised that there was an option of immediate exclusion, and that it was then that a decision on immediate exclusion was made instead. It is not clear when or if the Oversight Committee was informed about this.

As stated above, when I contacted Mr. Colin Weir on 16th January 2017, it was clear that management had not even intended to have a meeting with me until after 26th January 2017 when Mr. Weir was first scheduled to meet with a representative from Human Resources. It was only after I stressed the urgency of the need to have a meeting to discuss alternatives to exclusion that a meeting was held on 24th January 2017. I proposed alternatives to exclusion at that meeting and on 26th January 2017, a case conference was able to come to the conclusion that I should not be excluded and that there were alternative means of managing any suggested risks.

When the decision to exclude me was being made on the 22nd December 2016, it was recorded that I was scheduled to return to work on 2nd January 2017. The Oversight Committee had at least 10 days at that point to consider alternatives to exclusion. It is clear from the record that the Oversight Committee did not consider any alternatives to exclusion at the meeting nor did

they direct that the time between the meeting and my scheduled return to work be used to consider alternatives to exclusion.

Exclusion is a very serious decision. Pursuant to the Trust Guidelines, it is only to be made in exceptional circumstances and it is only to be made when there are no alternative ways of managing risks to patients and to the public. Moreover, it is clear that when an attempt was made on 24th January 2017 to consider alternatives to exclusion, it was possible to find alternatives. These alternatives included a phased return to work plan with reduced duties for the first few weeks.

The decision made on the 22nd December 2016 is a clear and indefensible breach of the Trust Guidelines and breach of contract. Even if the Trust Management believe that there would not likely have been alternatives to exclusion, it is clear that no effort was made whatsoever to even consider alternatives. That in and of itself is a breach of the Trust Guidelines and a Breach of Contract.

This decision caused indescribable distress to me and to my family. This caused me significant personal injury through the stress that resulted from the decision. Furthermore, the decision caused me actual financial loss as it was also the case that I stopped Private Practice during this period.

2.4.3 Communication with NCAS

I have referred to communication between Dr Wright and Dr Lynn of NCAS on 28th December 2016 above. This was recorded in the letter of Dr Lynne on 29th December 2016 (Tab 22). I was finally provided with this correspondence on 21st October 2018 by email from Dr Khan. I have also spoken to Dr Lynn by telephone about this correspondence since I received it.

I have a number of concerns about the information provided to Dr Lynn. Dr Lynn's letter followed on from Dr Fitzpatrick's letter of 13th September 2016, which she considered and summarised in her own letter. Dr Fitzpatrick had recommended a supportive, collaborative approach to dealing with the concerns. Dr Lynn's advice that "an informal approach is unlikely to resolve the situation" and that "a more formal approach is now warranted" was based on the suggestion that there was "no noted improvement despite the matter having been raised with" me. I am concerned that Dr Lynn was given the impression that the approach suggested by Dr Fitzpatrick had been attempted but had failed. Dr Lynn confirmed to me that this was her impression when we spoke on the telephone in October 2018.

When considering whether there was a need for any exclusion, and particularly in considering whether there was a likelihood of me hindering an investigation, Dr Lynn also related an allegation that "there had been a concern expressed previously about a record missing for 2 years inexplicably appearing on a secretary's desk". I do not know who expressed this concern, or to whom it was expressed. It certainly has never been expressed to me. I have never heard of this occurrence before reading of it in Dr. Lynn's letter in October 2018. I have no idea whatsoever what this allegation relates to. I expect to have this allegation rigorously investigated, and an explanation provided to me. Until this allegation can be strictly proven, it is a further defamatory and actionable statement made to NCAS that has a material impact upon the advice received from NCAS.

I believe that statements have been made to NCAS that were misleading and that that has impacted upon the advice received.

2.4.4 Lack of Transparency in Decision-making process.

In Appendix 2 of the Trust Guidelines, it is stated that the "Case Manager must ensure the Case Investigator gives the Practitioner an opportunity to see all relevant correspondence."

Many of the documents that are pertinent to the issues described above have not been made available to me throughout the investigative process. I first asked for the Minutes of Oversight Committee and the Correspondence with NCAS on 31st July 2017. It took almost 15 months before these documents were provided to me. They were provided by Dr Khan in his email of 21st October 2018. It is clear that they are relevant. I also asked for these documents during meetings that I had with the Case Investigator.

In addition, I was not even made aware that there had been any significant actions or events before December 2016 until I received the aforementioned email from Dr Khan. I was not aware that the Oversight Committee had had meetings on 13th September 2016 and 12th October 2016. I have since requested these minutes but at the time of writing, I have not received them. I was not aware that advice had been sought from NCAS on 7th September 2016 until Dr Lynn informed me of this during our telephone call. Had she not told me about this, I likely would not know about this at all.

I asked very specific questions about Management decision making around this period and I received responses from Dr Wright and Dr Khan that were silent on actions as significant as a decision to commence a formal investigation on 13th September 2016.

Furthermore, none of these details appear in the Case Investigators report or any of the witness statements made in the course of the investigation. This is despite the fact that a specific term of reference of the Investigation was "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."

Management have not been transparent and candid with me, or with the Investigation regarding the decision-making and actions taken in 2016.

2.5 Scoping Exercise

Following my meeting with Dr Wright on 30th December 2016, I was informed that the formal investigation would commence with a preliminary investigation to determine the scope of the investigation. Mr Weir was appointed as Case Investigator.

In her letter of 29th December 2017, Dr Lynn of NCAS had given advice on this:

"The investigation should not be an unfocussed trawl of Dr [O'Brien's] work but we discussed that if there are concerns that patients may not have received appropriate treatment, or that there are patients with inadequate records, then this could be managed separately with an audit/look back to ensure that patients have received the appropriate standard of care. We noted that further preliminary information (such as from the SAI and taking account of Dr

[O'Brien's] comments) may be helpful in determining the scope of the investigation and therefore the ToR."

Despite receiving advice against the conducting an unfocussed investigation, that is precisely what the Trust undertook. At my meeting with Mr Weir on 24th January 2017, I was made aware of the outcome of this scoping exercise and I was provided with an update. It was upon reading this update during the meeting that I became aware that Management had added an additional issue for investigation relating to my private practice.

2.5.1: Case Investigator did not carry out the Investigation

At Part 2.4 above, I mentioned my telephone call with Mr Weir on 16th January 2017. Mr Weir had advised me that apart from being informed of his appointment as Case Investigator, he had not yet received any further information at that point. He was only due to meet with the appointed representative from Human Resources for the first time on 26th January 2017 and that no meeting was scheduled to take place with me until after that date.

It is clear that Mr Weir was not taking part in or overseeing the investigation at that point. I am not clear who it was that was conducting the scoping exercise. However it is clear in the Trust Guidelines that a Case Investigator should be appointed and he or she should be conducting the investigation.

The role of Case Investigator is defined in Appendix 6 of the Trust Guidelines. The Case Investigator examines the relevant evidence in line with agreed terms of reference. In MHPS at Paragraph 8, it is stated that the Case Investigator "is the individual who will carry out the formal investigation and who is responsible for leading the investigation into any allegations or concerns, establishing the facts, and reporting the findings to the Case Manager".

2.5.2: Missing Notes

I was scheduled to meet Mr Weir on 24th January 2017 to consider alternatives to exclusion. In advance of the meeting, Mr Weir wrote to me on 23rd January 2017 attaching a list of 13 sets of patient notes that it was claimed were tracked out to me on PAS but were not located (See Tab 29). On the evening of the 23rd January 2017, I reviewed the patients and completed a response to each query (Tab 30).

Of these 13 sets of notes, eight of these patients had never been seen by me or under my care at all during my 26 years of employment with the Trust. Some of these patients do not even have a recorded clinical episode within the Trust whatsoever. Of the five patients who had been under my care, two were seen by me once each in the 1990s and I have not had their charts since that time or at all and one further patient had died in 2006, after which I definitely returned his chart. A further set of notes was actually returned on the 3rd January 2017, and the final set of notes had been unavailable to me when the patient attended my clinic for review in September 2016. Even though it was claimed that this patient's hospital chart remained tracked to me, it was provided by Records in the usual fashion upon her elective admission for surgery in July 2017.

On the eve of an important meeting at which my exclusion was going to be considered, I was asked to explain the location of missing notes. If these notes were tracked out to me on PAS, in many cases it was for unexplained reasons, given that I had never had any interaction with

them at all. This issue remained live throughout the investigation and the Case Investigator ultimately accepted my explanation for the location of the notes only at the conclusion of the Investigation in June 2018. I had not been advised at an earlier date.

2.5.3 Private Patients

The additional issue added related to private patients. In particular, an allegation had been made that I have given preferential treatment to nine patients who had consulted with me privately, in relation to waiting times for elective admission for prostatic resection as NHS patients.

I was informed of this at the meeting of the 24th January 2017. Mr Weir provided me with a document that included an update from the investigation (Tab 31). Mr Weir appeared to have become aware of the issue on the same date. He expressed the view that it was his experience that patients often consulted privately out of desperation, and as a consequence of their clinical condition.

The document itself stated:

> "A review of TURP patients identified 9 patients who had been seen privately as outpatients, then had their procedure within the NHS. The waiting times for these patients are significantly less than for other patients. Further investigations are on-going".

In Dr Wright's response to my questions on 30th March 2017 (Tab 27), he mentioned that it had been established that there were "at least 9 TURP patients who had been seen privately by you, who were routine in terms of clinical priority, but appeared to have had their NHS procedure done in non-chronological order".

In response to this allegation, I completed an analysis of all of the TURP patients that I operated on in 2016. There were indeed 9 NHS patients who had been seen privately and another 37 patients who had not been seen privately. I provided a breakdown of the waiting times for all of these patients, including a mean waiting time (Tab 32). There was no significant difference. The mean waiting time for the patients who had been seen privately was 202 days and the mean time for the remaining patients was 219 days. The Trust would ultimately change the 9 patients that were of concern and I will address this issue at the conduct panel.

There is no reasonable explanation how a scoping exercise relating to the triaging of GP referrals or the dictation of NHS clinics could give rise to any concerns about my private practice. It is my belief that this allegation was and continues to be a vexatious and frankly malicious attempt to cause me professional reputational harm and significant distress. It had nothing to do with the investigation that was ongoing and nothing to do with the issues of concern.

2.5.4 Failure to Liaise with NCAS

In her letter of 29th December 2016, Dr Grainne Lynn noted that she had discussed with Dr Wright that NCAS would keep their file open. Dr Lynn also stated a review date of 27th January 2017. This review did not take place. In my phone call with Dr Lynn in October 2018, she confirmed to me that NCAS had tried to contact the Trust on occasions in early 2017 but received no response from the Trust and that given the lack of communication, NCAS then proceeded to close their file in May 2017.

I have requested the full file from NCAS under a freedom of information request and it has now been provided to me. It is clear that NCAS made attempts to contact the Trust of 27th January 2017, 30th March 2017 and 30th May 2017. However, the Trust did not cooperate with these requests for a review. This resulted in NCAS closing its file on 30th May 2017. I have attached these emails at Tab 33.

2.6 The Conduct of the Formal Investigation

On 1st October 2018, a decision was made to refer me to a Conduct Panel by the Case Manager. There are many issues that I take with the substantive matters raised during the investigation and the subsequent report and in the Case Manager's determination that I will present during that conduct hearing. However there are several issues or procedural impropriety that I believe are relevant to this grievance and these are addressed below.

2.6.1 Case Conference Determination 26th January 2017

On 26th January 2017, a Case Conference was held to consider my exclusion. I do not have minutes of this meeting. I received a formal notification on 6th February 2017 from Dr Khan setting out the decision of the Case Conference (Tab 34). The Case Conference did lift my exclusion from clinical duties.

The Case Conference also considered a report from the Case Investigator and determined that I had a "case to answer" in respect of all four concerns and that a formal investigation of the issues was required. A decision had already been made by the Oversight Committee to launch a formal investigation and that was ongoing. It is not at all clear what the purpose of this decision was intended to be. There is no part of the Trust Guidelines that mandate this decision.

More concerning, however, is the fact that the Case Manager was involved in the decision that I had a case to answer at an early stage of the investigation and before I had even provided a response as part of that investigation. This was materially prejudicial for clear reasons and makes it impossible for the Case Manager to have an open mind when making a determination at the conclusion of the formal investigation.

2.6.2 Terms of Reference

The Terms of Reference of the Investigation are included at Tab 35.

I was unaware of the advice given by NCAS on 28th December 2016 until I received a copy of the correspondence from Dr Khan on 21st October 2018. It was only upon seeing this advice that I became aware that the Trust had been advised that if there were "concerns that patients may not have received appropriate treatment, or that there are patients with inadequate records, then this could be managed separately with an audit/look back to ensure that patients have received the appropriate standard of care."

The Trust had received advice that a review of the patients could have been conducted separately. This did not have to form part of the investigation into my practice and the Trust has once again taken an approach in conflict with the advice received from NCAS.

Of course, I appreciate that the Trust would have needed to review the patients in question. However, the question of whether or not any patients came to harm is not pertinent to the issue of whether there were concerns about my administrative practices that warranted further action. This decision to enlarge the scope of the investigation unnecessarily had the effect of lengthening the duration of the investigation and in fact, the investigation concluded before the conclusion of investigations into harm caused to patients.

2.6.3 Length of Investigation

The Trust Guidelines state at Appendix 2 that the "Case Investigator must complete the investigation within 4 weeks and submit to the Case Manager within a further 5 days. Independent advice should be sought from NCAS." The time limit is therefore compulsory and any investigation longer than 4 weeks is in breach of the Trust's policy.

I have raised this issue on several occasions throughout this process. The one, only and last time any reference was made to the Trust Guidelines was when I was provided with a copy at the meeting with Dr. Wright and Ms. Hainey on 30th December 2016. In Dr Khan's response to my concerns dated 24th February 2017, he ignored the Trust Guidelines and instead referred to the MHPS framework. MHPS allows for an investigation to take longer than 4 weeks in exceptional circumstances. However, MHPS does not form part of my contract. The Trust Guidelines are the relevant guidelines and they do not allow this extension.

The Trust has continued to ignore and thereby breach its own Policies and Procedures and in doing so, have breached my contract of employment.

The length of the extension of time beyond 4 weeks in this case has also been particularly egregious. The investigation took approximately 18 months to complete. Despite this fact, the findings in relation to the numbers of untriaged patients or undictated letters to GPs has not changed since the meeting on 24th January 2017.

It took a period of 3 months to interview 13 witnesses between March and June 2017. No explanation has been offered for the length of time taken to undertake these interviews.

I eventually was interviewed on 3rd August 2017. This was the first time I had met Dr Neta Chada, who had been appointed as Case Investigator some 6 months earlier. This too was contrary to NCAS Guidelines as these advise that the practitioner should be the first to be interviewed. This interview could not cover all of the issues in the case because on the morning of the interview, Dr Chada had just been provided with an anonymised list of patients whom the Trust alleged had been electively admitted for surgery after a shorter period of time because they previously had had a private consultation (see Tab 39). Dr Chada explained that she herself had just received the list of patients. This resulted in a further delay to conclude my interview. This meeting was not scheduled until 6th November 2017.

This delay is unexplainable and unreasonable. The delay has compounded the stress and anxiety that I have contended with since 30th December 2016. It is a breach of contract and has caused personal injury and damage.

2.7 The Investigation into Patients seen privately

At Paragraph 2.5.3 above, I have detailed my grievance about how an issue regarding the scheduling of patient's that had been seen privately had been added to the areas of concern. For the avoidance of doubt, I wish to state clearly that I have never provided advantageous treatment to a Patient as a result of seeing them privately. I believe that if this issue is put before a conduct panel, I will be able to demonstrate that conclusively. Nonetheless, I am raising in this grievance my concern about how this issue of concern has been approached and investigated by the Trust.

As I have stated above, I was informed of the inclusion of this issue at the meeting of the 24th January 2017 when Mr Weir provided me with a document that included an update from the investigation (Tab 31). The document stated:

"A review of TURP patients identified 9 patients who had been seen privately as outpatients, then had their procedure within the NHS. The waiting times for these patients are significantly less than for other patients. Further investigations are on-going".

In Dr Wright's response to my questions on 30th March 2017 (Tab 27), he mentioned that it had been established that there were "at least 9 TURP patients who had been seen privately by you, who were routine in terms of clinical priority, but appeared to have had their NHS procedure done in non-chronological order".

There are further mentions of this investigation included in the witness statements. In Mr Carroll's statement (Tab 36) he says as follows:

"11. I met with Martina Corrigan, Head of Service to look at the letter from Mr Glackin. I needed to look into his concerns and so we broke the letter down into the separate issue i.e. triage, unreturned patient notes, clinic outcomes etc. Separately I received an e-mail from Mr Haynes. Mr Haynes was aware of a patient seen privately by Mr O'Brien who was treated un-chronologically. As a result of the e-mail, we looked to see if there was a trend for TURP patients to be seen out of sequence and there were a number identified."

I asked for a copy of this email but I have not yet received a copy. I made this request in an email to Dr Khan on 2nd November 2018 (Tab 37). Mr Haynes does mention sending two emails to Michael Young and Martina Corrigan in June and December 2015. It is not clear if either of these emails is the e-mail that Mr Carroll is referring to.

It is clear that there have been several references to a review of TURP patients and a consistent reference to 9 patients having been identified, and who were alleged to have had procedures conducted more quickly. As I have shown, the TURP patients seen privately and publically have broadly similar waiting times (Tab 32).

I was scheduled to meet Dr Chada on 3rd August 2017. I was becoming increasingly concerned about the procedural breaches that the Trust were continuing to commit and to the escalating unfairness of the process. I had not received full documentation in advance of the interview and I would have been expected to comment upon issues that I did not have knowledge of. I wrote to the Case Manager on 30th July 2017. This letter is attached at Tab 38. In this letter I detailed my concerns at that point and I included my concern about the handling of private patients. In reference to the meeting of 24th January 2017 with Mr Weir, I stated:

"It was at that meeting that it was claimed that a fourth issue of concern was identified during the initial scoping exercise and relating to nine patients who had private outpatient consultations, and who then had prostatic resections performed as NHS patients, after waiting times significantly less than for other patients. However, it was not possible for this fourth concern to be identified during scoping of triage of NHS referrals, NHS outpatient consultations and NHS charts retained at my home. I requested how this concern had been raised or who had raised it. I was advised that I would be advised of the source. Six months later, I have still not been advised. I requested the identity of the nine patients concerned. I still have not been advised of their identity. I asked whether patients who had had private consultations and who still awaited prostatic resection had been identified, or whether NHS patients who had prostatic resections performed after a similarly short waiting time would be included in a comparative manner in such an investigation. Indeed, in a further communication from the Medical Director, dated 30 March 2017, he advised that all nine patients were classified as routine. I do not know how he could have come to such a conclusion, or who did so, on his behalf. Now, six months later and four days before interview by the Case Investigator, I have still not been advised of any further developments in the investigation of the fourth concern."

I never received a response to this letter from the Case Manager or from anyone. I met with Dr Neta Chada on 3rd August 2017. Dr Chada mentioned that she was aware of the correspondence and that some consideration was going to be given to the response. At this interview a list of 11 anonymized patients was provided to me (attached at Tab 39), of which 9 were said to have had their surgery performed unreasonably sooner than expected. It was clear at the meeting that Dr Chada had only recently been provided with the list and that she herself was not personally involved in that part of the investigation. Given that no detail had been provided about any of the patients, we could not discuss this issue at the meeting. I was given additional time and a second meeting was subsequently scheduled. Nonetheless, the provision of this list during the meeting was very distressing and impacted upon my ability to represent myself in the interview.

When I reviewed the patients, I discovered that of the 11 patients, only 3 were now prostatic resections (TURP). The other 8 patients were either day case surgery or had had investigative procedures. In all but one of these cases, the stated time periods that the patients had waited prior to the dates of their procedures, were wrong. I provided a corrected list together with a response in respect of each patient which is attached at Tab 40. The Case Investigator has stated in her report that these cases were reviewed by Mr Michael Young and that it is Mr Young's assessment that was being relied upon.

Mr Young provided a witness statement, signed on 5th October 2017 (Tab 41). In response, to the issue of private patients, Mr Young stated:

"33. In respect of TOR 4, I am aware that Mr O'Brien does private consultations at home, he doesn't see private patients in the hospital at all to my knowledge. I know this through conversations with Mr O'Brien. As far as I am aware Mr O'Brien does not perform surgery privately, patients convert to the NHS for their treatment.

34. I can't comment on the placement of private patients in the NHS queue. I don't track Mr O'Brien's patients. Any concerns I heard about private patients were just hearsay. I had no idea when patients were seen by Mr O'Brien at his home. I would have thought patients go on to the NHS list as per clinical priority. I have subsequently heard that some private patients might

have been given dates sooner on the list but I was not aware if this was down to clinical priority. While I have recently heard this, I personally had no evidence of it."

Mr Young's statement clearly contradicts any assertion that he was providing a clinical assessment of the priority given to patients or the appropriateness of their placement on the waiting list.

Dr Chada attached Mr Young's assessment to her report. The assessment is simply a post it note put on each of 11 letters that I had dictated to GP's for private patients. These are attached at Tab 42.

Dr Chada never conducted a comparative analysis of NHS patients. Without such an analysis, it is not possible to state that the private patients were given favourable treatment to NHS patients. I have been able to demonstrate that there was no favourable treatment given to TURP patients and I intend to review all of my elective patients to provide a similar comparison given the Trust's failure to do so. The sum total of the Trust's investigation was 11 post-it notes placed on 11 letters by a colleague who did not appear to know that he was providing an assessment of whether the waiting times were justified.

The investigation of patients seen privately by me has been handled in a vexatious manner. It is my belief that the approach taken has been to cause me the maximum distress and reputational damage. The Trust has not conducted a reasonable investigation into this matter. The Case Investigator was not the individual conducting the investigation. The investigation has not been transparent in providing the basis for which the patients were chosen from all of the procedures conducted in 2016 or the details of the individual/individual(s) who chose them. It is not clear who compiled the list at Tab 39.

As part of my grievance, I am relying on Appendix 2 of the Trust Guidelines where it is stated that the Case Manager must ensure the Case Investigator gives the Practitioner an opportunity to see all relevant correspondence. Accordingly, I am requesting the opportunity to see the following all correspondence that gave rise to the concern about private patients becoming part of this investigation and relating to the handling of the investigation. I believe that it is essential that the Trust be transparent about how these cases came to be assessed.

2.8 Investigation Report

As I have alluded to above, I have significant concerns about the manner in which the investigator's report has been completed. I can provide full detail of these concerns as part of this grievance process. However, I intend to raise these in a submission that I will make before the Conduct panel.

The other concerns I have relate to the apparent failure to attempt to establish key findings of fact and the manifest failure to include and consider mitigation that I provided to the Case Investigator. The key facts relate to the volume of undictated clinics and notes that I had tracked out to me on PAS. These were issues that were in dispute and the information provided by individuals (I am unsure as to who compiled these figures) to the Case Investigator differed from the information that I had collated before returning these files in January 2017. In addition, assertions are made about the amount of administration time provided to me, stating that clinics were shortened and that extra PAs were paid for to allow for more administration

time. This has never been particularised. To date, I am unaware of how the administration time that I have been provided with compares exactly with that of my colleagues. Since completion of the investigation, I have enquired of Mr. Weir whether I had been allocated more time for patient related administration than my colleagues. He has assured me that he is unaware of my having been allocated more time. I believe that any fair and reasonable investigation, properly discharging its function, to be required to clearly establish these findings of fact. The self-evident failure to do so clearly constitutes a breach of sections 3 and 17 of my contract of employment.

In relation to the points of mitigation, I explained the extraordinary pressure that I was under to operate on patients given the length of waiting lists. I provided the Case Investigator with statistics to evidence the amount of additional theatre sessions undertaken for inpatient operative and day-case surgery, as well as data related to the demands from being lead clinician for the Urology MDT, NiCan group and chairing MDM. These documents are attached at Tab 43. **None of these documents were provided as part of the Investigator's report.**

This failure to provide key documentation as part of the Investigator's report represents a clear breach of sections 3 and 17 of my contract of employment, and a breach of Article 6 to the European Convention as provided in the first Schedule to the Human Rights Act 1998.

2.9 Case Manager's Determination

Following receipt of the Case Investigator's report, I provided a response which I have referred to earlier in this grievance, and which is attached at Tab 5. I have further attached the Case Manager's Determination at Tab 44. This was provided to me at a meeting of 1st October 2018. As this determination is largely based on the Investigator's report, many of the concerns about the Investigators report are also repeated in this determination. However, once again, I believe that it is more appropriate to raise the majority of these concerns at the Conduct hearing.

That said, there are three specific concerns that I must raise in this grievance.

2.9.1 Facts not investigated or considered forming part of the Determination.

Section 5 at page 6 of the Determination contains the Case Manager's Determination. As part of that determination, the Case Manager has made assertions that were not subject to the investigation.

There is an assertion that I did not "*adhere to the requirements of the GMC's Good Medical Practice specifically in terms of recording his work clearly and accurately, recording clinical events at the same time of occurrence or as soon as possible afterwards*". This is simply not true. But more than that, this was never the subject of the Formal Investigation. It has never been an allegation or subject of concern relating to the recording of work. I record my work after each episode. The concern that was the subject of the investigation was whether I had followed this by dictating a letter to the GP. Dictating letters to GPs is *not* a requirement in the GMC's Good Medical Practice.

It is a breach of natural justice, and a violation of sections 3 and 17 of my contract of employment, and – moreover – a breach of Article 6 of the European Convention to come to

this conclusion without this issue ever being raised with me during an investigation. If the Trust is making this assertion, then I believe it is reasonable to expect that the Trust would have provided examples of this happening, and that I should have been given a reasonable opportunity to respond to the allegation. None of this has happened despite an investigation lasting approximately 18 months. That this is so add further to the egregiousness, unlawfulness and unfairness of how I have been treated throughout this process.

2.9.3 Failure to consider corrections of factual inaccuracies

The Formal Process outlined at Appendix 2 to the Trust Guidelines provides that the "Case Manager gives the Practitioner an opportunity to comment on the factual content of the report including any mitigation within 10 days." It was within this context that I provided my response at Tab 5.

From page 12 of my response, I provided corrections to the Investigation Report and at page 15, at the first paragraph, I corrected an assertion that I had acknowledged that there were 66 undictated clinics and no dictated outcomes for these. I stated that this was untrue. I provided the correct number of clinics and patients and I provided the Case Manager with the documentation in support of this (Tab 17).

Despite this, the Case Manager writes in his determination at Paragraph 3(a) that:

> "It was found that there were 66 undictated clinics by Mr O'Brien during the period 2015 and 2016. Mr O'Brien accepts this."

It is clear that Case Manager did not consider the Response that I provided to him nor the corrections that were contained therein. This is clear because not only has the Case Manager failed to consider the corrections that I have made but he has gone one step further to falsely state that I have accepted assertions that I directly rebutted.

At the meeting on 1st October 2018 when I was provided with the determination, this point was made to the Case Manager directly. In reply, the Case Manager asserted that "it did not matter whether it was 700 patients or 1".

Despite my grave concerns about the procedural impropriety and unfairness of this process, I have cooperated with this investigation. I have provided representations both upon request and upon my own initiative to ensure that the investigation was informed with factual accuracy. I did so in the face of increasing concern that the investigation was not interested in establishing reliable findings of fact, and that the entire process was prejudicial. I provided these factual corrections to the Case Investigator in August 2017. When I found that the Case Investigator had not referenced nor included my corrections, I then provided them to the Case Manager. The Case Manager's assertion on 1st October 2018 has confirmed my concerns.

In failing to consider the corrections that I have provided, the Case Manager has committed a breach of the Trust Guidelines and this is a further breach of contract.

2.9.3 Failure to consider mitigation

The response that I comprised (Tab 5) provided an historical background to my work at the Urology Service, detailed a criticism of the investigation and provided a response to the specific terms of reference. In addition, the response provided detail of the points in mitigation that I wished to make. I provided substantial detail of the additional workload that I had undertaken in the years before my exclusion. I provided detail of the physical discomfort that I faced whilst waiting for the opportunity to take time for my own Personal information redacted by the USI In addition, I noted that I was additionally assisting Mr Suresh, at the Trust's request, by providing support when he was Urologist of the Week.

None of this mitigation finds its way into the Case Manager's determination. The Case Manager did make a solitary note at an earlier part of the document that I had "*provided a detailed context to the history of the Urology Service and the workload pressures he faced*". However, it does not appear that the Case Manager has considered this relevant to his determination whatsoever.

The failure to consider these factors is prejudicial to any determination of these issues, and represents a breach of the Trust Guidelines and of sections 3 and 17 of my contract of employment, a breach of natural justice, and a breach of Article 6 of the European Convention.

2.9.4 Wrongful Classification of Misconduct

It is my view that the determination has wrongly classified the issues of concern as Misconduct. Appendix 3 of the Trust Guidelines states as follows:

> *"If the Practitioner considers that the case has been wrongly classified as misconduct, they are entitled to use the Trust's Grievance Procedure or make representations to the designated Board Member"*

Accordingly, this grievance filed pursuant to the Trust Grievance Procedure should also be treated as a Grievance in relation to the classification of the case as a case of misconduct. For the reasons outlined at Paragraph 2.7 above, it would be unreasonable to refer the issue relating to private patients to a Conduct panel in any case. In relation to the other concerns, my reasons follow.

At section 3 of the determination, the Case Manager has found that there are no concerns about my clinical ability. I agree that the concerns should not be considered as concerns about my clinical ability. However, the Case Manager goes on to state:

> "It is clear from the report that this has been a consequence of Mr O'Brien's conduct rather than his clinical ability."

It is my view that the Case Manager has erred in coming to the view that if the issues are not a related to my clinical ability, then they must be related to conduct. I contend that it does not follow that these issues are acts of misconduct, even taken at their absolute height.

I believe that it should be clear that I have and continue to work extensive hours over and above my job plan to try to meet the needs of patients as part of a service that is known to be severely stretched. Referring back to the letter given to me on 23rd March 2016, senior management stated, "We are fully aware and appreciate all the hard work, dedication and time spent during

the course of your week as Consultant Urologist". I do not believe that the Case Manager has shown that same awareness.

The reason I was unable to undertake triage of all referrals was because I found that did not have the time to do it. I appreciate that the Case Manager is critical that I did not "ensure managers within the Trust were fully and explicitly aware that [I] was not undertaking routine and urgent triage as was expected", but it is also noted that I had raised on numerous occasions the fact to colleagues and management that I found it impossible to complete triage and that it was known to a range of staff within the Directorate that I did not complete triage and that as a consequence, a default system had been put in place to deal with this. The Investigation report provides examples of individual witnesses relating that I said, on numerous occasions that I could not complete triage. This could not be considered to be a case where any reasonable decision maker could conclude that I was wilfully failing to meet any expectation or deliberately failing to inform management.

Taken at its very height, a reasonable employer would not consider this to be a misconduct issue but rather a performance issue. Furthermore, to the extent that it could be considered a performance issue, it is a performance issue that has been resolved. Since my return to work on 20th February 2017, I have completed all triage in a timely manner. I have done this by taking a day of annual leave after my week as Urologist of the Week to undertake triage, in my own time. In doing so, I have conducted up to 65 virtual consultations with patients, advising them of investigations requested and treatment to be initiated, in addition to dictating letters to referrers, GPs and patients. This has been equivalent to conducting up to nine additional New Patient Clinics, whilst Urologist of the Week and during the days following Urologist of the Week. Latterly, during this past month of November 2018, the Trust has accepted that additional time was required for consultants to undertake triage, and that new job plans for all consultants will include additional sessions, out of hours, to complete triage.

With regard to the dictation of GP letters and outcomes, it is my belief that the Case Manager has fundamentally misunderstood the issue. His reference to the GMC Good Medical Practice indicates that he is of the belief that there was a failure to record work following reviews of patients. However, I have always made legible, written notes of consultations in the patient's charts, and, in addition, as a clinical summary or update on CaPPS (the Cancer Patient Pathway System), as required by the National Cancer Plan. The issue that was being investigated was whether I was also dictating letters following each patient consultation. The Trust was certainly aware that there was a backlog with regard to this administration. As stated at Paragraph 2.3.4 above, I had agreed an action plan with the Head of Service on 14th November 2016 to resolve this issue and I had already made substantial progress in entirely addressing the issue before my exclusion on 30th December 2016.

Accordingly, this was not an issue about misconduct. I was working to the best of my ability to clear this backlog and I had been open about asking for time to address it. Taken at its height, a reasonable employer would have considered this to be a performance issue and a performance issue that has been resolved since I returned to work. There are a number of reasons why I have been able to resolve this. The first reason was that the backlog that had built up was taken away from me as a direct consequence of the investigation. For the first month of my return to work, I was unable to undertake clinics or operating sessions because the schedules had already been completed prior to my return. This enabled me to complete any outstanding administration work that had not been taken away as part of the investigation. I have been able to avoid any further backlog developing because I have declined to take on extra theatre sessions and extra

clinics. Additionally, in more recent months my job plan has been revised and I am now completing one less clinic per week. This means that I have less administration to complete and more time to complete it.

The Case Manager acknowledges that I have worked successfully to the action plan since my return to work in February 2017. I have done this without assistance or support from the Trust. Paradoxically, this fact appears to be considered as an aggravating factor rather than a mitigating factor. On the 31st October 2018, the Case Manager had a further communication with Dr Lynn of NCAS which is recorded in a letter of 6th November 2018 (Tab 45). In this letter the fact that I have been able to undertake my work satisfactorily without additional support has been raised in support of the decision to send this matter to a conduct hearing.

I contend that the Case Manager has erred in his classification of the concerns as misconduct and I am invoking Appendix 5 of the Trust Guidelines and formally requesting that this determination be reconsidered. This position is clearly unreasonable and the Case Manager has failed to take into account the further sacrifices that have been made to ensure that all expectations are being met. It is in breach of Sections 3 and 17 of the Contract of Employment.

2.10 Events since the Case Manager's Determination

I was provided with the Case Manager's Determination on the 1st October 2018. I was accompanied by my wife and my son. The meeting was a devastating experience. During the meeting, I did raise once again the fact that I had not been provided with certain documents that I had been requesting for a considerable period of time and I agreed that I would write an email to further request the documents. I did so that evening. Whilst my email was acknowledged I did not receive the documents for a number of weeks.

On 11th October 2018, I had my first call with Dr Lynn of NCAS and I learned about the earlier correspondence between NCAS and the Trust. Dr Lynn had agreed with me that she would inform Dr Khan of our conversation. By the 23rd October 2018, I had still not received the documents. I wrote again to Dr Khan on 23rd October 2018, requesting the documents once more and further documents in light of what Dr Lynn had informed me. The chain of emails has been previously referenced and is attached at Tab 11.

During the last two months, the Trust has engaged in further activity that I have serious concerns about and I have contend have amounted to harassment and in breach of the Trust's "Working Well Together Policy" of July 2009.

2.10.1 Further Requests for Notes

During the Scoping Exercise, I was advised on 23rd January 2017 of all the charts that had been tracked out to me that remained unaccounted for. I provided a full response to this and this has been accepted. I have detailed this issue at Paragraph 2.5.2 above.

Since my return to work on 20th February 2017, there has been only one meeting to discuss my job plan. I attended the meeting on 25th July 2017 with Ms Corrigan, Mr Carroll and Mr Weir. In advance of the meeting, Ms Corrigan on 19th July 2017 provided me with an update which I have attached at Tab 46 relating to all charts that had been tracked out to me at that time and this referenced the length of time that they had been tracked out to me. The earliest was noted as 3rd February 2017. No charts were tracked out to me from an earlier date.

On 18th October 2018, I was advised by my secretary Ms Elliot that Ms Wendy Clayton, Head of Service had made an enquiry about whether my office was open because she wanted to see what charts were in my office.

In the afternoon 19th October 2018, my secretary received a further call to enquire where I was. My Secretary advised that I was in my office. Approximately an hour later, Mr Carroll's secretary attended at my office. I was in in the middle of a call relating to a patient. Mr Carroll's secretary advised me that she was seeking three sets of patient notes that had been tracked out to me and she had the patient numbers on a Post-it note. As I was busy on the call, she suggested she could come back at a later time. However, I suggested that she leave the Post-it note with me and I would address the issue. The Post-it note is attached at Tab 47. One chart related to a patient I had reviewed on the 25th September 2018.

The request for the other two charts is a cause for grave concern. The first chart related to a patient who had died on 30th August 1997, and who had never been a urological patient. This patient's chart was not amongst the 13 sets notes that were said to be unaccounted for in January 2017. I subsequently related my concerns to Mr. Weir, Clinical Director, who subsequently advised me that he had been advised that the direction to have my office searched for these two charts had come from the Medical Director's Office.

There is no reason why this set of patient notes referred would ever have been tracked out to me. I cannot comprehend how this would not have been picked up when the Trust reviewed what charts were tracked out to me but were unaccounted for during the scoping exercise. I also cannot understand how they would not have been picked up when Ms Corrigan completed "*a fresh report*" on 19th July 2017.

The second chart related to a patient who has been allocated a Banbridge Hospital number, but who has never had a clinical episode at any Southern Trust facility, documented on PAS, and has no record on NIECR. This patient was one of the 13 patients whose notes were unaccounted for on 23rd January 2017. I provided a response in respect of this patient on 24th January 2017 and this response has been accepted by the Case Investigator provided in June 2018.

That the Trust as my employer continues to search for a patient file which has already been accepted to not be in my possession at all relevant times raises the grave suspicion in my mind that there is an ongoing campaign against me to attribute a missing patient file to me.

At around 12pm on 23rd October 2018, Collette McCaul, Line Manager to the Personal Secretaries, arrived at my office in my absence asking my secretary for admission into my office to count the number of charts in my office and to ask why they are there. It was also the 23rd October 2018 at 4:57pm when Dr Khan replied to my repeated requests for the outstanding documents (Tab 11). At the end of that email, Dr Khan asked "*Aidan, I take this opportunity to ask if you are adherent to agreed MHPS action plan (attached)?"*

I am concerned that notes are being tracked out to me without my knowledge and there may be attempts to hold me responsible for notes that I have not sought and that I have had no reason to seek. These actions have resulted in concern that there may be further unfounded allegations made against me.

Following these incidents, I made a telephone call to Mr Weir, as my line manager. Mr Weir advised me that he would find out what was happening and put a stop to it. Mr Weir advised me that he spoke to Mr Carroll and Ms Clayton. He was informed that these requests would not be made through him as my line manager. Following Mr Weir's intervention, there was a pause in these searches.

However, I have been informed that a further request was made of my secretary on 16th November 2018 to count the number of charts in my office.

I have raised this issue informally with my line manager in line with Stage 1 of the Working Well Together Policy. As there has been a further search of my office, I am now proceedings to engage Stage 2 of this Policy entitled "Formal Process". I seek an assurance in writing that there will be no further searches of my office pending the outcome of this grievance and that requests of this nature will cease.

2.10.2 Unlawful Deduction of Wages

On occasions where I work extra sessions as a locum consultant, I must submit claim forms for payment. The procedure is that if I submit the claim form within the first five working days on the month, the payment will be made by the end of the month.

On 6th September 2018, I submitted a completed claim form for payment of £Personal Information, due and owing for work as locum consultant urologist during July and August 2018. This claim was made to Mrs. Martina Corrigan on 6th September 2018. The 6th September was the fourth working day of the month. I received an automated email response from Mrs Corrigan, confirming receipt.

On failing to receive payment in September 2018, and upon further enquiry, Mrs. Corrigan advised by text that the claim had been approved by Mr. Mark Haynes, Associate Medical Director, and the Director. At this stage I presumed that the payment would be received at the end of October 2018.

When the payment was not been received in October 2018 I made further enquiries. I asked Mr Haynes to confirm that he had approved the payment. Mr. Haynes confirmed, both by text and verbally, that he had it approved immediately upon request in early September 2018.

I have finally received this payment today, two months after it fell due and owing.

On 7th November 2018, I wrote a letter to Mrs Esther Gishkori, Associate Director, to addressing my grievance about an unlawful deduction of wages. This letter is attached at Tab 48. I have regarded the failure to make this payment as an unauthorised deduction of wages, pursuant to Article 45 of the Employment Rights (NI) Order 1996. It was a further breach of contract. I request an investigation into why this deduction had been made and a full explanation to be provided.

To date I have received no response to this letter.

The Trust has a history of making unlawful deductions from my wages. I had previously addressed a formal written grievance to the former Medical Director, Dr Gillian Rankin, on

30th January 2012. This is attached at Tab 49. I never received an explanation as to why those deductions were made. I now formally reactivate this grievance.

2.11 Duty of Clinical Care

Prior to concluding this formal grievance, I wish to take this opportunity to express my concerns regarding the Trust's duty of care to its urological patients, and particularly as that duty of care has been breached by the Investigation itself.

During these past 26 years, I have worked well beyond any expectation to maximise the care that I could possibly provide to those in most need of it. During more recent years, I have carried out additional operating in order to minimise actual and potential harm to patients. During recent years, I did not take annual leave on any available operating day in order to do. A record of the additional sessions for the years 2012 – 2016 were submitted to the Case Investigator who chose not to include the record or refer to it in her Report to the Case Manager. A record of additional clinics during the same five years suffered a similar fate.

During my sick leave in November and December 2016, I continued to work. By the time of my scheduled return to work in January 2017, I had timetabled operating for that month, and had scheduled clinics for January and February 2017. The devastation that I experienced in my meeting with Dr. Wright and Ms. Hainey on 30 December 2016 was exacerbated by my concern for the welfare of the patients whose surgery and review I had scheduled. I pleaded with Dr. Wright to allow me to process the remaining 189 patients, but he refused to allow that to be done, insisting that these patients' charts be returned by 03 January 2018. Dr. Wright subsequently informed me in writing that these charts would be returned to my office so that they could be processed. They never were. Six months later, in June 2017, I learned that their outcomes had still not been processed or implemented. Whilst their outcomes were then implemented on PAS, letters were never dictated.

During the course of the investigation, I was advised that 24 patients referred as urgent or routine, had subsequently been upgraded to Red Flag status, and of these, four had a diagnosis of cancer. The delays between referral and diagnosis of cancer had been 238 days, 207 days, 179 days and 151 days. There had been a period of 282 days between my receipt of the letter of 23 March 2016 and the meeting with Dr. Wright on 30 December 2016. There were 354 days between Ms. Helen Trouton's meeting with Dr. Wright in January 2016 and my meeting with Dr. Wright in December 2016. If the actions of the Trust had been different in during 2016, **none** of these patients would have had a delayed diagnosis.

Scheduled reviews of patients in the early months of 2017 were cancelled as a consequence of my exclusion which was subsequently considered to have been unnecessary. Some of these patients are still awaiting review. Two who have their reviews only recently scheduled have had cancer diagnoses confirmed since 01 October 2018, one of whom has advanced prostatic carcinoma. **These delayed diagnoses have been solely, exclusively and directly a result of the investigation and of my exclusion**.

Meanwhile, the same Trust management personnel have overseen an increasing disparity between urological waiting list and those for other specialties, and to the extent that, in June 2018, there were 597 patients awaiting urgent elective admission for surgery up to 208 weeks, while there were only 28 patients awaiting urgent elective gynaecological surgery, the longest waiting up to 11 weeks. Those awaiting elective admission for urological surgery, now dating

back to August 2014, include approximately 400 patients awaiting prostatic resection. Based on international data it can be expected that at least 10% of these, some 40 patients, will have a delayed diagnosis of prostatic carcinoma.

It has appeared to me that the conduct of Trust management personnel since January 2016 has been a case of purpose replaced by process, conducted improperly.

For the avoidance of all doubt, let it be clearly understood that I am disclosing these facts not merely in my own interests as part of my grievance but in the interests of the public in general and these urological patients in particular.

3. The Issues

In this section of the grievance, I summarise the issues referred to above. References to Paragraphs or Appendices in this section are references to the Trust Guidelines unless expressly stated otherwise.

3.1 In respect of the handling of the concerns in March 2016:

a) The Trust breached Paragraph 1.5 by failing the handle the concerns in accordance with these procedures.

b) The Trust failed to raise the concerns with my Clinical Manager, but they were instead raised with the Medical Director in breach of Paragraph 2.2.

c) Upon receipt of the concerns, the Medical Director failed to direct the concerns to my Clinical Manager in breach of Paragraph 2.2.

d) An initial verification of the concerns was not undertaken by my Clinical Manager in breach of Paragraph 2.4.

e) The Trust failed to offer any support to me when addressing the letter to me and when I asked for some guidance, none was provided. This is in breach of the General Mutual Obligations of my Contract of Employment.

3.2 In respect of the frustration of attempts by Clinical Managers to assist me:

a) The Trust failed to allow my Clinical Managers to take the lead in handling the concerns and in failing to do so, breached Paragraph 2.2.

b) Individual servants/agents of the Trust actively frustrated efforts to assist me by informing the Clinical Manager not to address the concerns with me.

c) The Trust has breached Appendix 1 of the Trust Guidelines by failing to inform me that issues of concern about my practice were being screened.

3.3 In respect of the Communication with NCAS and meetings of the Oversight Committee in September/October 2016.

a) The communication with NCAS was not undertaken by the responsible Clinical Manager in breach of Paragraph 2.6.

b) The Trust failed to inform me that advice had been sought from NCAS

c) In communicating with NCAS, the Trust made several misrepresentations including a false and libellous allegation that I was not taking notes on patient consultations.

d) The advice offered by NCAS on 7th September 2016 was not considered by the Oversight Committee on 13th September 2016. This is in breach of the Oversight Committees stated role to promote fairness, transparency and consistency of approach pursuant to Paragraph 2.8.

e) The Trust failed to inform me about the recommendation from the Oversight Committee on 13th September 2016 to commence a formal investigation.

f) The Trust failed to inform me of the approach taken by the Oversight Committee on 12th October 2016, breaching the requirements of transparency in Paragraph 2.8.

g) The Trust failed to make an approach in line with the advice of NCAS given on the 7th September 2018 in breach of section 3 and section 17 of my contract of Employment.

3.4 In respect of the breach of the agreed Action Plan of 14th November 2016

a) The escalation to a formal investigation in and around December 2016 broke away from an agreed action plan which I was fully engaged with and in doing so the Trust breached Appendix 1 of the Guidelines and also section 3 of my Contract of Employment.

3.5 In respect of the Decision-making and Investigations at or around December 2016

a) In all of the circumstances, Senior Management's decision to move to a formal investigation on foot of being informed of the Serious Adverse Incident was so unreasonable that no reasonable employer would have made that decision.

3.6 In respect of the Decision on Immediate Exclusion

a) The Oversight Committee breached Appendix 5 in failing to regard Immediate Exclusion as a step to be taken in exceptional circumstances and where there are no alternative ways of managing risks.

b) Between 22nd December 2016 when Immediate Exclusion was recommended and 2nd January 2017 when I was due to return to work following sick leave, the Trust failed to consider alternatives to exclusion in breach of Appendix 5.

3.7 In respect of the Communication with NCAS on 28th December 2016

a) The Trust failed to advise NCAS that the Trust had not followed the advice previously provided to them on 7th September 2016.

b) The Trust made a further false and actionable statement that there would be concerns that I would hinder an investigation due to a previous concern about a record missing for 2 years inexplicably appearing on a secretary's desk.

3.8 In respect of the Lack of Transparency in Decision-making Process

a) The Case Manager failed to ensure that I had an opportunity to see relevant correspondence during the investigation in breach of Appendix 2. This included the Minutes of the Oversight Committee meetings and the correspondence with NCAS.

b) The Trust failed to ensure that the Case Investigator was aware of the meetings of the Oversight Committee in September and October 2016 and the correspondence with NCAS in September 2016 despite this falling under the Investigator's terms of reference.

3.9 In respect of the Conduct of the Preliminary Investigation in January 2017.

a) The appointed Case Investigator did not conduct the Preliminary Investigation in breach of Appendix 6 and Paragraph 8 of MHPS.

b) The Trust breached the requirements of fairness and natural justice when it required me to explain the whereabouts of 13 sets of patient notes on the eve of the meeting of 24th January 2017 when I was due to discuss alternatives to exclusion.

c) The Trust conducted an unfocused trawl through unrelated issues and added the issue relating to Private Patients despite this being entirely unrelated to the issues of concern. In doing so the Trust carried out a preliminary investigation that was prejudicial and procedurally unfair.

d) The Trust failed to cooperate with NCAS by failing to review the process as agreed on 28th December 2016.

3.10 In respect of the Conduct of the Formal Investigation

a) The Case Manager and/or the Case Conference determined that I had a "Case to Answer" on 26th January 2016 before the completion of an investigation thereby prejudicing the Formal Investigation at its inception.

b) The Trust failed to follow the advice of NCAS by not separating any look back exercise into the treatment of patients from the Formal Investigation.

c) The Trust have breached the requirement of Appendix 2 of the Trust Guidelines by failing the conclude the investigation within 4 weeks.

d) By conducting an investigation for 18 months, the Trust have breached my right to have a determination made subject to a fair hearing within a reasonable time as guaranteed under Article 6 of the European Convention of Human Rights and the rights to natural justice.

3.11 In respect of the Investigation into my Private Practice

a) The Case Investigator did not conduct a reasonable investigation into the private patients and did not seek to establish key facts about the length of time waited by those patients or whether there were substantial differences in treatment by conducting a comparative analysis with NHS patients in breach of Appendix 6 of the Trust Guidelines and Paragraph 8 of MHPS.

b) The Trust has failed to be transparent in providing me with relevant correspondence in relation to this investigation in breach of Appendix 2.

3.12 In respect of the Investigator's Report.

a) The Case Investigator failed to establish key facts around the numbers of patients affected by the issues of concern and the amount of administration time provided to me as compared to my colleagues.

b) The Case Investigator failed to include in her report documents that I had provided showing the additional workload undertaken in the years 2012-2016.

3.13 In respect of the Case Managers Determination

a) The Case Manager has failed to ensure that I was given an opportunity to respond to a concern about following the requirements of GMC Good Medical Practice Guidance by making this assertion for the first time in his determination without putting this to me. This in breach of Appendix 2.

b) The Case Manager has failed to have regard to the points raised in Mitigation.

3.14 In respect of the Classification of Misconduct

It is my contention that the issues of concern have been incorrectly categorized as misconduct and in making his determination the Case Manager failed to have regard to the following facts:

a) I had made efforts to meet expectation relating to my administrative work expectation and there is no suggestion that any failure was due to a lack of effort.

b) I had made numerous attempts to raise that I found it impossible to complete triage.

c) Numerous witnesses confirm that I had raised this issue and they were aware that I was having difficulty completing triage.

d) I had always completed a note on patients' charts in respect of any consultation.

e) I had agreed an action plan with the Head of Service to complete the remaining dictation during my sick leave.

f) I had completed dictation on over 60% of the patients seen in the clinics concerned.

g) I have made significant efforts to address these issues since my return to work in February 2017.

3.15 In respect of the Events since the Case Manager's determination.

a) The Trust has instructed to staff to make several unreasonable interventions in my practice and the cumulative effect of these interventions amounts to harassment.

b) The Trust has made an unlawful deduction of wages contrary to Article 45 of the Employment Rights (Northern Ireland) Order 1996.

c) The Trust has failed to acknowledge my written grievance regarding the unlawful deduction of wages.

4. The Details of the Immediate Action that the Trust is Expected to Take

This grievance includes a grievance about the misclassification of concerns as concerns relating to misconduct pursuant to the Trust Guidelines at Appendix 3. The Trust should immediately confirm that no steps will be made to bring these matters to a Conduct panel before this grievance has been resolved.

I seek an immediate acknowledgement of receipt of this grievance within 36 hours of the date presentation. Further, I expect that it will be confirmed that the Trust will arrange for a preliminary meeting to take place to discuss the next steps in addressing this grievance as early as possible **and in any case within two weeks of the date of this letter**.

The Trust is expected to be in a position to set out what steps will be taken to address this grievance within two weeks.

5. The Details of any Documents that are Considered Relevant and Necessary

I request that the following documents be provided by 15th December 2018.

i) My Personnel File

ii) The Minutes of the meeting of the Oversight Committee of 13 September 2016.

iii) The Minutes of the meeting of the Oversight Committee of 12 October 2016.

iv) All Minutes, notes or records pertaining to any and all meetings or case conferences of the Oversight Committee relating to my practice from 2015 to date.

v) All Minutes, notes or records of the meeting held by Ms. Heather Trouton and the Medical Director on 11 January 2016 at 10.00 am, and to which Ms. Trouton referred in her unsigned, undated witness statement.

vi) The correspondence from Mr. A. Glackin to Mr. R. Carroll and to Ms. E. Gishkori relating to my practice, and to which Mr. Carroll referred at Paragraph 9 of his witness statement of 17 August 2017.

vii) The email sent from Mr. M. Haynes, received by Mr. R. Carroll and relating to concerns regarding my private practice, and to which Mr. Carroll referred at Paragraph 11 of his witness statement of 17 August 2017.

viii) All correspondence about my practice sent between and amongst management in 2016.

ix) All Minutes, notes or records of any meetings or discussions by management regarding me and my practice in 2016.

6. Proposed Reply Date

I should be grateful to receive your response and the information and documentation requested by 15th December 2018.

Please be advised that if there is no response to this correspondence, I will conclude that I have exhausted my internal remedies.

I look forward to receiving your response.

Yours sincerely

Aidan O'Brien

Hynds, Siobhan

From: Khan, Ahmed [redacted]
Sent: 03 December 2018 10:35
To: Hynds, Siobhan
Subject: FW: Re; MHPS Investigation

Follow Up Flag: Follow up
Flag Status: Flagged

Siobhan, FYI

AK

From: O'Brien, Aidan
Sent: 02 December 2018 22:39
To: Khan, Ahmed
Cc: Wilkinson, John
Subject: RE: Re; MHPS Investigation

Dear Dr. Khan,

In response to your email of 28 November 2018, please be advised as follows;

1. I have submitted an extensive Formal Written Grievance, dated 27 November 2018, to the Chief Executive of the Southern Health & Social Care Trust, Mr. Shane Devlin, in person, on Friday 30 November 2018. In doing so, I have requested that the Trust should immediately confirm that no steps will be taken to bring matters to a Conduct Panel hearing until the Grievance has been fully resolved.

2. This notwithstanding, all clinical scheduling for the month of January 2019 has been arranged.

3. The scheduling of clinical commitments is further exacerbated by the requirement of both Mr. Michael Young and myself to be available as witnesses in a civil action listed for hearing by the High Court during the week beginning Monday 21 January 2019. If this matter proceeds as listed, we would wish to be available to the High Court, whilst minimising disruption of clinical services. Therefore, I would not be available to attend a Conduct Panel hearing until February 2019 or thereafter.

4. For the avoidance of any doubt, I shall not notify of my availability to attend a Conduct Panel Hearing until I have received all documentation previously and repeatedly requested, most recently to you on 02 November 2018, and requested once again on foot of the Grievance, and by Notice of this email, nor shall I do likewise until I have received complete, strict proof of each and all of the contentions made by Ms. Siobhan Hynds, and all documentary proof of same, as detailed in my letter to you, dated 12 November 2018.

5. Moreover, I shall not notify you of my availability to attend a Conduct Panel Hearing until I have been provided with the following;

(A) All documentation pertaining to the Charge or Charges I must answer at the Conduct Panel;

(B) A complete and definitive list of the Witnesses to be called by the Trust;

(C) A complete Book / File of the documentation that the Trust intends to submit to the Conduct Hearing.

On foot of receipt of 5(A)-(C), I shall, in return, then submit to the Trust a complete list of the Witnesses I will call to the Hearing, and a complete File of the documentation which I would intend to submit to the Hearing.

When the above has been completed, I would then be in a position to advise of my availability.

Yours sincerely,

Aidan O'Brien.

From: Khan, Ahmed
Sent: 28 November 2018 12:53
To: O'Brien, Aidan
Cc: Hynds, Siobhan; Wilkinson, John
Subject: Re; MHPS Investigation
Importance: High

Dear Mr O'Brien

I have forwarded your attached email to Mrs Siobhan Hynds.

We have also been working to identify a suitable date for the MHPS conduct hearing we discussed at our meeting on 1st October. There are a significant number of diaries to be co-ordinated and a number of dates we were holding in November and December are no longer viable due to the diary commitments of others.

I am therefore contacting you to let you know that it is likely it will early January before a date is able to be confirmed. To this end, I would be grateful if you could let me know your availability for a full day hearing in the first 3 weeks of January. You will need to ensure your representative is also available. I will try to co-ordinate other diaries around your availability.

All paperwork for the hearing will be shared with you in advance of any date set for the hearing.

Please don't hesitate to contact me if required.

Regards,
Ahmed

Dr Ahmed Khan
Case Manager- MHPS
Interim Medical Director
SHSCT

to suggest that Mr. O'Brien wasn't clearly and accurately writing a note into the patient's record following the encounter. They are two different things, are they not?

A. Yes. They are two separate things but they are interlinked in a way. 14:21

101 Q. You, with respect, have suggested that the offence or the shortcoming is the latter when, in fact, it was a dictation issue that was front and central of the investigation. Do you accept that? 14:21

A. Yes, that's the terms of reference. That's correct.

102 Q. Looking then at your determination, you have set out the advice that you have received. Let's just deal with the misconduct issue. If we go over the page, page 910 for you. If we scroll down, thank you. You 14:21 decided that you don't consider an exclusion from work to be necessary. Let's deal with that, sorry, a restriction on practice. The top of the page.

You set out the purpose of the action plan. As you 14:22 were reflecting just before lunch, you considered that a fresh action plan was necessary; isn't that's right?

A. That's correct, yes. So as part of adding this into my determination, I was very clear in my mind what part would be necessary in terms of having a continuous and 14:22 ongoing assurance. The action plan would have a number of elements. The first element is how the action plan should be developed in consultation with NCAS, Mr. O'Brien, and the Trust coming together, putting

together an action business plan which is, in essence, a combination of, you know, minds and brain coming together forming this action plan which will be owned by the consultant as well, and the Trust in terms of monitoring. That was the first element. 14:23

But then the monitoring of that action plan was not necessarily an operational line manager's, but I wish to add that into -- the clinical and the line management structure to the monitoring support and 14:23 escalation. Then at the same time, I wanted to include an agreed job plan, an enhanced appraisal element into part of the action plan as well.

103 Q. In terms of the scope of the action plan, you've described a need, in this second paragraph at the top 14:24 of the page, for continuing assurance about Mr. O'Brien's administrative practice and management of his workload. Did you anticipate that this action plan, if it had been developed at this time, would have scrutinised any other aspects of his practice, whether 14:24 other administrative issues or even clinical issues, or did you think in the alternative that you would be repeating the same issues that were the subject of the existing action plan?

A. So my thinking of developing the action plan in 14:25 consultation with NCAS, and Mr. O'Brien as well, to expand the action plan more a little bit wider to include the administrative practice but which can lead to poor clinical performance or poor clinical outcomes.

So, expanding that in a way that it will cover broader elements of Mr. O'Brien's practice into the action plan.

104 Q. The role of NCAS in providing professional support, how did you anticipate that that might work? They had sent you the forms, as we saw. They can be found at page 900 of your bundle. I needn't bring them up on this screen. Did you think that that element was going to be important? 14:25

A. I felt that inclusion of NCAS into the action plan formation and putting together would be very useful. I had no previous experience of putting together an action plan with NCAS, and I had no previous understanding or experience of involving NCAS in relation to that. It wasn't very explicit or clear in my mind how, but I felt it would be necessary to involve NCAS into the formation of a further going-forward action plan. 14:26 14:26

105 Q. In terms of the ownership of this issue, who did you understand would be responsible for taking this forward? 14:27

A. So, as for the implementation of action plan, I suppose the three elements in my determination were presented and I provided this to the Chief Executive, the Director of HR and the Medical Director. So, I suppose, it was in combination with the Acute Directorate with the Medical Director and the Director of HR because the action plan included the appraisal which is Medical Director's responsibilities, but it 14:27

also included the job plan would be the Director of HR in combination with Medical Director's responsibility. So, I felt that would be a combined effort by the Director of Acute Services, by Director of HR and Medical Director, I suppose, in -- and the Chief Executive as the overall, you know, in charge of the organisation.

106 Q. What is your understanding as to why this aspect of the action plan wasn't implemented?

A. Soon after the determination came out we had some brief discussions, not formally, but we wanted to get things moving. But soon afterwards we were informed that the grievance request has came in and everything is on hold until the grievance will be completed. Nobody, I don't think anyone contemplated how long it took eventually to complete that, but at that point in time the general advice coming back was we have to wait until the grievance is completed before we can take on further anything. 14:28 14:28 14:29 14:29

107 Q. And was that the view of HR? Whose view was it?

A. Mainly from HR, yes.

108 Q. So, it was your understanding that the grievance provided the obstacle to moving this forward?

A. That's correct. That was my understanding, yes.

109 Q. At that time there was concern, as we saw this morning, or there was to be concern within a number of weeks about aspects of Mr. O'Brien's compliance with the existing action plan, and mainly the investigation report from the Trust perspective, and accepted by you, 14:29

21.5 I don't have a complete knowledge of what steps were taken to implement these recommendations.

a. 21.6 However, I was approached by Mr Stephen Wallace from the Medical Director's Office in July 2020 to review the Terms of Reference of the administrative review in the Acute Directorate. I provided my comments and suggested that the proposed TOR were very narrow and needed to be broader. (See my comments for those TOR – email attached). Then in October 2020, Mrs Siobhan Hynds shared some initial findings of the admin review however this was to be completed in more detail later. **Evidence : see email with 2 pages of draft findings- URGENT FOR DISCUSSION AT 1.30PM**
Admin Review document- This can be located at Attachment folder S21 31 of 2022- Attachment 40.

G. If applicable, what factors prevented that implementation.

21.7 I am not in position to provide comment on this as I wasn't involved in implementation. The Director of Acute Services, Chief Executive, Medical Director, and Director of HR should be able to provide this information.

H. If the Action Plan as per 21(I) was not implemented, fully outline what steps or processes, if any, were put in place to monitor Mr O'Brien's practice, and identify the person(s) who were responsible for these? Did these apply to all aspects of his practice and, if not, why not?

21.8 My understanding was that the Clinical Director, along with the Head of Service and Assistant Director of Surgery and Elective Care, were to continue to provide assurance until a review of the current action plan was completed. Especially as there was some concern of possible breaches of existing action plan after the Manager's Determination (already mentioned above). Therefore the action plan that had been in place since February 2017 remained in place with monitoring arrangements until a review and/or new action plan was implemented.

22. Outline the nature of any interactions you had with the GMC with regard to Mr. Aidan O'Brien in your capacity as Case Manager.

A. So, if you look at my determination, I put together a number of points there. Essentially, what it means is that going back to the point of terms of reference and looking at the investigation report, there were failings from The Trust, yes, but Mr. O'Brien as a senior clinician had an obligation to ensure there is a proper -- and that this was properly known and understood by his line managers. Obviously, there was elements of failure to triage off red flags which led to a number of -- we know from afterwards, failing to take his other elements of his administrative duties. So, there were a number of elements which was clearly indicating that he was failing in regards of his administrative duties, known, standardised practices, policies and procedures, and also failed to maybe not recognise or not, you know, inform the wider system in relation to that. 14:33 14:33 14:34

112 Q. Yes. Before we get to the bullet points, you make the point that - this is at the top of page 911 for you, 1922 for us - you make the point that at this time there's no requirement for formal consideration, IPPA or referral to GMC. 14:34

Again, just on the GMC issue, why do you think the threshold for referral had not been met? 14:35

A. At that point in time I was aware that this case is already known at the GMC ELA. We were going to discuss the threshold meeting, and we did afterwards. But at that point in time, taking the advice from NCAS, I was

that?

A. Yes. Yes.

115 Q. You then, then if we scroll over the page, in your conclusion section you insert a fourth decision or a fourth aspect of your determination, and that relates to the actions of management - both clinical and operational. 14:38

Tell us about that. Why did you formulate a binding or a decision around that? 14:38

A. So, by looking through and reading through and considering all the evidence presented to me in the investigation report but also in the statements, it was becoming quite clear that these issues were known by many in the operational and clinical and medical leadership roles. It was also becoming clear that they were not addressed, they were not escalated, they were not addressed to the full extent. They were partially addressed, they were partially dealt with, and then there was gaps. So, becoming very clear to me that this issue requires more in-depth analysis investigation by independent team. I also was trying to find in the report, in terms of whether I can reach to any conclusion in that part of the terms of reference, and I wasn't able to reach to any specific conclusion. Therefore, my determination was that this area of the terms of reference required further investigation by the independent team. 14:39 14:39

116 Q. The terms of reference of the investigation report at

So there must be -- I was trying to explore there must be other reasons and I wasn't finding that in the report. Therefore, I requested that there needs to be a further in-depth analysis investigation by the team which is independent, and they can do independent assessment and they should provide for learning for the organisation to go forward. That was my thinking, I suppose.

119 Q. Can I trouble you for an example of what you might have been thinking about, perhaps, for example, triage. You would have observed from your reading of Dr. Chada's report over a period of time, going back several years, triage was an issue being raised both clinically and operationally by management, but the issue was never resolved to the satisfaction of management so that a default arrangement was put in place whereby if triage wasn't performed, then the patient was placed on a waiting list in accordance with the general practitioner's designation. If that's a useful example, or pick another example of what you would seek to communicate in identifying this concern.

A. I suppose there were many examples, but more troublesome for me at that point in time was I could not find a valid reason that these issues were raised on multiple occasions and they were not addressed, so there might be a system-wide failure to get to that point. I was really troubled by thinking what's going wrong? Why is the system not working? There is a professional governance structure, there's a clinical

governance structure, there are operational managers. There are so many levels of safety netting, so why we are not able to protect patients. That was troubling me quite a lot at that time, and still is.

120 Q. You were obviously a medical manager yourself. You were sitting with the Interim Medical Director's hat on your head at that point in time. Obviously you were an Associate Medical Director (AMD) at that time. I suppose that was in abeyance while you were Interim but you had that in the background. What, from your perspective, were you seeing when reading this about the shortcomings of medical management? What should they have been doing but weren't doing? 14:44 14:45

A. I suppose my experience as Associate Medical Director before and as part of the Interim Medical Director, I was mindful of the shortcomings in the succession planning, the resources, the roles and responsibilities of all of that. That was the reason why one of the three key priorities I took as part of the Interim Medical Director was to start a process of looking at the professional governance structures in the Trust and the whole medical leadership structure. As part of my role as Interim Medical Director, we produced a paper to the Senior Management Team, SMT, for reviewing medical management or medical leadership structure. 14:45 14:46 14:46

The other element was about the whole Clinical Governance and how it fits into the bigger picture of governance structures and supporting the clinicians and

managers. But also highlighting and raising and providing the assurance to the system was also something I was mindful of and entrusted at that point in time. Therefore, I started another piece of work which I put in the statement report. 14:47

121 Q. Yes, and that's your report on medical leadership review, which the Inquiry can find at WIT-31532. We're not going to have the time to deal with it today, Dr. Khan.

14:47

Just again glancing back at your conclusions in this respect, you had it in mind and, indeed, you recommended the Trust would carry out an independent review of the relevant administrative processes, with clarity on roles at all levels within the Acute 14:47 Directorate and appropriate escalation processes.

"The review should look at the full system-wide problems to understand and learn from the findings".

14:48

So, a number of elements there. It was to be independent; does that mean out with the Trust or simply out with the Acute Directorate?

A. I suppose in my mind it was to be independent to the organisation. 14:48

122 Q. Why did you think that important?

A. It was important because whilst the learnings are mainly from the Acute Directorate, they were previously escalated to the corporate level as well. I felt that

it would be necessary to bring in a fresh pair of eyes. An independent view of finding out and learning from those findings are going to be more useful.

123 Q. Now, presumably you saw this matter as being of some significance to go to the bother of making such a recommendation. Was there any urgency about it in your mind? 14:49

A. I suppose the determination was to be implemented immediately. We know it did not happen. However, the intention or -- certainly in my mind when I was writing the determination, it was very clear to me that these should be implemented - all three of them - should be implemented immediately. So there was an emergency, not only the administrative review but also the action plan and the conduct panel, all three were to be reviewed immediately. 14:49 14:50

124 Q. Was any reason associated with the grievance given to you as an explanation for the failure to carry out the administrative review immediately?

A. I suppose the advice I received, that everything was to be on hold until the grievance is completed, I suppose in hindsight perhaps it would have been useful if some elements of the recommendations or the determination could be proceeded, and this is probably one of them which would easily be proceeded. Unfortunately it did not happen until much, much later. 14:50 14:50

125 Q. Did you understand then that the administrative review wasn't going to be taken forward until after the grievance, or did you assume it would be?

I'm trying to ask you is would you agree now that the term "administrative review" perhaps doesn't do justice to the extensive thinking that you did around it and that we can now see. It was just to make that point because it is much more than that, isn't it? 15:35

A. Yes, it is.

152 Q. On another aspect, this lack of dictation of letters, have you ever come across this particular degree of problem in relation to that with any other clinician?

A. No, I'm not aware of any -- I am not aware of any other clinic who would leave that length. The extent of that was remarkable. It was unbelievable. 15:35

153 Q. There was a monitoring plan put in; we talked about that extensively. But it is my perception, and you can correct me if I'm wrong, that there wasn't any regular standard or data presented in that regard for the department. I can't see any evidence to the length of time dictation was taking for the other consultants, for example, or any regular report of that; is that correct? 15:36

A. That was my understanding as well, yes.

154 Q. In that context, is it entirely equitable to monitor only one consultant in a department and not put it into the context of how their colleagues are performing?

A. I suppose if you take it in the count of this case, there was a clear action plan around one consultant, and that was to have -- that would be the standard for that particular consultant's monitoring arrangements. I appreciate your point is it was kind of not taking 15:36

Toal, Vivienne

From: Corrigan, Martina [redacted]
Sent: 31 July 2020 12:35
To: Wallace, Stephen; OKane, Maria; Haynes, Mark; McClements, Melanie; Hynds, Siobhan; Toal, Vivienne
Subject: RE: Terms of Reference - Review of Administrative Processes

Thanks Stephen and just to confirm that Rose and Mary are meeting with me next Thursday afternoon to commence

Regards

Martina

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

Telephone:
[redacted]

From: Wallace, Stephen
Sent: 31 July 2020 12:33
To: OKane, Maria; Haynes, Mark; Corrigan, Martina; McClements, Melanie; Hynds, Siobhan; Toal, Vivienne
Subject: Terms of Reference - Review of Administrative Processes

Dear all,

Please see below terms of reference for the review of administration processes as per MHPS recommendation, these have been reviewed by Dr Khan. Dr's Rose McCullagh and Mary Donnelly have agreed to conduct this work and will commence next week.

Regards
Stephen

Purpose

The purpose of the review, is to review the Trust urology administrative processes for management of patients referred to the service.

Objectives

The review will consider the present Trust urology administrative processes regarding referrals to the service and recommendations for the future, rather than past and pre-existing processes. The review in particular will consider the following:

- The administration processes regarding the receipt of and triage of patients referred to the urology service from all sources
- The effectiveness of monitoring of the administration processes including how and where this is information is reviewed
- The roles and responsibilities of operational management and clinical staff in providing oversight of the administrative processes
- The effectiveness of the triggers and escalation processes regarding non-compliance with administration processes
- To identify any potential gaps in the system where processes can be strengthened

Outputs

The Reviewer should provide a report which seeks to address the issues listed above. The report should provide recommendations on improvements to Trust urology administrative processes. Any recommendations should be evidence-based and proportionate, with consideration given to their implementation.

Scope

The review should consider current Trust urology administrative processes for the management of referrals to the service. This is a forward-looking review and, as such, will not consider past decisions.

Timing

The report, including any recommendations of the review, must be submitted to the Trust Acute Director by end September 2020.

Governance and Methodology

The Reviewer will be accountable to, the Trust Acute Director for delivery of the review. Details of the governance which achieves this accountability and the methodology for the review - including evidence gathering, consultation with operational and clinical staff - will be agreed between the Reviewer and the Trust Acute Director by 5th August 2020.

Cunningham, Hannah

From: Wallace, Stephen [redacted]
Sent: 29 July 2020 12:40
To: Khan, Ahmed
Subject: FW: MHPS Case Manager Determination

From: Khan, Ahmed
Sent: 29 July 2020 12:33
To: Wallace, Stephen
Cc: Hynds, Siobhan
Subject: RE: MHPS Case Manager Determination

Stephen, thanks. It was clear during this investigations; system wide failure happed at many levels within Acute directorate therefore my recommendation was to provide recommendation for system wide problems in acute Directorate & not to just only focus on urology department. Happy to discuss further.

Regards,
Ahmed

From: Wallace, Stephen
Sent: 27 July 2020 13:47
To: Khan, Ahmed
Cc: Hynds, Siobhan
Subject: MHPS Case Manager Determination

Ahmed,

Further to the AOB investigation conducted in 2018 under MHPS framework the report makes reference to an administrative review (below).

- *I recommend the Trust to carry out an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. The review should look at the full system wide problems to understand and learn from the findings.*

Below you will see are a draft terms of reference regarding this, can you confirm if these terms of reference encapsulate the requirements of the recommendation?

Thanks
Stephen

Purpose

The purpose of the review, is to review the Trust urology administrative processes for management of patients referred to the service.

Objectives

From: Hynds, Siobhan
Sent: 05 October 2020 12:45
To: Khan, Ahmed
Cc: Kingsnorth, Patricia
Subject: URGENT FOR DISCUSSION AT 1.30PM
Attachments: Document2 (2).docx

Hi Dr Khan

Please find attached document setting out draft findings from the initial look at the administrative review. It is only 2 pages – if you get a chance could you take a quick read for discussion at 1.30pm.

Many thanks

Siobhan

Findings

1. **The administration processes regarding the receipt of and triage of patients referred to the urology service from all sources**

Current process – *Referrals to Southern Trust Urology come from a number of different sources within Primary and Secondary Care and also include referrals from the private sector. Referrals are made mainly via CCG (Clinical Communications Gateway) from Primary care (although not exclusively) and in paper format from other sources.*

All referrals are triaged by the Consultant of the week, for the CCG referrals this involves working through a digital list and paper referrals are viewed physically by the Consultant after they have been scanned and dated.

Recommendation –*We recommend moving to an amalgamated electronic list which would incorporate all CCG referrals and also all paper referrals, this list would be locked at an agreed time each week to ensure no patient could be added after the list had been triaged. This process would provide an additional layer of assurance regarding the avoidance of referrals becoming mislead and also to ensure chronicity of referrals in terms of triage was adhered to.*

2. **The effectiveness of monitoring of the administration processes including how and where this is information is reviewed**

Current process- *The monitoring of this service is carried out by the Administration team with cross cover arrangements in place*. There is also a level of oversight by the booking centre.

Recommendation-*We recommend that this process in terms of the administration team and booking centre is formalised and an effective Standard Operating Procedure is put in place with regular review*.

3. **The roles and responsibilities of operational management and clinical staff in providing oversight of the administrative processes**

Current process – *The role of the Consultant of the week and the checking mechanism by the member of the administration team are clear.*

Recommendation – *Again we recommend an effective SOP for the administration processes but also feel that increased communication between clinical teams regarding roles may be helpful and may prevent*

the need to escalate difficulties. In particular the role of locum Consultants should be clearly defined with appropriate safety-netting in place.

4. **The effectiveness of the triggers and escalation processes regarding non-compliance with administration processes**

Current Process – *The administration checking process allows non-compliance to be detected and remedied.*

Recommendation – *Formalisation of the current escalation processes involving the administration team is likely to be beneficial and as already described open communication between clinical teams where difficulties arise may result in the need for less escalation.*

5. **To identify any potential gaps in the system where processes can be strengthened**

Current Process- *The dual system of digital referrals and paper referrals may present issues with dealing with referrals in an appropriate chronological manner.*

Recommendation – *In conclusion the amalgamation of both paper and digital referrals into a single list which can be easily checked is likely to be beneficial.*

Formalised Standard Operating procedures for all processes with adequate safety netting and increased open communication between clinical teams and locum Consultants is likely to see benefits

professionals discussing that. Certainly Siobhán Hynds was there, I was there. I think there were possibly a few other professionals discussing the outcomes. Certainly, I was surprised or shocked to see the so limited amount of outcome and whether there was really any learning from this activity. And I did voice my view on that, that it doesn't appear to be what I anticipated as part of my determination.

135 Q. Thank you for that.

15:03 15:04

Just before we finish, a couple of threads, just to tidy up. We know, and we saw a glimpse of your meeting with Mr. O'Brien after your determination was released, you met with him, and his wife and son. He sought assistance from NCAS as well and I just want to ask you about that. If we look -- if you go to page 961 of the core bundle and if we could have up WIT-53469. That's a letter to you from Dr. Lynn. And if we go to the last paragraph on this page. Clearly, Mr. O'Brien is explaining from his perspective what he thinks of the determination. He indicates in the last paragraph that notwithstanding advice provided to The Trust in September 2016, he wasn't afforded any opportunity to address the concerns which had been raised with him. And his view is that had this been done, it might have avoided a formal investigation. And over the page, please. It is suggested at the bottom of the page that -- at the bottom of the page. Thank you. Just up a bit. In your discussion with Dr. Lynn, the issue had

15:04 15:05 15:06

A. I don't recall that I was charged to do that. Again, that goes back to the point of lack of clarity in terms of roles and responsibilities. There was a lot of links happening outside of the normal -- or I should say formal arrangements. There was lots of discussions and lots of emails from Ms. Siobhán Hynds to this Oversight Committee which, for various reasons, were happening. Then there was a lot of discussions happening through me, Case Investigator, and the Oversight Committee. So again it was back to the point that certainly it wasn't clear to me am I supposed to escalate to Oversight Committee if there is a formal exclusion required. 12:46 12:47

79 Q. What did you understand would be, I suppose, the trigger for bringing something back to Oversight Committee? 12:47

A. I suppose my understanding at that point in time would be that if -- a number of things, I suppose. The first element is if there are series of or major deviation from the action plan; if there are any other concerns, a patient safety concern or clinical concern arising from the investigation; or if there is anything else coming from the overall Clinical Governance system, such as complaints, such as, you know, SAIs, such as MM incidents. All of those would feed in the decision of do we need to meet as an Oversight Group or Oversight Committee and discuss again in terms of further formal exclusion. 12:47 12:48

80 Q. Did any issue come across your desk or to your

knowledge in the period between this meeting in January 2017 and the conclusion of your involvement with Mr. O'Brien that would have merited referral back to the Oversight Committee?

A. There were a number of occasions there was some deviation or departure from the action plan. We know now -- certainly I know more now, because on a number of occasions it wasn't escalated directly to the Case Manager in my case. But most of them were immediately addressed, immediately dealt with, immediately managed, immediately rectified. And it wasn't for a period of time or anything else. 12:49 12:49

Apart from that, as a Case Manager, I wasn't receiving any other figures from the Clinical Governance or Operational Governance point of view. As a Case Manager, obviously I wasn't receiving any other triggers from the Clinical Governance meetings or SAIs, so I wasn't aware of any of those. 12:49

81 Q. In one of your earlier answers when I rudely cut across you, you mentioned the issue of appraisal. We can see in the minutes of this meeting how that issue arose. If you go back to page 404 of your bundle and if we go back to TRU-00038, just a few pages back. It says just below the middle of the page, Dr. Khan: 12:50 12:50

"It was noted that Mr. O'Brien was successfully revalidated in May 2014 and that he had also completed satisfactory annual appraisals. Dr. Khan reflected a

14. With specific reference to each of the concerns listed at (12) (i)-(iv) above, indicate if any departures from the Return to Work Plan were identified at any time, describe those departures (if any) and, if applicable, indicate what action you took to address and/or escalate same.

14.1 To the best of my recollection, I wasn't informed of any departure from the Return to Work Action Plan during the MHPS investigation during 2017.

14.2 However, in October 2018 (Just after the case manager's report was completed and released) there was an indication that he may have departed from the plan. Therefore, I took the following actions:

a. I sought an assurance by way of a Return to Work Action Plan implementation report from the Assistant Director (Ronan Carroll) of the Acute Directorate on 20th October 2018.
b. I informed the Chief Executive (Mr Shane Devlin) and Director of Human Resources (Mrs Toal) of some possible deviation from the Return to Work Plan on 22nd October 2018. See email**. This can be located at Attachment folder S21 31 of 2022- Attachment 60.**
c. Then I followed this issue with the Acute Directorate to ensure monitoring arrangements were in place to identify any departure.
d. I was assured by Mr Ronan Carroll (Assistant director) in Acute Directorate, on 23rd October 2018 that there wasn't any significant departure from the Plan and that there were only 16 clinic dictations awaiting completion from 28th September. I requested close monitoring of the Plan and its implementation. **See email FW AOB notes and dictation1** (from Ronan Carroll to Ahmed Khan, Siobhan Hynds & Simon Gibson) . **This can be located at Attachment folder S21 31 of 2022- Attachment 23.**
e. On 30th October 2018, I also wrote to Mr O'Brien regarding his obligations under the Plan.

15. On what basis was it decided that you, as Case Manager, and Dr Wright, as Medical Director, would respond to representations lodged by Mr. O'Brien with the designated Board member on 7th February 2017 and 6th March 2017 respectively.

15.1 It was the Oversight Committee's decision. I wasn't involved in or invited to this decision-making process. The Oversight Committee was comprised of the Medical Director, Director of HR, and Director of Acute Services.

that to manage this. This escalation, when it came to my attention, obviously I was off on annual leave. When I came back from annual leave, I was assured that the issue of charts had been resolved.

10:49

Now, on reflection, possibly it was going up from June, end of May/June time, and on reflection and hindsight with all that information available, I could have taken a more robust arrangement, or meeting with the team or even indeed meeting with Mr. O'Brien. But every time 10:49 with these issues were raised, it appears to be before this email came that there was an arrangement in place to address those.

30 Q. In fairness to the team, a meeting was arranged by them with Mr. O'Brien in your absence. If you could look at 10:50 page 531 of the core, and if we could have up on the screen AOB-56210. That's the first page after a recording or a transcript of a recording made by Mr. O'Brien of this meeting attended by the persons named there, Weir, Corrigan and Carroll. 10:51

As appears from the content of this meeting, if you go through to 533 of your core, and if we could go down to AOB-56212, another couple of pages down. Just scroll down. At this meeting, in fairness to Mr. O'Brien, 10:51 he's explaining that, if you just read that page, that the notes that are in his office from his perspective do not need to be there, that they are being brought there by secretarial staff. He says at the top of the

page or about a third of the way down that page:

"I don't ask for them. I'm not the person responsible for storing them. There's no need for them. It is an obsolete system". 10:52

It seems, if you read the full account, and the Inquiry can read the full account, that he's making the case that notes are being brought to his office by members of the secretarial team to draw his attention, for 10:52 example, to results relevant to the case, the results are placed on the file and the file is left in his office and multiple files are generated, but he doesn't see the need for that kind of system. 10:53

Was that drawn to your attention up your return from holiday or not?

A. When I returned from my annual leave, I was assured by Ronan Carroll just that the issue of notes had been resolved. I must say, I wasn't aware that they met 10:53 with Mr. O'Brien and the issue of the charts brought to his office had been discussed in detail. But I was assured that the issues had been resolved, you know, in agreement with Mr. O'Brien and the team which is on the ground. 10:53

31 Q. Now, I think it's fair to say that no other issue of concern regarding the action plan was drawn to your attention during 2017. I want to ask you about an issue that arose in 2018. If you go to page 1389 of

Toal, Vivienne

From: Khan, Ahmed [redacted]
Sent: 24 May 2018 11:14
To: Toal, Vivienne
Subject: RE: Return to Work Action Plan February 2017 FINAL.

Vivienne, I have been receiving it until earlier this year from Ronan Carroll, haven't received it in few months now. Have spoken to him recently & he will forward this to me.
Is the report ready ?
Regards,
Ahmed

From: Toal, Vivienne
Sent: 23 May 2018 07:40
To: Khan, Ahmed
Subject: FW: Return to Work Action Plan February 2017 FINAL.

Ahmed
See below re AOB

Have you been getting these updates on a regular basis in terms of assurance?

Vivienne

From: Hynds, Siobhan
Sent: 23 May 2018 00:48
To: Toal, Vivienne
Subject: FW: Return to Work Action Plan February 2017 FINAL.

Hope this helps!

From: Corrigan, Martina
Sent: 22 May 2018 17:29
To: Hynds, Siobhan; Carroll, Ronan
Subject: RE: Return to Work Action Plan February 2017 FINAL.

Hi Siobhan

Apart from one deviation on 1 February 2018 when Mr O'Brien had to be spoken to regarding a delay in Red Flag Triage and he immediately addressed it, I can confirm that he has adhered to his return to work action plan, which I monitor on a weekly basis.

CONCERN 1 – one deviation when the red flag was not triaged for 6 days – he was spoken to and it was resolved that evening and his reason was due to the busyness of his oncall week when he had spent quite a bit of it in emergency theatre.
CONCERN 2 – adhered to – no notes are stored off premises nor in his office
CONCERN 3 – adhered to – Mr O'Brien uses digital dictation and dictates on all charts after clinics and he has an outcome on all patients including DNA patients

now. Have spoken to him recently and he will forward this to me. Is the report ready", and that's a reference to the MHPS investigation report.

Is this explaining then that you hadn't been advised of the triage issue in February which, on Mrs. Corrigan's description, seems to have been relatively quickly resolved, is that right? You didn't know about that? 10:56

A. That's correct. I wasn't aware of that, no.

33 Q. Plainly, as it's explained here, you had been receiving updates from Mr. Carroll but hadn't been receiving them recently. How did that happen; was that outside of your expectations from him? 10:56

A. So at that point in time there were a couple of things happening. I was preoccupied with my appointment to the Interim Medical Director. I was appointed after the recruitment and selection process in April of 2018. I was also talking or discussing the issues of the progress of the MHPS investigation report with Siobhán Hynds, with Dr. Neta Chada. I would have spoken to Ronan Carroll about the understanding and the management of action plan. So, I was assured by talking to various peoples that the action plan is monitored and the investigation is coming to -- the formal investigation is coming to an end. So I was assured on those bases. 10:57 10:57 10:58

But I must say I didn't go looking for a report, an assurance report. I was under the impression that

18. With regard to the Return to Work Plan / Monitoring Arrangements dated 9th February 2017, see copy attached, outline your role, as well as the role of any other responsible person, in monitoring Mr O'Brien's compliance with the Return to Work Plan and provide copies of all documentation showing the discharge of those roles with regard to each of the four concerns identified, namely:

    I. Un-triaged referrals to Mr Aidan O'Brien;
    II. Patient notes tracked out to Mr Aidan O'Brien;
    III. Undictated patient outcomes from outpatient clinics by Mr Aidan O'Brien; and
    IV. The scheduling of private patients by Mr Aidan O'Brien

18.1 I have already addressed these issues in my response to Section 21 Notice No.24 of 2022 (in particular at Questions 1 (paragraph 1.8) and 58-60). I rely upon those answers here but I have attempted to re-organise that material below in order to focus on the points raised in this question.

18.2 I can confirm that, in February 2017, Mr Carroll, Assistant Director, shared with me the Return to Work Plan that Mr O'Brien had agreed to adhere to in order to allow him to return to work. He asked me to monitor all four elements which I agreed to do and I commenced this and continued it until March 2020 (when, due to Covid, there was no longer any triage/clinics/theatres and I was unable to get access to the office due to restriction of movement throughout the hospital). So, I can confirm that I had responsibility for monitoring Mr O'Brien's Return to Work Plan, and below is the detail on how I monitored this on a weekly basis (with the exception of when I was on annual leave and also for the 18 weeks when I was off [redacted] Personal Information redacted by the USI from 25 June 2018 until 5 November 2018).

Documents attached namely;

20170207 - updated notes from meeting on RTW- Attachment 84

20170207 - updated notes from meeting on RTW att1- Attachment 85

20170208 - MC comments on RTW action plan- Attachment 86

perhaps, that others in the team were doing the monitoring but, for whatever reason, the issue or the task was not performed. Who was giving you assurance that it was? Was it Mrs. Gishkori?

A. At that point in time I remember there were a number of discussions with Esther Gishkori. Not in October; I'm talking about in June. When I started Interim Medical Director in April, I realised there was no one-to-one discussion with the Medical Director and the Direct of Acute Service in terms of a predicted or dedicated time to discuss issues, so I approached Mrs. Gishkori and we established an informal discussion time, either after the Trust SMT or another time. During the period of from May until June -- May and June, certainly, I was getting assurances this was monitored. 11:03

Now, I must say she was off, I knew she was off in the summertime on sick leave. I had, I think, one meeting with Ann McVey, but I was getting -- my impression was that I will be informed of any deviation, and I was in October, but I wasn't informed of any deviation before that. 11:04

38 Q. If I could ask you to look at page 919 of the core bundle, and if we could have up on the screen, please, TRU-251526. At the bottom of that page, Dr. Khan, you can see that Mr. Weir is writing to you. 11:04

"Please for your urgent consideration and action. See email correspondence below. Please see attached

From: Carroll, Ronan
Sent: 18 October 2018 12:39
To: Gibson, Simon; Weir, Colin; Khan, Ahmed; Haynes, Mark
Subject: RE: Return to Work Action Plan February 2017 FINAL.
Importance: High

Simon
I think you are stating the obvious.
With Martina having been off since June the overseeing function has not taken place and in the day to day activities was overlooked
But We need to understand why this the dictation has gone out, this could explain the volume of notes or there may be some other reason
Ronan

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

From: Gibson, Simon
Sent: 18 October 2018 12:31
To: Weir, Colin; Khan, Ahmed; Carroll, Ronan; Haynes, Mark
Subject: RE: Return to Work Action Plan February 2017 FINAL.

Dear Ronan

What is most concerning here is that there were monitoring and supervision arrangements put in place, which we confirmed to a range of interested parties.

If he has a backlog of clinic letters and discharges going back to June, have these arrangements fallen down?

Kind regards

Simon

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

From: Weir, Colin
Sent: 18 October 2018 11:33
To: Khan, Ahmed; Gibson, Simon; Carroll, Ronan; Clayton, Wendy; Haynes, Mark
Subject: FW: Return to Work Action Plan February 2017 FINAL.
Importance: High

Ahmed/Simon

Please for your urgent consideration and action

See email correspondence below. Please see attached excel spreadsheet and go to Oct TAB or see below in email trail

Mr O'Brien has accumulated a large backlog of dictated letters and large numbers of charts in his office.

I am his Clinical Director

I have NOT seen the review and results and recommendations into his practice, but I am assuming he is in breach of this given these findings

Can you instruct me on how you would like to proceed.

I can certainly meet his with Ronan to discuss and record outcome from any meeting with him but I need to know if any sanctions need to be put in place if he has breached any of the review requirements or if your office wish to take this over?

Colin

From: Clayton, Wendy
Sent: 18 October 2018 11:07
To: Weir, Colin
Subject: FW: Return to Work Action Plan February 2017 FINAL.
Importance: High

From: Carroll, Ronan
Sent: 17 October 2018 15:52
To: Young, Michael; Haynes, Mark
Cc: Clayton, Wendy
Subject: FW: Return to Work Action Plan February 2017 FINAL.
Importance: High

Michael/Mark
Please see update from Wendy

1. Dictation to be completed
2. Notes in office

Aidan needs spoken with and asked to address dictation asap & to return notes (possible notes are for dictation)
I am in CAH tomorrow pm

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

From: Clayton, Wendy
Sent: 17 October 2018 15:11
To: Carroll, Ronan; Corrigan, Martina
Subject: RE: Return to Work Action Plan February 2017 FINAL.

See below dictation report. There are approx 82 charts in the office on level 2. Do you need me to try and find out how long they have been there?

UROLOGY				Backlog - Number of c
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinic letters to be dictated**	**oldest date of clinic letters to be dictated**

Mr Jakob				
Mr Glackin	5	6	7	06/06/2018 (1 letter)
Mr Haynes	0	0	19	26.09.18
Mr O'Brien	17	0	91	15.06.18
Mr O'Donoghue				
Mr Young	12	0	0	0
Sub Speciality Totals	**34**	**6**	**117**	

From: Clayton, Wendy
Sent: 16 October 2018 19:41
To: Carroll, Ronan; Corrigan, Martina
Subject: RE: Return to Work Action Plan February 2017 FINAL.

I have check PAS and there are 82 charts tracked out specifically to Mr O'Brien

I will ask Collette for an update typing backlog report which will show clinic/results to be dictated, hopefully this will be through tomorrow.

Wendy

Wendy Clayton
Acting HOS for G Surg, Breast & Oral Services
SEC
Ext: Personal Information
External number: Personal Information redacted by USI
Mob: Personal Information redacted by USI

EXT 61597 if dialling from Avaya phone.
If dialling from old phone please dial 7753 61597.

External No. Personal Information redacted by USI

From: Carroll, Ronan
Sent: 15 October 2018 23:01
To: Clayton, Wendy; Corrigan, Martina
Subject: FW: Return to Work Action Plan February 2017 FINAL.
Importance: High

Wendy
Can i ask you as a matter of urgency to update the position re Notes checked out to AOB (74) & Digital Dictation also 91 letters pls
Ronan

Ronan Carroll