

Respondent Statement

NAME OF WITNESS	Mr Aidan O'Brien
OCCUPATION	Consultant Urologist
DEPARTMENT / DIRECTORATE	Directorate of Acute Services, Craigavon Area Hospital
STATEMENT TAKEN BY	Dr Neta Chada, Associate Medical Director / Case Investigator
DATE OF STATEMENT	Thursday 3 August 2017
PRESENT AT INTERVIEW	Mrs Siobhan Hynds, Head of Employee Relations Mr Michael O'Brien, son
NOTES	The terms of reference were shared prior to the date of statement.

1. The meeting commenced with welcome and introductions. The format of the meeting was outlined to me and it was explained that the meeting would be based on the previously shared Terms of Reference for the investigation.
2. I asked for a full updated list of witnesses to be sent to me. I also asked for all witness statements to be shared with me. This was agreed.
3. I have been asked to provide this statement in respect of an investigation in response to concerns about my conduct/clinical practice being carried out in accordance with the Trust Guidelines for Handling Concerns about Doctors and Dentists and the Maintaining High Professional Standards Framework.
4. I agreed to answer questions specifically related to the terms of reference previously shared with me.
5. My name is Mr Aidan O'Brien, I am employed by the Southern Health and Social Care Trust as a Consultant Urologist. I have been in this position for 25 years.

Term of Reference 1

6. I explained that when patient referrals are sent to me there are only a minority which are personalised to me. To my knowledge I have always responded to these referrals.

Respondent Statement

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OCCUPATION	Consultant Urologist
DEPARTMENT / DIRECTORATE	Directorate of Acute Services, Craigavon Area Hospital
STATEMENT TAKEN BY	Dr Neta Chada, Associate Medical Director / Case Investigator
DATE OF STATEMENT	Monday 6 November 2017
PRESENT AT INTERVIEW	Mrs Siobhan Hynds, Head of Employee Relations
NOTES	The terms of reference were shared prior to the date of statement.

1. The meeting commenced with welcome and introductions. The format of the meeting was outlined to me and it was explained that the meeting would be based on the previously shared Terms of Reference for the investigation.
2. The purpose of the meeting is to address Term of Reference 4 which had not been previously responded to.
3. Dr Chada explained that this was the final meeting after which she could conclude the process. I explained to Dr Chada that I have a number of priorities in November / December including my Appraisal which I wish to get completed. I advised that I would be concentrating on this in the coming weeks. I outlined that this process is having a significant impact on myself and my wife – it is a difficult time. Dr Chada outlined that once we have agreed statements, a case report can be provided to the Case Manager.
4. I advised that I have a number of issues with and comments to make on the previously shared notes from my first meeting with Dr Chada and also with the witness statements shared with me. I noted I intend to make commentary on both.
5. I advised that of the 9 patients, highlighted to me for response in respect of time being added to the waiting list and when they came in for a procedure, only 2 were TURP patients. The initial information shared with me in respect of these concerns related only to TURP patients. I asked for clarification on this and if there had been a full review of my private patients undertaken – not just TURP patients.

Comments relating to the Respondent Statement of Thursday 03 August 2017

The following is a list of comments relating to the interview conducted by Dr. Chada on Thursday 03 August 2017:

- The statement did not include my enquiry relating to my failure to receive amended Notes of previous meetings following my submission of those proposed amendments. (This related to the Note of the meeting with Dr. Wright and Ms. Hainey on 30 December 2016 and to the Note of the meeting with Mr. Weir and Ms. Hynds on 24 January 2017.)
- Paragraph 3 relates that I have been asked to provide this statement in respect of an investigation in response to concerns about my conduct / clinical practice being carried out in accordance with the Trust Guidelines for Handling Concerns about Doctors and Dentists and the Maintaining High Professional Standards Framework. Paragraph 3 is incorrect as I was not asked to provide this statement in accordance with either the Trust Guidelines or the Framework, nor could I have possibly been asked to do so, for the reasons as detailed in my letter of 30 July 2017, addressed to Dr. Khan. Succinctly, the Trust formulated its Guidelines in September 2010 in response to its obligation to do so, in order to implement the Framework. Therefore, such an investigation can only be conducted by the Trust in accordance with its Guidelines, and as the investigation was not completed by 30 January 2017, its continuation since then cannot have been, and has not been, in accordance with its Guidelines.
- Paragraph 7 should read: 'Of the non-personalised referrals allocated to me, i.e., those allocated to me as Consultant Urologist of the week, I triaged all red flag referrals during 2015 and 2016, but did not triage the remaining referrals during 2015 and 2016.'
- Even though later paragraphs elaborate further, Paragraph 8 requires some amendment by way of clarification. The practice of allocating referrals to be triaged by the Consultant Urologist of the week, whilst being Consultant Urologist of the week, was introduced concurrent with the introduction of the Consultant Urologist of the week model in 2014. Whilst I did agree with it being so, I soon found it impossible to do, and I did advise by early 2015 that I had found it impossible to do. The possibility or otherwise of doing so was not assisted by the complete lack of any clarity or agreement regarding the detail of the triaging process.
- Paragraph 9 referred to the number of referrals which I had not triaged during 2015 and 2016. I have been provided with the details of 319 referrals which I had not triaged during that time, and agree that that number is factually correct.
- The second sentence in Paragraph 13 should read: 'The *quantity* of referrals is such that you cannot properly triage them'.
- Paragraph 14 is very important. Did I ever say that I was no longer doing this. I believe that I did by advising that I had found it impossible to do. I did not use the words 'I am no longer

**STRICTLY
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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. Having suffered increasingly Personal Information redacted by USI throughout 2016, I had been on Personal Information redacted by USI leave following Personal Information redacted by USI surgery since 15th November 2016. On 28th December 2016, whilst still on Personal Information redacted by USI 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 Personal Information redacted by USI 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 Personal Information redacted by USI 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 a 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: The Letter dated 23rd March 2016

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^{not} 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 McAllister 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 2018⁶ (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 Personal Information 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 manager 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, I was increasingly suffering Personal Information redacted by the USI
However, I had undertaken to delay surgery 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 own surgery. I scheduled the surgery for 17th 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 surgery on 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 surgery on 17th November 2016. 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 Personal Information redacted leave recovering from surgery. 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 to undergo my surgery.

My plan was disrupted somewhat when I experienced a symptomatic deterioration due to a [REDACTED] in mid-December 2016 and I was in fact scheduled for readmission on 24th December 2016 for a [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 surgery during my Personal Information redacted leave. 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 Personal Information redacted 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 Personal Information redacted 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 Personal Information redacted leave and suffered significant post-operative pain and discomfort.

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 from 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, [REDACTED] 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 The SAI Investigation

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 201~~6~~⁷, 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 2018⁶ 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 surgery in November 2016. 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 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 I 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 of 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 proceeding 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
redacted by the 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 Personal Information 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 Personal Information 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 to 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 Personal Information 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) 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^y 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

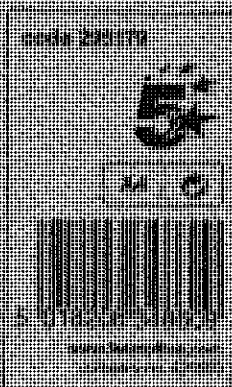
Aidan O'Brien

Schedule Of Documents

1. Notes of the Meeting of 30th December 2016
2. Correction to Notes of the Meeting of 30th December 2016
3. Contract of Employment
4. Trust Guidelines for Handling Concerns about Doctor's and Dentists' Performance, 23rd September 2010.
5. Response to the Investigator's Report.
6. Job Plan 2015
7. Job Plan 2016
8. Letter of 23rd March 2016
9. Statement of Heather Trouton, unsigned and undated
10. Statement of Colin Weir dated 7th June 2017
11. Email from Dr Khan 23rd October 2018
12. Letter from NCAS dated 13th September 2016
13. Performance Date of 13th October 2016
14. Minutes Of Oversight Committee 22nd December 2016
15. Email to Siobhan Hynds 31st July 2017
16. Emails between Aidan O'Brien and Martina Corrigan dated 14th November 2016
17. Numbers of Undictated Clinics
18. Letter from Dr Wright dated 6th January 2017
19. Letter to Dr Wright dated 17th January 2017
20. Letter from Mr Weir dated 20th January 2017
21. Letter from Dr Wright dated 23rd January 2017
22. Minute of the Meeting of 24th January 2017 with Corrections
23. List of Questions dated 7th February 2017
24. Letter from Mr Wilkinson dated 13th February 2017
25. Letter from Dr Khan dated 24th February 2017
26. List of Questions provided on 6th March 2017
27. Letter from Dr Wright dated 30th March 2017
28. Letter from NCAS dated 29th December 2016
29. Letter from Mr Weir dated 23rd January 2017
30. Response to 13 Sets of Notes 24th January 2017
31. Update from Preliminary Investigation 24th January 2017

32. Analysis of TURPs in 2016
33. Emails from NCAS 27th January 2017, 30th March 2017, 30th May 2017
34. Letter from Dr Khan dated 6th February 2017
35. Terms of Reference
36. Statement of Ronan Carroll dated 17th August 2017
37. Email to Dr Khan on 2nd November 2018
38. Letter to Dr Khan dated 30th July 2017
39. List of Anonymized Private Patients
40. Corrected list of Private Patients and Responses
41. Statement of Michael Young dated 5th October 2017
42. Michael Young's Review of Private Patient Letters
43. Record of Additional Work 2012-2016
44. Case Manager's Determination
45. Letter from NCAS dated 6th November 2018
46. Email from Martina Corrigan dated 19th July 2018
47. Post-It Note from Mr Carroll's Secretary
48. Grievance Letter to Mrs Gishkori dated 7th November 2018
49. Grievance Letter to Dr Rankin dated 20th January 2012

1



Note of Meeting with Mr Aidan O'Brien, Consultant Urologist – 30th December 2016Present:

Mr O'Brien (accompanied by his wife, Personal Information redacted by USI)

Dr Richard Wright, Medical Director

Ms Lynne Hailey, Employee Relations

Introductions were made and Dr Wright thanked Mr O'Brien for attending the meeting. It was explained that the reason the meeting had been called was to make Mr O'Brien aware that concerns had been raised with Dr Wright as a result of an ongoing Serious Adverse Incident (SAI) investigation. Dr Wright noted that some of these concerns had been raised with Mr O'Brien previously and attempts had been made to resolve the matters informally, with no success. Ms Hailey made Mr O'Brien aware of the nature of the concerns that had been raised with Dr Wright i.e concerns relating to his administrative practices, and the possibility that patients may have come to harm as a result of those administrative practices. In particular:-

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

Ms Hailey referred to the ongoing SAI investigation relating to a Urology patient who may have a poor clinical outcome due to the lengthy period of time taken by Mr O'Brien to undertake triage of GP referrals. Mr O'Brien was also informed that the SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason.

2. That there is a backlog of over 60 undictated clinics going back over 18 months and therefore there is approximately 600 patients who may not have had their clinic outcomes dictated, so the Trust is unclear what the clinical management plan is for these patients.
3. That some of the patients seen by Mr O'Brien may have had their notes taken back to his home, and are not available within the hospital. There is a concern that the clinical management plan for these patients is unclear, and may be delayed.

Mr O'Brien advised that he was not aware of the cases in question being investigated through the SAI, and that he had no involvement in the SAI process. Dr Wright advised that he would raise this with the SAI Team, stating that the process remains ongoing and they may not have contacted Mr O'Brien yet because he had been on leave.

Dr Wright advised that nevertheless concerns had been raised with him in relation to Mr O'Brien's administrative practices and because of the seriousness of these, and the fact that informal steps had been unable to resolve the issues previously, a decision had been taken to investigate the matter formally in accordance with the Maintaining High Professional Standards Framework and associated local guidance. Ms Hailey provided Mr O'Brien with a copy of both documents for his information, explaining that these outline the process by which an investigation is undertaken and Mr O'Brien's rights in the process.

Dr Wright confirmed that a Case Manager and Case Investigator had been appointed (Mr Ahmed Khan, Case Manager and Mr Colin Weir, Case Investigator). Ms Hainey explained that Mr Weir will be supported in the investigation by a representative from Human Resources (as yet to be appointed). Dr Wright advised that a Non-Executive Director will also be appointed to oversee the investigation process, and the detail of this person would be communicated to Mr O'Brien once confirmed.

Mr O'Brien was informed that as an interim precautionary measure, he was being placed on immediate exclusion with full pay. He was informed that the decision had been taken by the Oversight Committee in the Trust and that advice from NCAS had been received prior to the meeting. It was explained that this "immediate exclusion" would be for no longer than 4 weeks, and that during that time, further preliminary information would be collated to decide the scope of the formal investigation, and therefore the Terms of Reference for the formal investigation which would be forwarded in due course. Mr O'Brien was informed that a meeting would be arranged to take place with him during the 4 week period, and that he would be kept informed of any progress in relation to the investigation.

Mr O'Brien advised that the concerns needed to be considered in the context of the enormous pressure on him to operate. He stated that clinical outcomes are compromised because of a lack of capacity. He stated that there is an inequity within the department and gave an example that in October, he had a waiting list of 288 for inpatient admission whilst a colleague had a waiting list of 29. He advised that he had previously asked through his Clinical Director, that this situation be addressed. But that because of the waiting list the demand on him was to operate.

Mr O'Brien stated that it was important to appreciate the totality of the work that he does, and as a result he does not have time to triage non red flag referrals. He advised that the referral of these was a historical hangover from the time when it was felt there was not enough to do when on-call. The triage of non-red flag referrals was undertaken to justify on-call time. Mr O'Brien advised however that this time is now spent on operations eg the last week he was in work, he undertook 21 operations whilst on-call.

Dr Wright noted the points made by Mr O'Brien and advised that whenever an investigation is undertaken, there may be criticisms of the Trust, and its systems but that would have to await the outcome of the investigation.

Mrs O'Brien stated that her husband had worked for 25 years as a Consultant in the Trust and that during that time he had worked 70-90 hours per week including week-ends. She advised that when taking someone off the waiting list in chronological order ie those longest on the waiting list, her husband is conscious that so much could have changed for the patient during the intervening period and so he would take the time to ring and speak to the patient to find out how doing etc. Mr O'Brien advised that he had 19 additional theatre sessions and 15 extra oncology sessions, and is under pressure to do all of these.

Dr Wright advised that he is well aware of the work that Mr O'Brien does for the Trust, but that given the concerns that have been brought to his attention, the matters have to be investigated. Ms Hainey stressed that it is an investigation to establish the facts and that Mr O'Brien would be given every opportunity to respond in full as part of the investigation process.

Mrs O'Brien stated her view that the system needs to change as there is too much work being placed on Consultants. She advised that when she worked as a nurse practitioner 40 years previous, it was her role to triage the referrals. Mr O'Brien reiterated that he had raised two years previous that he did not have capacity to deal with non-red flag triage. He said that it is his view that you need to speak to patients rather than ticking a box, and that to do so takes time.

Dr Wright referred to the need to return any notes as a matter of urgency. Mr O'Brien was requested to return these to Martina Corrigan, Head of Service for Urology by 11.00 am on Tuesday 3rd January 2017. Mr O'Brien stated that he could not return these without processing them. Dr Wright stated that the notes needed to be returned by the above date and time, as he was accountable and needed to deal with the matter. He stated that if there were notes missing, this was a very major problem that would need to be dealt with through Information Governance. Mr O'Brien advised that he has all the notes that are tracked out to him. Both Mr and Mrs O'Brien queried what happens with the patients given that Mr O'Brien has not processed them, and would be the best person to process the cases. Dr Wright advised that he will deal with this. Mr O'Brien asked for a deferment of two weeks to allow him to process the files and Dr Wright advised that no deferment could be granted. Ms Hailey reiterated that in the interests of all parties, and of the investigation process, that the notes needed to be returned as per Dr Wright's management request.

Mr O'Brien said that he was shell-shocked. Mrs O'Brien said that there would be no better person to process the cases. Dr Wright said Mr O'Brien had been asked to return all the information in March 2016 but did not. Mr O'Brien said that the emphasis for him at that time was operating. It was made clear that the notes had to be returned as requested and that anything associated with the care of those patients would be reviewed by others. Ms Hailey asked Mr O'Brien to comply with the request and Mrs O'Brien stated that she was concerned about how the cases would be dealt with. Dr Wright advised that he would take responsibility for this. He advised that the matter would have to be reported to the Chief Medical Officer who would be querying where all the notes are, and therefore that it is imperative that Mr O'Brien return the notes as requested.

As it was obvious that both Mr and Mrs O'Brien were upset, Ms Hailey asked if anyone wished a glass of water or cup of tea/coffee. This was declined. Mrs O'Brien stated that there was too much bureaucracy in the Health Service and she felt this was a major issue. She advised that Mr O'Brien's SPA time was spent operating or reviewing cancer patients, and that he took time in December to do his appraisal. Mr O'Brien said that he had been pleading for the past 2-3 years that he should not see any new patients because of the immorality of not being able to do what he had pledged to do. He said that as a consequence of operating, other duties get neglected. He said that there were not enough hours to be faultless, that he had tried in the past without sleeping or without food.

Mr O'Brien stated that he was devastated by what had been communicated to him today. Dr Wright queried if Mr O'Brien's job plan was unrealistic. Both Mr and Mrs O'Brien stated that the job plan is OK but things were often allocated to SPA time, which were not admin work. Dr Wright stated that if the job plan does not cover all the work that has to be done, then it is not right. Mrs O'Brien stated that the first job plan was 15.5 when in reality it should have been about 18. She said that now the job plan is 10 sessions. Mrs O'Brien stated that she and her children have sacrificed their

family life for her husband's job and 'this is how we are repaid' referring to the discussion taking place.

It was again reiterated that there is an obligation to address concerns when these are raised, and that Dr Wright had been made aware of serious concerns about Mr O'Brien's administrative practices which may have / has the potential to lead to harm for patients.

Mr O'Brien was made aware of the paragraphs in the MHPS documentation relating to exclusion. He queried if he can continue to work with private patients. Dr Wright suggested that he take advice from his union, but said that as RMO, he would discourage this. Dr Wright suggested that Mr O'Brien ask his colleagues to review any private patients that he has.

Mr O'Brien was made aware of support services available through Care-call and OH. He was advised that an OH appointment would be made for him and would be communicated to him. Prior to meeting concluding, Mr O'Brien apologised to Dr Wright.

2

Personal Information redacted by USI



14 February 2017.

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

Dear Dr. Wright,

Re: Note of Meeting with Mr. Aidan O'Brien on 30 December 2016.

Thank you for your letter of 18th January 2017, enclosing a Note of the Meeting of 30th December 2016. I wish to take this opportunity to advise of a number of factual errors and omissions:

1. In the first paragraph, the Note states that 'Dr. Wright noted that some of these concerns had been raised with Mr. O'Brien previously and attempts had been made to resolve the matters informally, with no success'.

This statement is incorrect and should have read 'Dr. Wright noted that these issues had been highlighted with Mr. O'Brien in March'.

2. Again, in the third paragraph, the Note states that 'Dr. Wright advised that nevertheless concerns had been raised with him in relation to Mr. O'Brien's administrative practices and because of the seriousness of these, and the fact that informal steps had been unable to resolve the issues previously, a decision had been taken to investigate the matter formally in accordance with the Maintaining High Professional Standards Framework and associated local guidance'.

This statement is incorrect, as Dr. Wright did not make reference to informal steps having been unable to resolve the issues previously.

3. In the sixth paragraph, the Note states that Mr.O'Brien, referring to the inequity of waiting lists, advised that 'he had previously asked through his Clinical Director that this situation be addressed'.

This statement is incorrect, and should have read that 'he had previously asked that this situation be addressed.'

4. The Note records that 'both Mr. and Mrs. O'Brien stated that the job plan was OK'.

This statement is incorrect as, while Mrs. O'Brien may have been of the view that the job plan was OK, I certainly did not state that the job plan was OK.

5. The Note records that Mrs. O'Brien stated that she and her children had sacrificed their family life for her husband's job and 'this is how we are repaid' referring to the discussion taking place.

This statement is incorrect as Mrs. O'Brien did not make any reference to being 'repaid'.

With regard to omissions:

- The Note did not include any record of my being advised of immediate exclusion. The only reference to exclusion is in the second last paragraph when 'Mr. O'Brien was made aware of the paragraphs in the MHPS documentation relating to exclusion', and the query regarding private practice.
- The Note did not include any record of Mrs. O'Brien's concerns regarding one of the signatories of the letter of 23rd March 2016 having caused problems previously.

I would be grateful if you would have the Note amended and a copy of the amended Note returned to me.

Yours Sincerely,

Aidan O'Brien.

3

CRAIGAVON AREA HOSPITAL GROUP TRUST

Statement of Main Terms and Conditions of Employment

CONSULTANT APPOINTMENT

THE POST

1 Consultant

Your job title is Consultant Urologist

Your employing organisation is Craigavon Area Hospital Group Trust.

2 Commencement Of Employment

Your continuous employment for the purposes of this contract began on 6th July 1992.

Your continuous service for the purposes of the Employment Rights (Northern Ireland) Order 1996 began on 6th July 1992.

Schedule 1 of the Terms and Conditions of Service contains guidance on commencement of employment.

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 judgements 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.

THE WORK**4 Location**

Your principal place of work is Craigavon Area Hospital. Other work locations including off site working may be agreed in your Job Plan where appropriate, e.g. for supporting professional activities and some direct clinical care such as audit notes. You will generally be expected to undertake your Programmed Activities at the principal place of work or other locations agreed in the Job Plan. Exceptions will include travelling between work sites and attending official meetings away from the workplace.

You may be required to work at any site within your employing organisation, including new sites.

5 Duties**5.1 Main Duties and Programmed Activities**

Except in emergencies or where otherwise agreed with your manager, you are responsible for fulfilling the duties and responsibilities and undertaking the Programmed Activities set out in your Job Plan, as reviewed from time to time in line with the provisions in section 6 below.

5.2 Associated Duties

You are responsible for the associated duties set out in Schedule 2 of the Terms and Conditions of Service.

5.3 Objectives

The purpose of including agreed personal objectives in your Job Plan is to set out in clear and transparent terms what you and your clinical manager have agreed should reasonably be achieved in the year in question. These objectives are not contractually binding in themselves, but you have a duty to make all reasonable efforts to achieve them.

5.4 On-Call Duties and Emergency Responses

You may also be required to participate in an on-call rota to provide emergency cover (see section 9). When not on an on-call rota, we may in exceptional circumstances ask you to return to site for emergencies if we are able to contact you. You are not, however, required to be available for such eventualities. Where emergency recalls of this kind become frequent, we will review the need to introduce an on-call rota.

6 Job Planning

Your clinical manager has drawn up an outline job description that sets out your main duties and responsibilities, along with an initial work

programme for carrying out your programmed activities. A finalised job plan will be agreed between you and your clinical manager within 3 months of taking up post.

You and your clinical manager will review the Job Plan annually in line with the provisions in Schedule 3 of the Terms and Conditions of Service. Either may propose amendment of the Job Plan. You will help ensure through participating in Job Plan reviews that your Job Plan meets the criteria set out in the Terms and Conditions of Service and that it contributes to the efficient and effective use of HPSS resources.

7 Programmed Activities

7.1 *Scheduling Of Activities*

You and your clinical manager will agree in the schedule of your job plan the programmed activities that are necessary to fulfil your duties and responsibilities, and the times and locations at which these activities are scheduled to take place. You and your clinical manager will seek to reach agreement in the scheduling of all activities. We will not schedule non-emergency work during premium time without your agreement.

Subject to the provisions for recognising work done in Premium Time (see section 8 below), a Programmed Activity has a timetable value of four hours. Each Programmed Activity may include a combination of duties.

A job plan will contain 10 Programmed Activities per week on average, subject to the provisions below for recognising emergency work arising from on-call rotas and in Paragraph 7.6 to agree up to two extra Programmed Activities. Remuneration for Programmed Activities is set out in section 21 below and Schedules 13 and 14 of the Terms and Conditions of Service.

7.2 *Flexibility*

Attaching a time value to Programmed Activities is intended to provide greater transparency about the level of commitment expected of consultants by the HPSS. However, you and your clinical manager can agree flexible arrangements for timing of work.

Programmed Activities may be scheduled either as a single block of four hours, or in half units of two hours each.

The precise length of Programmed Activities may vary from week to week around the average assessment set out in the Job Plan.

You and your clinical manager may agree, as part of your Job Plan, arrangements for the annualisation of Programmed Activities. In such

a case, you and your clinical manager will agree an annual number of Programmed Activities and your Job Plan will set out variations in the level and distribution of Programmed Activities within the overall annual total.

You and your clinical manager may agree, as part of your Job Plan, other arrangements for flexible scheduling of commitments over an agreed period of time.

Any variations in your scheduled weekly commitments should be averaged out over 26 weeks, so that your average commitment is consistent with the provisions of the Working Time Regulations.

7.3 Balance Between Direct Clinical Care and Other Programmed Activities

Subject to the provisions for recognising emergency work arising from on-call rotas below, the schedule in a Job Plan will typically include an average of 7½ Programmed Activities for Direct Clinical Care duties and 2½ Programmed Activities for Supporting Professional Activities. Where your agreed level of duties in relation to supporting professional activities, additional responsibilities and other duties is significantly greater or lower than 2½ programmed activities there will be local agreement as to the appropriate balance between activities. Part-time consultants need to devote proportionately more of their time to Supporting Professional Activities. This should be agreed on an individual basis. Refer to the guidance on part time and flexible working for further information

The precise balance will be agreed as part of Job Plan reviews and may vary to take account of circumstances where the agreed level of duties in relation to Supporting Professional Activities, Additional HPSS Responsibilities and External Duties is significantly greater or lower than 2½ Programmed Activities.

Responsibilities as a Medical Director or Clinical Director may be reflected by substitution for other whole or part Programmed Activities or by additional remuneration agreed locally.

7.4 External Duties

Where you wish to seek agreement to have External Duties included in your Job Plan, you must notify your clinical manager in advance. Scheduling of such duties will be by agreement between you and your clinical manager. Where carrying out these External Duties might affect the performance of direct clinical duties, where possible you will give us sufficient notice to ensure that, where such external duties are agreed, you and your clinical manager can agree a revised schedule of activities at least a month in advance.

7.5 Recognition For Emergency Work Arising From On-Call Duties

Where emergency work takes place at regular and predictable times, your clinical manager will seek to schedule it as part of the Programmed Activities in your Job Plan schedule. You may, however, be required to participate in an on-call rota to respond to less predictable emergencies.

The provisions in Schedule 5 of the Terms and Conditions of Service apply to recognise unpredictable emergency work arising from on-call rota duties that takes place other than during a Programmed Activity scheduled in your Job Plan.

7.6 Extra Programmed Activities

You and your clinical manager may agree that you will undertake extra Programmed Activities over and above the 10 Programmed Activities that constitute your standard contractual duties, up to the maximum permitted under the Working Time Regulations. The remuneration for these activities is covered by section 21 below and Schedules 13 and 14 of the Terms and Conditions of Service.

Any such agreement will be made in writing and the additional Programmed Activities will be incorporated into your Job Plan schedule.

Subject to the provisions in section 7.7 below, and without prejudice to section 7.8 below, you do not have to agree to carry out more than 10 Programmed Activities on average per week. However, where you do give your agreement, you must undertake such activities. The remuneration for these activities is covered by Section 21 below and Schedules 13 and 14 of the Terms and Conditions of Service. Any additional Programmed Activities that you carry out beyond the standard Programmed activities, will be paid at the rates set out in Schedules 13 and 14 of the Terms and Conditions of Service.

7.7 Transitional Arrangements

Where the provisions for recognising on-call work in Schedule 5 of the Terms and Conditions of Service would otherwise result in a reduction in the time available for the other duties undertaken by you and other colleagues on these new contractual arrangements, compared with the time normally available for such duties in the immediate period before the introduction of this contract, we will agree appropriate arrangements with you and your consultant colleagues to prevent such a reduction, if necessary by arranging for additional Programmed Activities to be provided. These arrangements may apply only during the period ending on 31 March 2006.

7.8 *Extra Programmed Activities And Additional Professional Capacity*

Where you intend to undertake private professional services other than such work carried out under the terms of this contract, whether for the HPSS, for the independent sector or for another party, the provisions in Schedule 6 of the Terms and Conditions of Service will apply.

8 *Premium Time*

From 1 April 2004, the provisions in Schedule 7 of the Terms and Conditions of Service will apply to recognise the unsocial nature of work done in Premium Time and the flexibility needed by consultants who work at these times as part of a more varied overall working pattern.

On any occasion where a consultant is scheduled to work during the Premium Time period, the employing organisation will ensure that the consultant has adequate rest both before and after this period of duty.

9 *On-Call And Emergency Duties***9.1 *On-Call Rotas***

Where you are on an on-call rota, the provisions in Schedule 8 of the Terms and Conditions of Service will apply.

Your on-call duties will be set out in the published rota or in accordance with any alternative arrangements that you agree with your colleagues for providing on-call cover.

9.2 *On-Call Availability Supplements*

Where you are on an on-call rota, you will receive an on-call availability supplement according to the provisions in Schedule 16 of the Terms and Conditions of Service. The level of supplement will depend on the frequency of your rota and the typical nature of the required response when you are called.

OTHER CONDITIONS OF EMPLOYMENT**10 *Registration Requirements***

It is a condition of your employment that you are, and remain, a fully registered medical practitioner and are included on the Specialist Register held by the General Medical Council (GMC), and continue to hold a licence to practice.

11 *Fee Paying Services And Private Professional Services***11.1 *Minimising Potential For Conflicts Of Interest***

In carrying out any Fee Paying Services or Private Professional Services, you will observe the provisions in Schedule 9 of the Terms

and Conditions of Service in order to help minimise the risk of any perceived conflicts of interest to arise with your work for the HPSS.

11.2 *Fee Paying Services and HPSS Programmed Activities*

Examples of Fee Paying Services are set out in Schedule 10 of the Terms and Conditions of Service.

You will not carry out Fee Paying Services during your Programmed Activities except where you and your clinical manager have agreed otherwise. Where your clinical manager has agreed that you may carry out Fee Paying Services during your Programmed Activities, you will remit to us the fees for such services except where you and your clinical manager have agreed that providing these services involves minimal disruption to your HPSS duties. Schedule 11 of the Terms and Conditions of Service contains guidance on this subject.

11.3 *Private Professional Services and HPSS Programmed Activities*

Subject to the provisions in Schedule 9 of the Terms and Conditions of Service, you may not carry out Private Professional Services during your Programmed Activities.

11.4 *Publications, lectures, etc*

A practitioner shall be free, without prior consent of the employing authority, to publish books, articles, etc., and to deliver any lecture or speak, whether on matters arising out of his or her HPSS service or not.

12 *Deductions From Pay*

We will not make deductions from or variations to your salary other than those required by law without your express written consent.

13 *Appraisal And Clinical Governance*

The Appraisal Scheme for Consultant Staff (DHSSPS Circulars HSS(TC8) 3/01 and HSS(TC8) 11/01) applies to your post. You must co-operate fully in the operation of the appraisal scheme. You must also comply with our clinical governance procedures.

14 *Gifts And Gratuities*

You are required to comply with our rules and procedures governing the acceptance of gifts and hospitalities.

15 *Policies And Procedures*

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

16 *Grievance Procedures*

The grievance procedures, which apply to your employment are set out in Trust policies.

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.

18 Intellectual Property

You will comply with our procedures for intellectual property which are in line with 'A Framework for the Management of Intellectual Property in the HPSS'.

19 Other Conditions of Service

The provisions in Schedule 12 of the Terms and Conditions of Service will apply.

PAY**20 Salary*****20.1 Basic Salary And Pay Thresholds***

Your basic salary as at 1st April 2004 is £72,423 per annum. This has been calculated in accordance with the provisions in Schedules 13 and 14 of the Terms and Conditions of Service.

Your basic salary will increase when you receive pay thresholds in accordance with the provisions of section 20.2 and Schedule 15 of the Terms and Conditions of Service.

The value of each pay threshold and the number of years' service required before you become eligible for pay thresholds are set out in Schedules 13 and 14 of the Terms and Conditions of Service.

Where a pay threshold is awarded, the date on which your salary will increase to take account of the threshold will be the anniversary of transfer to this contract.

Your basic salary, together with any payments for extra Programmed Activities (see section 21 below) includes payment for all Contractual and Consequential Services.

20.2 Criteria for Pay Thresholds

You will not receive pay thresholds automatically, but it is expected that you will progress through the thresholds and will do so if the

criteria set out in Schedule 15 are met. We will make all reasonable efforts to support you in meeting the criteria for pay thresholds.

21 Payment For Additional Programmed Activities

Any additional Programmed Activities that you carry out, beyond the standard 10 Programmed Activities, will be paid at the rates set out in Schedules 13 and 14 of the Terms and Conditions of Service.

22 Clinical Excellence Awards

Where the Clinical Excellence Awards Committee has recommended that you receive a Higher Award, or we have decided that you should receive one or more Local Award/s, these will be paid at the rates set out in the latest Circular from the Department of Health, Social Services and Public Safety concerning pay and conditions of service for hospital medical and dental staff and doctors in public health medicine and the community health service.

23 On-Call Availability Supplement

If you are required to participate in an on-call rota, you will be paid a supplement in addition to your basic salary in respect of your availability to work during on-call periods. The supplement will be paid in accordance with, and at the appropriate rate shown in, Schedule 16 of the Terms and Conditions of Service.

24 Recruitment and Retention Premia

We may under certain circumstances decide to award a recruitment or retention premium in addition to your basic salary in line with the provisions in Schedule 16 of the Terms and Conditions of Service.

25 Directors of Public Health

Directors of Public Health will be entitled to supplements in addition to basic salary in line with the provisions in Schedule 16 of the terms and conditions of Service.

PENSION

26 Pension

The provisions in Schedule 17 of the Terms and Conditions of Service shall apply.

You will be eligible for membership of the HPSS Superannuation Scheme, the provisions of which are set out in the HPSS Superannuation Scheme Regulations 1995 (as amended). The Scheme is a final salary scheme with benefits based on the best of the last three years pensionable pay. Pensionable pay will include basic salary (up to ten programmed activities, but not any additional programmed activities above this), on-call availability supplements, any discretionary

points or distinction awards (or their agreed replacement), and any other pay expressly agreed to be pensionable.

You are contracted out of the State Second Pension Scheme.

LEAVE AND HOLIDAYS

27 Leave And Holidays

Schedule 18 of the Terms and Conditions of Service sets out your entitlements in respect of:

- annual leave and public holidays
- professional and study leave
- sabbaticals
- sick leave
- special leave
- maternity leave and domestic personal and care relief.

The leave year runs from 1st April to 31st March the following year.

OTHER ENTITLEMENTS

28 Expenses

You are entitled to be paid expenses, which should be submitted in a timely manner (normally within one month), for:

- excess travel
- subsistence; and
- other expenses in accordance with schedule 21.

29 Charges for Residence

Except where facilities are provided for a doctor to be on-call a charge may, where appropriate, be made for residing at your place of work in accordance with our local procedures.

DURATION OF EMPLOYMENT

30 This is a permanent post.

TERMINATION OF EMPLOYMENT

31 Provisions governing termination of employment are set out in Schedule 19 of the Terms and Conditions of Service.

The employment is subject to 3 months notice on either side subject to Schedule 19 of the Terms and Conditions of Service.

ENTIRE TERMS**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 agreements, practices and understandings between us (if any) are superseded and of no effect. Where any external term is incorporated by reference such incorporation is only to the extent so stated and not further or otherwise.

I, **Mr A O'Brien**, and **Craigavon Area Hospital Group Trust** have understood and agree to honour the terms and conditions set out in this contract of employment.

*Representative of employing
authority's signature:*

RP

Personal Information redacted by USI

Consultant's signature:

Personal Information redacted by USI

Date of this agreement:

16.08.06.

4



**Southern Health
and Social Care Trust**

**Trust Guidelines for Handling
Concerns about Doctors' and Dentists'
Performance**

23 September 2010

1.0 Introduction

1.1 Maintaining High Professional Standards in the Modern HPSS ***A framework for the handling of concerns about doctors and***

dentists in the HPSS (hereafter referred to as Maintaining High Professional Standards (MHPS)) was issued by the Department of Health, Social Services and Public Safety (DHSSPS) in November 2005. MHPS provides a framework for handling concerns about the conduct, clinical performance and health of medical and dental employees. It covers action to be taken when a concern first arises about a doctor or dentist and any subsequent action including restriction or suspension.

1.2 This document seeks to underpin the principle within the MHPS Framework that the management of performance is a continuous process to ensure both quality of service and to protect clinicians and that remedial and supportive action can be quickly taken before problems become serious or patient's harmed.

1.3 The MHPS framework is in six sections and covers:

- I. Action when a concern first arises
- II. Restriction of practice and exclusion from work
- III. Conduct hearings and disciplinary procedures
- IV. Procedures for dealing with issues of clinical performance
- V. Handling concerns about a practitioner's health
- VI. Formal procedures – general principles

1.4 MHPS states that each Trust should have in place procedures for handling concerns about an individual's performance which reflect the framework.

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 for 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 any underlying problem.

1.6 This guidance also seeks to take account of the new role of Responsible Officer which Trusts in Northern Ireland must have in place by October 2010 and in particular how this role interfaces with the management of suspected poor medical performance or failures or problems within systems.

1.7 This guidance applies to all medical and dental staff, including consultants, doctors and dentists in training and other non-training grade staff employed by the Trust. In accordance with MHPS, concerns about the performance of doctors and dentists in training will be handled in line with those for other medical and dental staff with the proviso that the Postgraduate Dean should be involved in appropriate cases from the outset.

1.8 This guidance should be read in conjunction with the following documents:

“Maintaining High Professional Standards in the Modern NHS”
DHSSPS, 2005

“How to conduct a local performance investigation” NCAS, 2010

SHSCT Disciplinary Procedure

SHSCT Procedures for Initiating and Responding to Referrals to Professional Regulatory Bodies and the Independent Safeguarding Authority and Requesting DHSSPS to issue an alert.

2.0 SCREENING OF CONCERNS – ACTION TO BE TAKEN WHEN A CONCERN FIRST ARISES

- 2.1 NCAS Good Practice Guide – “How to conduct a local performance investigation” (2010) indicates that regardless of how a concern is identified, it should go through a screening process to identify whether an investigation is needed. The Guide also indicates that anonymous complaints and concerns based on ‘soft’ information should be put through the same screening process as other concerns.
- 2.2 Concerns¹ should be raised with the practitioner’s Clinical Manager – this will normally be either the Clinical Director or Associate Medical Director. If the initial report / concern is made directly to the Medical Director, then the Medical Director should accept and record the concern but not seek or receive any significant detail, rather refer the matter to the relevant Clinical Manager. Such concerns will then be subject to the normal process as stated in the remainder of this document.
- 2.3 Concerns which may require management under the MHPS Framework must be registered with the Chief Executive. The Clinical Manager will be responsible for informing the relevant operational Director. They will then inform the Chief Executive and the Medical Director, that a concern has been raised.
- 2.4 The Clinical Manager will immediately undertake an initial verification of the issues raised. The Clinical Manager must seek advice from the nominated HR Case Manager within Employee Engagement & Relations Department prior to undertaking any initial verification / fact finding.
- 2.5 The Chief Executive will be responsible for appointing an Oversight Group (OG) for the case. This will normally comprise of

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.

the Medical Director / Responsible Officer, the Director of Human Resources & Organisational Development and the relevant Operational Director. The role of the Oversight Group is for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.

2.6 The Clinical Manager and the nominated HR Case Manager will be responsible for investigating the concerns raised and assessing what action should be taken in response. Possible action could include:

- No action required
- Informal remedial action with the assistance of NCAS
- Formal investigation
- Exclusion / restriction

The Clinical Manager and HR Case Manager should take advice from other key parties such as NCAS, Occupational Health Department, in determining their assessment of action to be taken in response to the concerns raised. Guidance on NCAS involvement is detailed in MHPS paragraphs 9-14.

2.7 Where possible and appropriate, a local action plan should be agreed with the practitioner and resolution of the situation (with involvement of NCAS as appropriate) via monitoring of the practitioner by the Clinical Manager. MHPS recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather than solely through formal action. However, it is not intended to weaken accountability or avoid formal action where the situation warrants this approach. The informal process should be carried out as expeditiously as possible and the Oversight Group will monitor progress.

2.8 The Clinical Manager and the HR Case Manager will notify their informal assessment and decision to the Oversight Group. The role of the Oversight Group is to quality assure the decision and recommendations regarding invocation of the MHPS following

informal assessment by the Clinical Manager and HR Case Manager and if necessary ask for further clarification. The Oversight group will promote fairness, transparency and consistency of approach to the process of handling concerns.

- 2.9 The Chief Executive will be informed of the action to be taken by the Clinical Manager and HR Case Manager by the Chair of the Oversight Group.
- 2.10 If a formal investigation is to be undertaken, the Chief Executive in conjunction with the Oversight Group will appoint a Case Manager and Case Investigator. The Chief Executive also has a responsibility to advise the Chairman of the Board so that the Chairman can designate a non-executive member of the Board to oversee the case to ensure momentum is maintained and consider any representations from the practitioner about his or her exclusion (if relevant) or any representations about the investigation.

Reference Section 1 paragraph 8 – MHPS 2005

3.0 MANAGING PERFORMANCE ISSUES

- 3.1 The various processes involved in managing performance issues are described in a series of flowcharts / text in Appendices 1 to 6 of this document.

Appendix 1

An informal process. This can lead to resolution or move to:

Appendix 2

A formal process. This can also lead to resolution or to:

Appendix 3

A conduct panel (under Trust's Disciplinary Procedure) OR a clinical performance panel depending on the nature of the issue

Appendix 4

An appeal panel can be invoked by the practitioner following a panel determination.

Appendix 5

Exclusion can be used at any stage of the process.

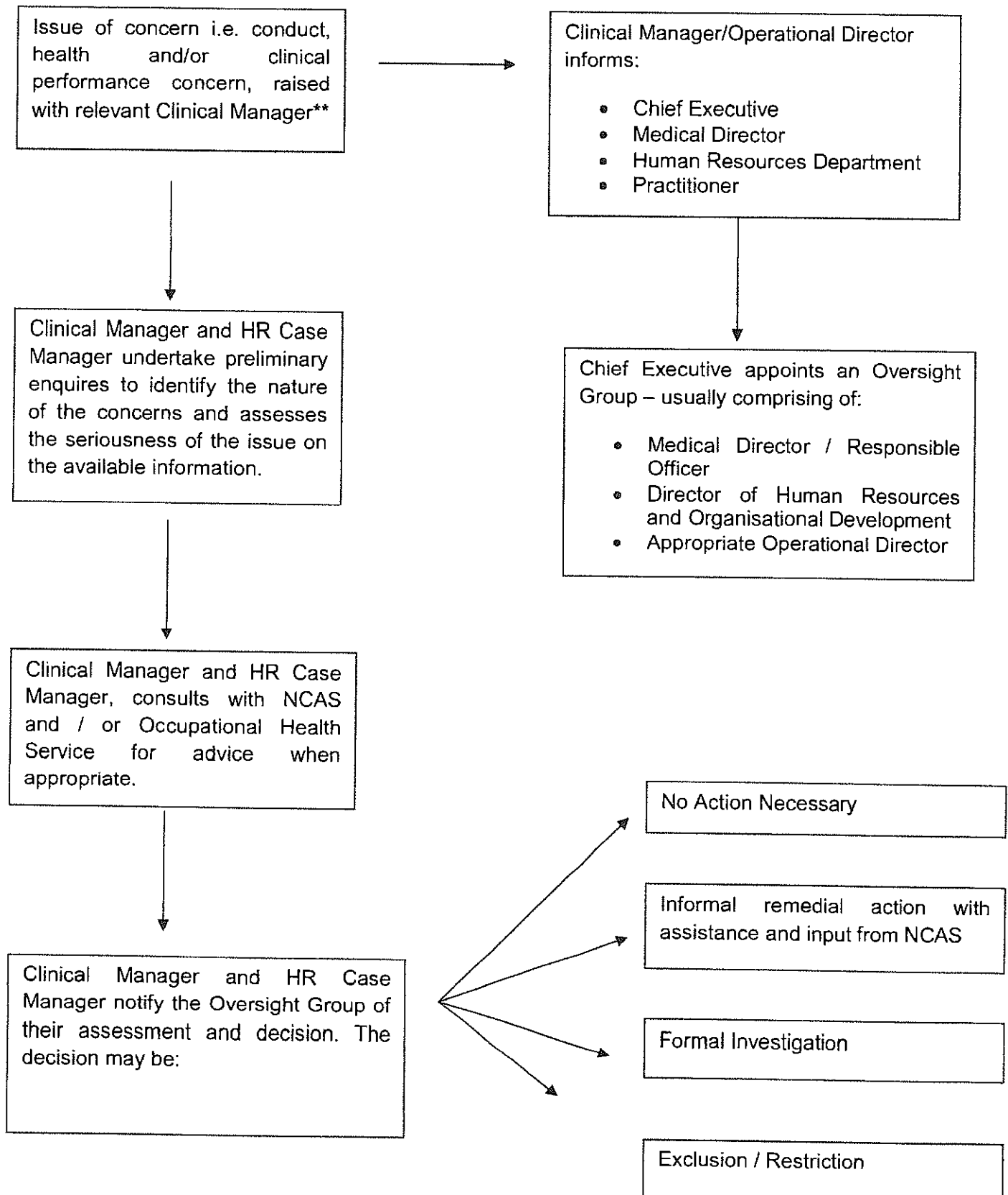
Appendix 6

Role definitions

- 3.2 The processes involved in managing performance issues move from informal to formal if required due to the seriousness or repetitive nature of the issue OR if the practitioner fails to comply with remedial action requirements or NCAS referral or recommendations. The decision following the initial assessment at the screening stage, can however result in the formal process being activated without having first gone through an informal stage, if the complaint warrants such measures to be taken.
- 3.3 If the findings following informal or formal stages are anything other than the practitioner being exonerated, these findings must be recorded and available to appraisers by the Clinical Manager (if informal) or Case Manager (if formal).
- 3.4 All formal cases will be presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review when the case is closed.
- 3.5 During all stages of the formal process under MHPS - or subsequent disciplinary action under the Trust's disciplinary procedures – the practitioner may be accompanied to any interview or hearing by a companion. The companion may be a work colleague from the Trust, an official or lay representative of the BMA, BDA, defence organisation, or friend, work or professional colleague, partner or spouse. The companion may be legally qualified but not acting in a legal capacity. Refer MHPS Section 1 Point 30.

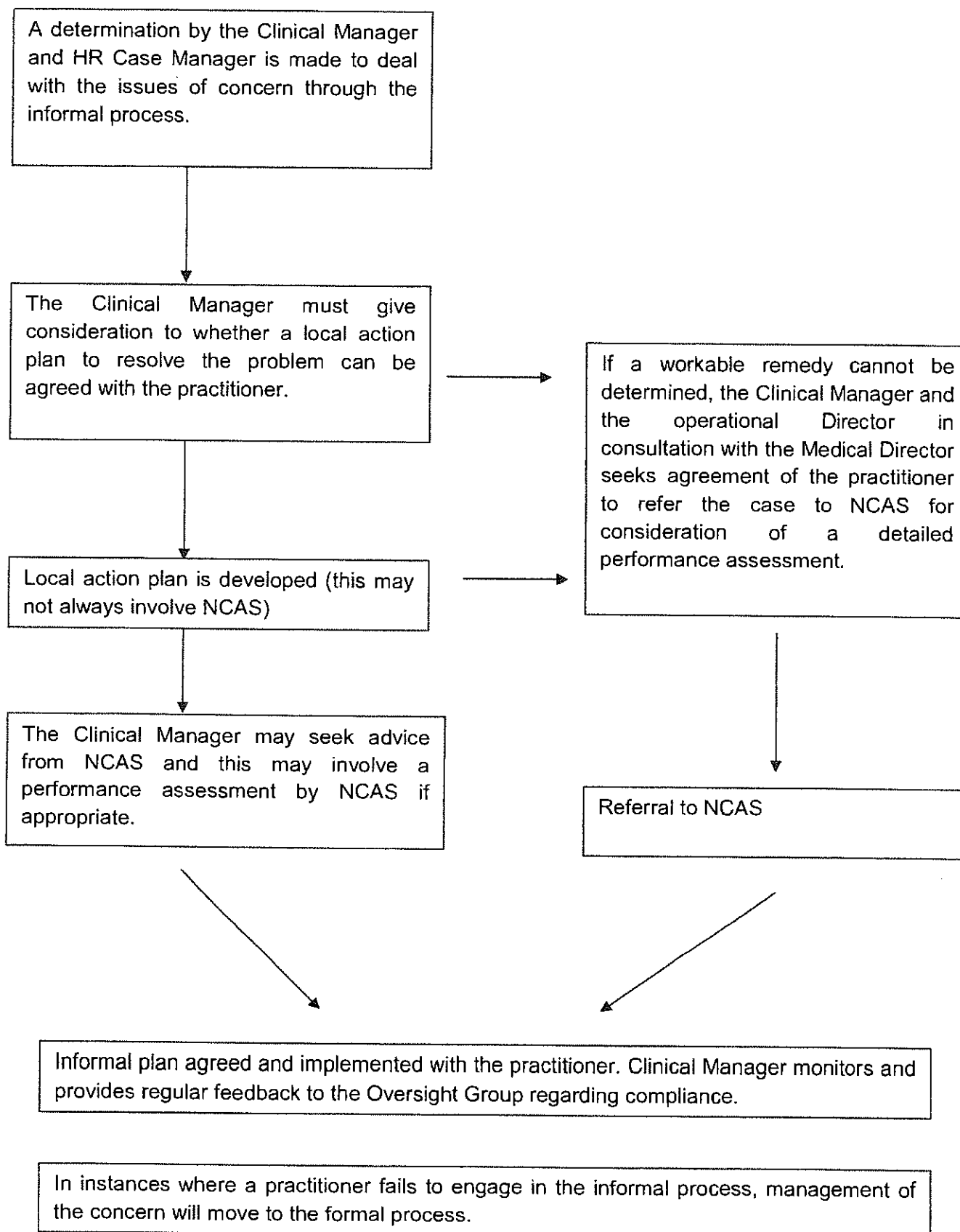
Appendix 1

Step 1 Screening Process



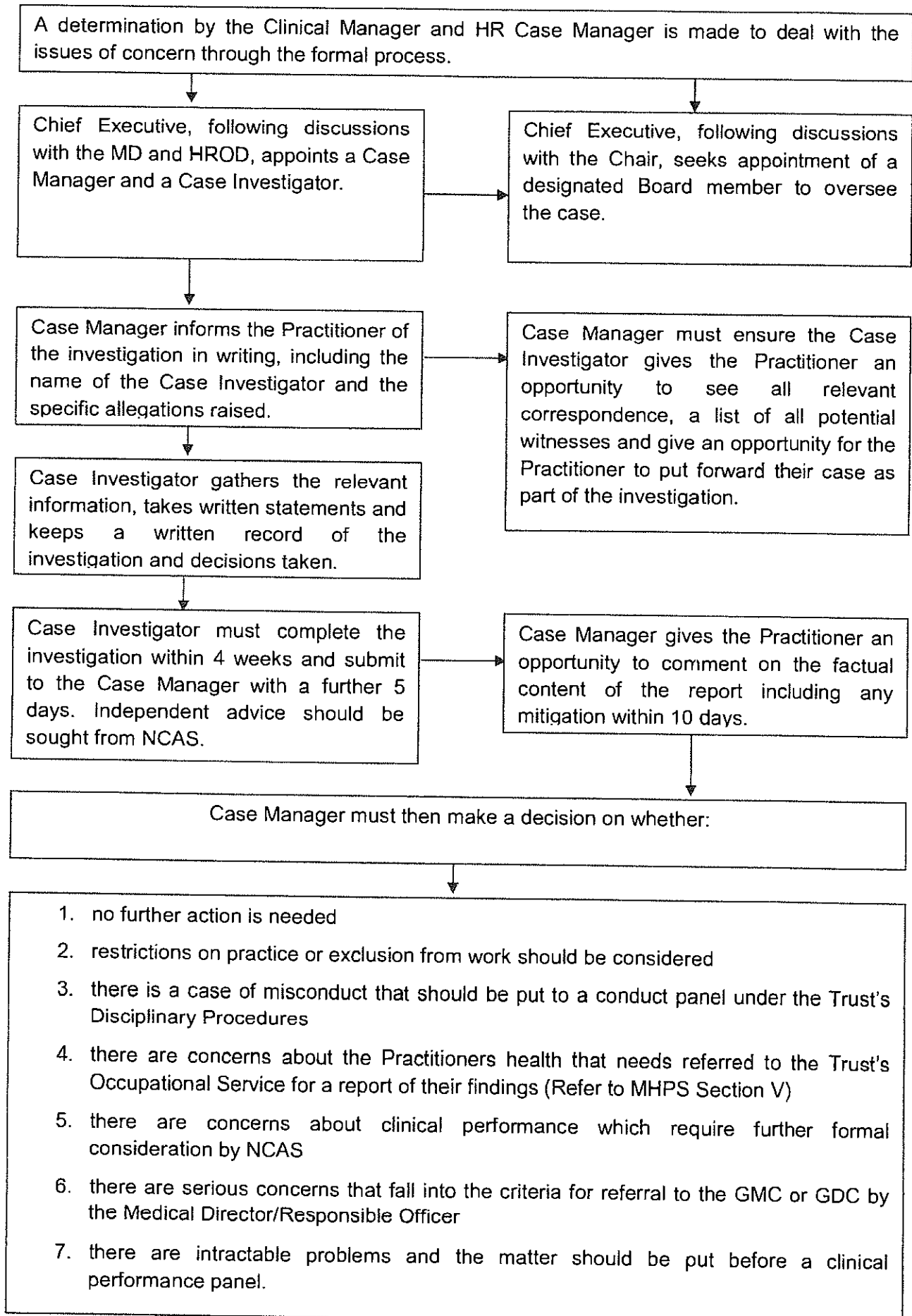
** If concern arises about the Clinical Manager this role is undertaken by the appropriate Associate Medical Director (AMD). If concern arises about the AMD this role is undertaken by the Medical Director

Appendix 1

Step 2 Informal Process

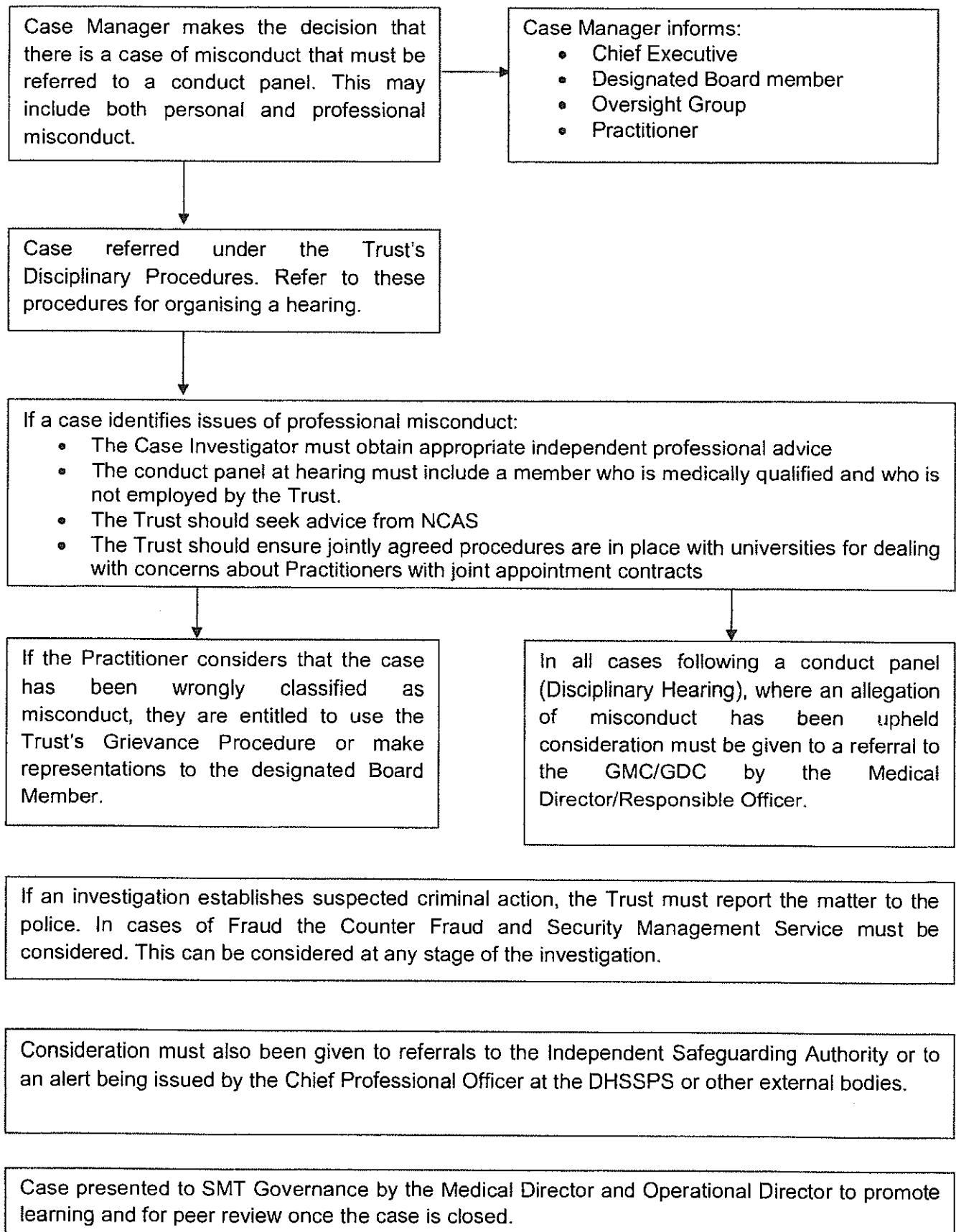
Appendix 2

Formal Process



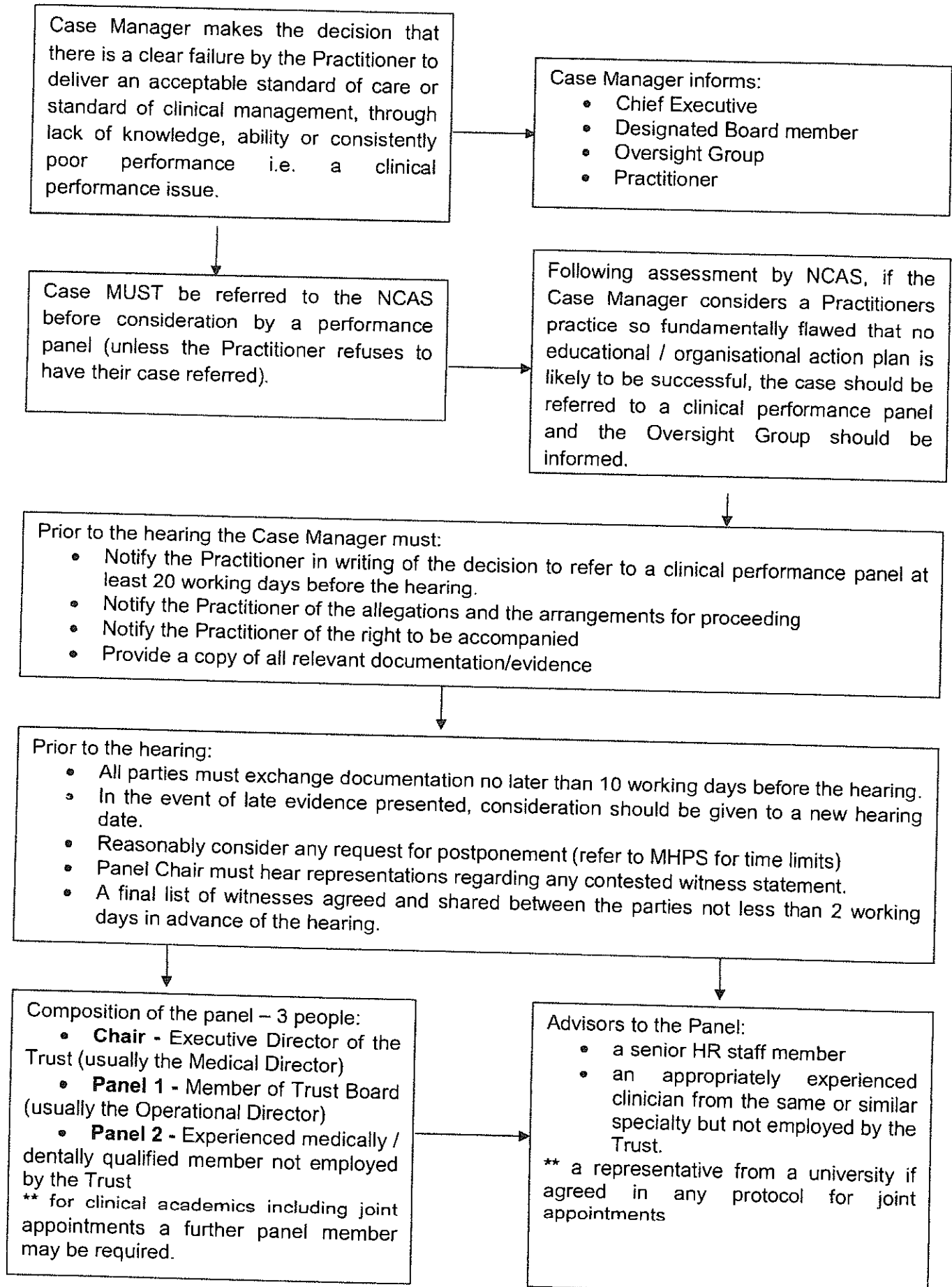
Appendix 3

Conduct Hearings / Disciplinary Procedures



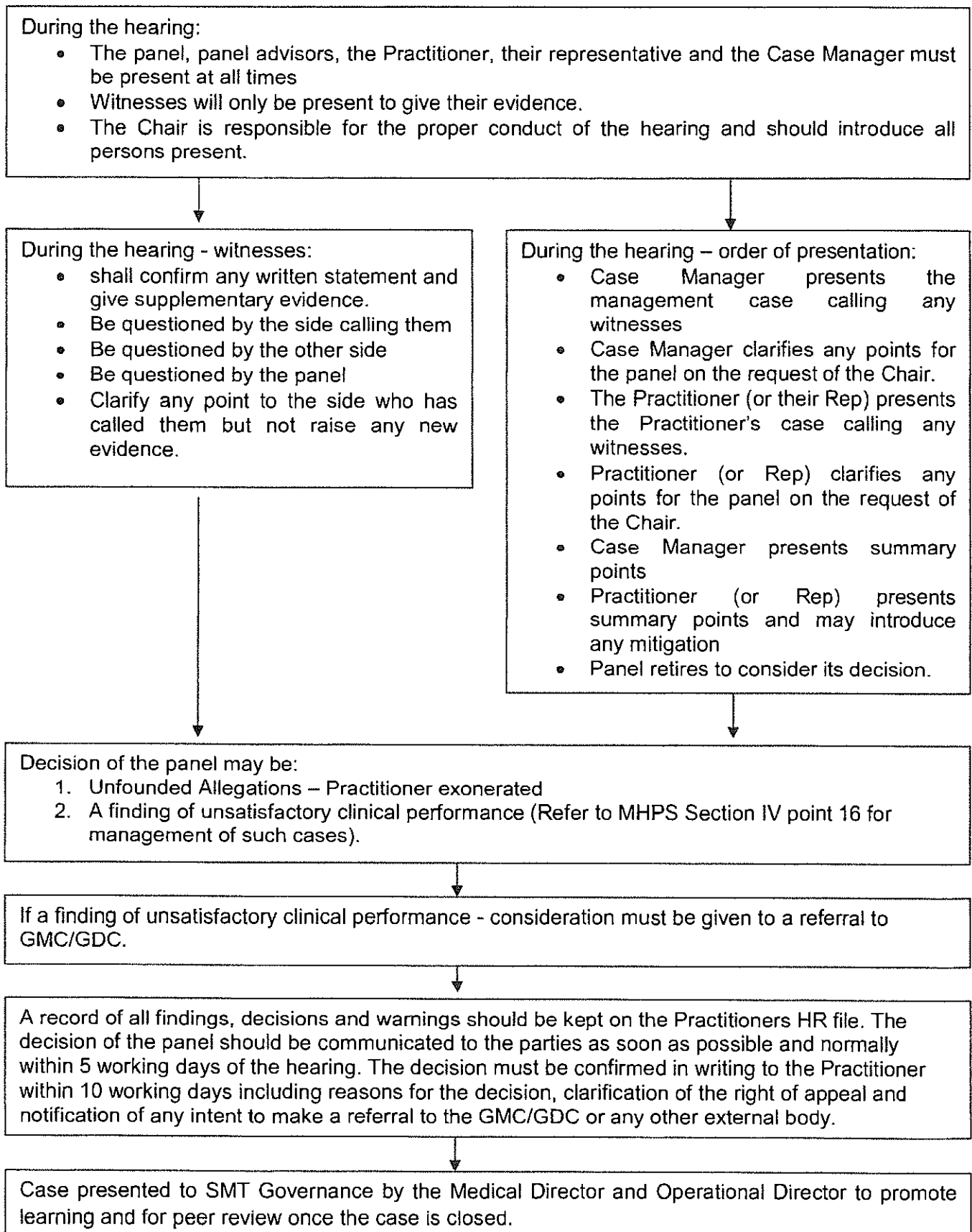
Appendix 3a

Clinical Performance Hearings

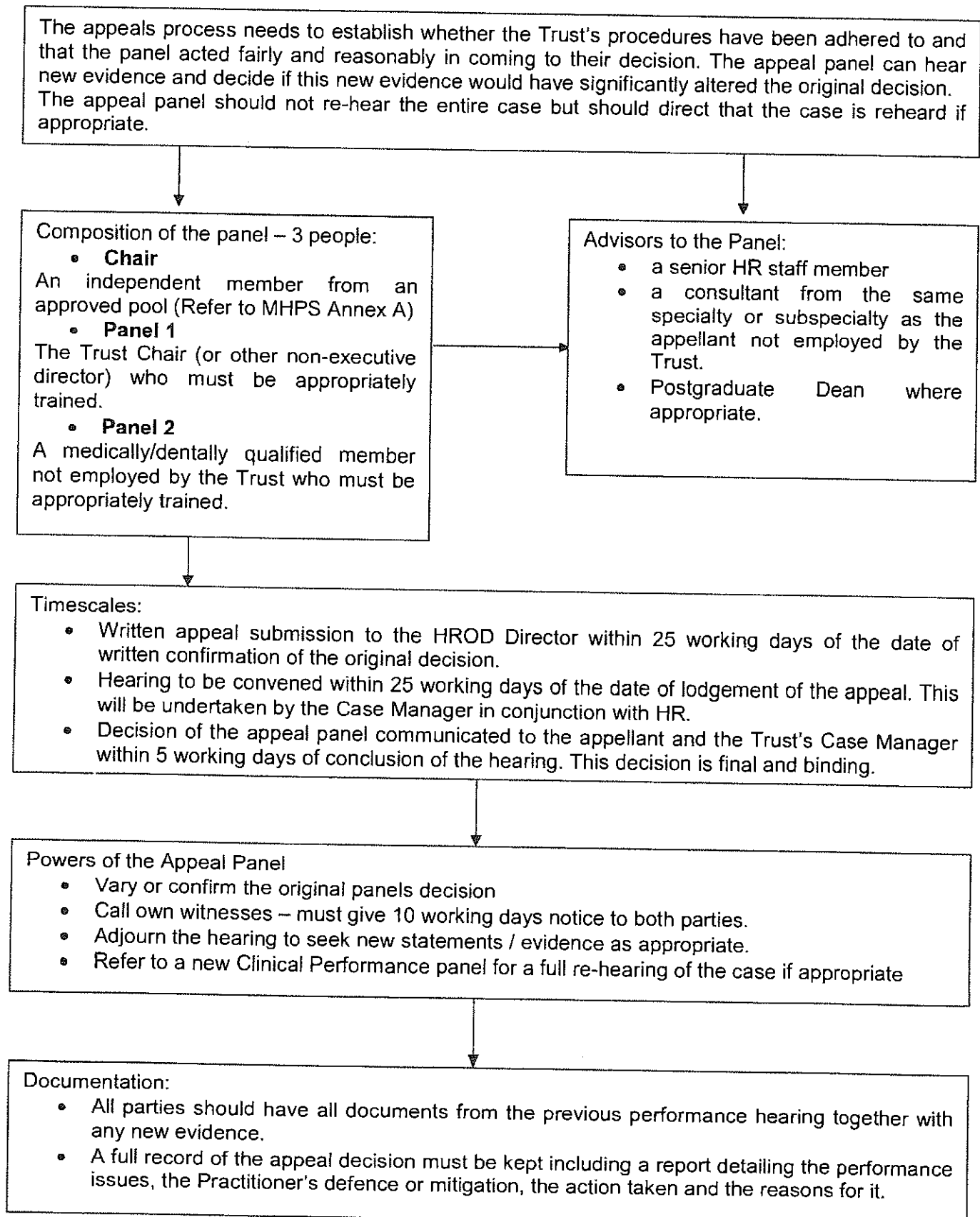


Appendix 3a

Clinical Performance Hearings



Appendix 4

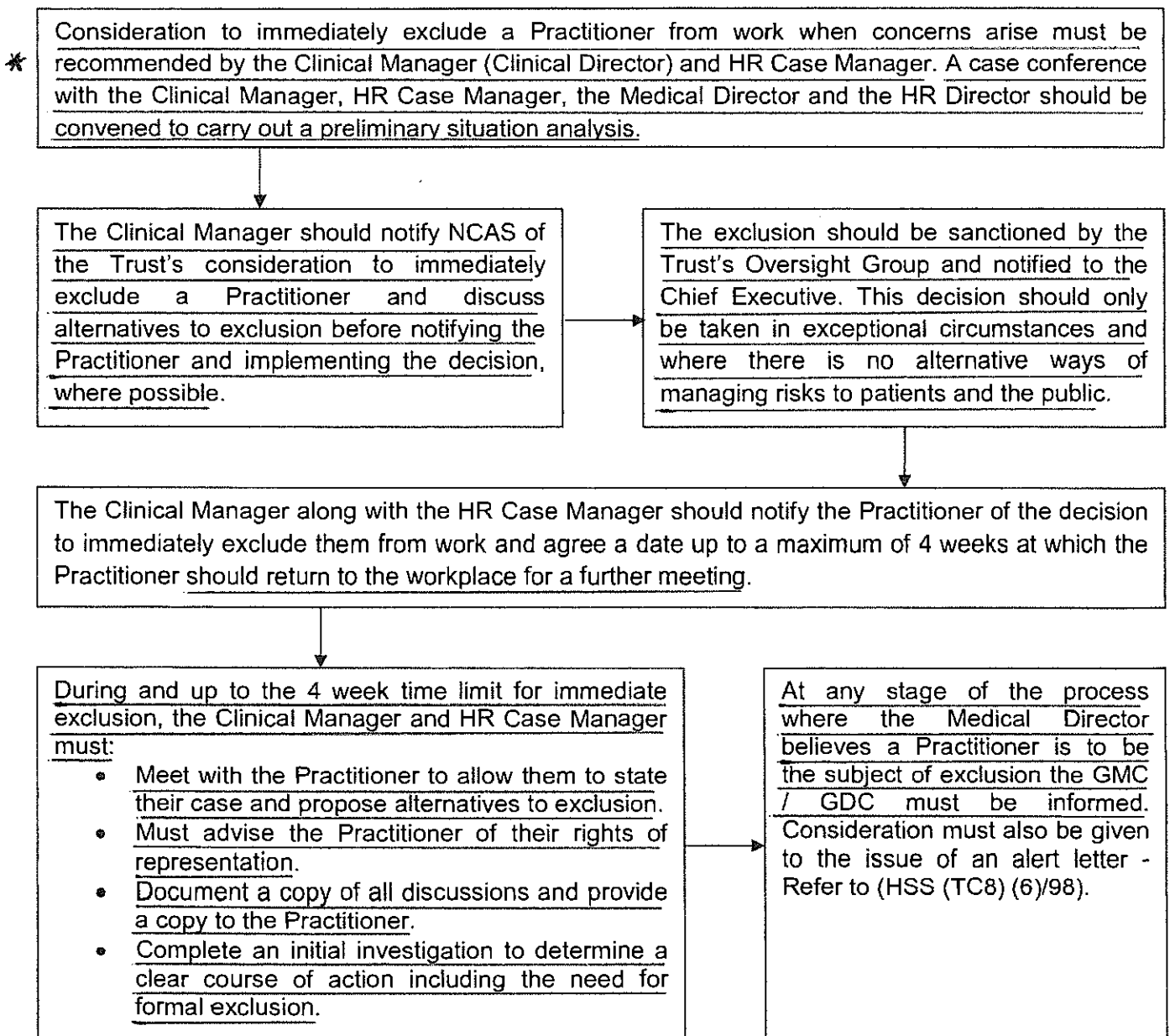
Appeal Procedures in Clinical Performance Cases

Appendix 5

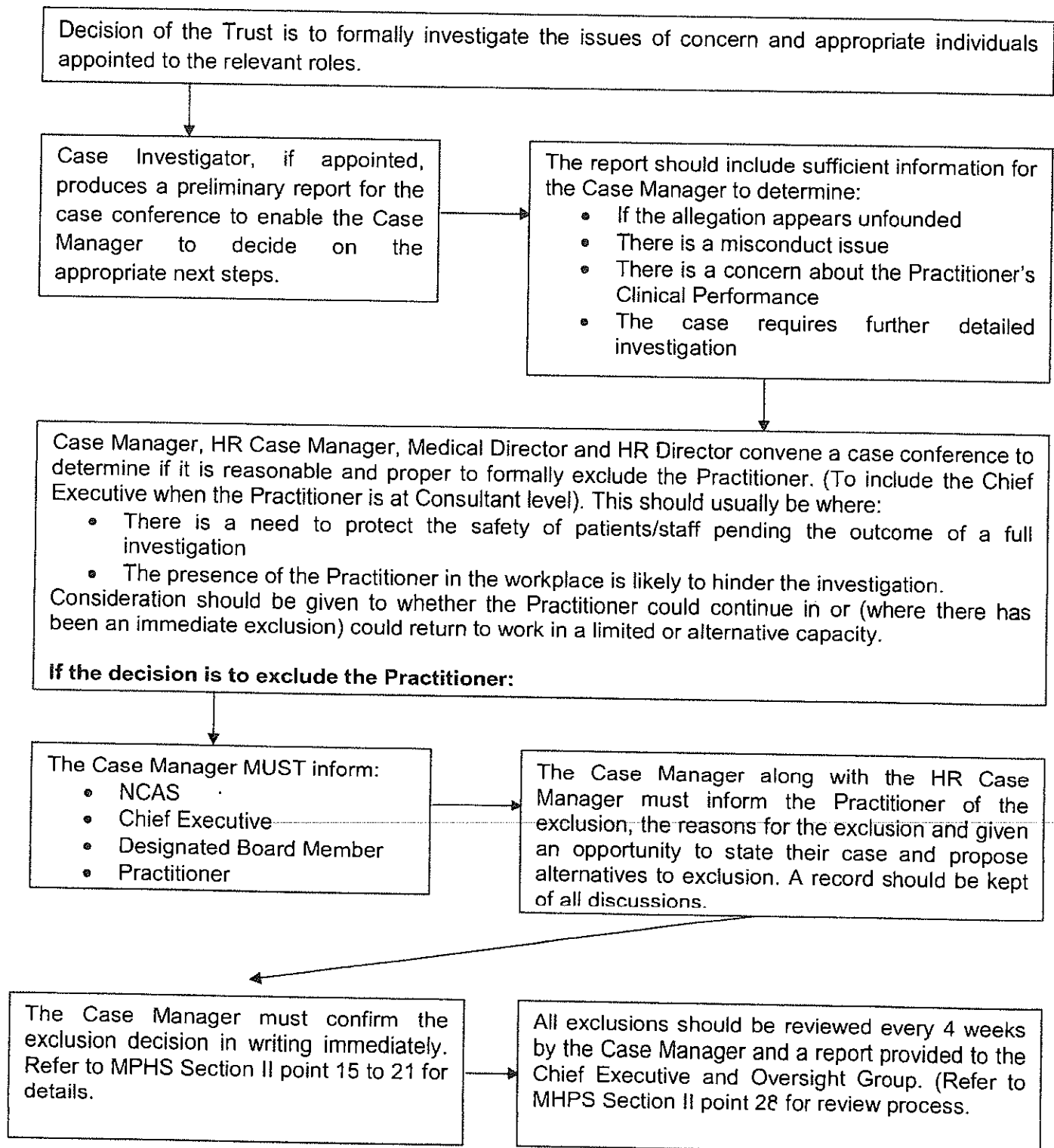
Restriction of Practice / Exclusion from Work

- All exclusions must only be an interim measure.
- Exclusions may be up to but no more than 4 weeks.
- Extensions of exclusion must be reviewed and a brief report provided to the Chief Executive and the Board. This will likely be through the Clinical Director for immediate exclusions and the Case Manager for formal exclusions. The Oversight Group should be informed.
- A detailed report should be provided when requested to the designated Board member who will be responsible for monitoring the exclusion until it is lifted.

Immediate Exclusion



Appendix 5

Restriction of Practice / Exclusion from Work**Formal Exclusion**

Role definitions and responsibilities**Screening Process / Informal Process****Clinical Manager**

This is the person to whom concerns are reported to. This will normally be the Clinical Director or Associate Medical Director (although usually the Clinical Director). The Clinical Manager informs the Chief Executive and the Practitioner that concerns have been raised, and conducts the initial assessment along with a HR Case Manager. The Clinical Manager presents the findings of the initial screening and his/her decision on action to be taken in response to the concerns raised to the Oversight Group.

Chief Executive

The Chief Executive appoints an appropriate Oversight Group and is kept informed of the process throughout. (The Chief Executive will be involved in any decision to exclude a practitioner at Consultant level.)

Oversight Group

This group will usually comprise of the Medical Director / Responsible Officer, Director of Human Resources & Organisational Development and the relevant Operational Director. The Oversight Group is kept informed by the Clinical Manager and the HR Case Manager as to action to be taken in response to concerns raised following initial assessment for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.

Formal Process**Chief Executive**

The Chief Executive in conjunction with the Oversight Group appoints a Case Manager and Case Investigator. The Chief Executive will inform the Chairman of formal the investigation and requests that a Non-Executive Director is appointed as "designated Board Member".

Case Manager

This role will usually be delegated by the Medical Director to the relevant Associate Medical Director. S/he coordinates the investigation, ensures adequate support to those involved and that the investigation runs to the appropriate time frame. The Case Manager keeps all parties informed of the process and s/he also determines the action to be taken once the formal investigation has been presented in a report.

Case Investigator

This role will usually be undertaken by the relevant Clinical Director, in some instances it may be necessary to appoint a case investigator from outside the Trust. The Clinical Director examines the relevant evidence in line with agreed terms of reference, and presents the facts to the Case Manager in a report format. The Case Investigator does not make the decision on what action should or should not be taken, nor whether the employee should be excluded from work.

Note: Should the concerns involve a Clinical Director, the Case Manager becomes the Medical Director, who can no longer chair or sit on any formal panels. The Case Investigator will be the Associate Medical Director in this instance. Should the concerns involve an Associate Medical Director, the Case Manager becomes the Medical Director who can no longer chair or sit on any formal panels. The Case Investigator may be another Associate Medical Director or in some cases the Trust may have to appoint a case investigator from outside the Trust. Any conflict of interest should be declared by the Clinical Manager before proceeding with this process.

Non Executive Board Member

Appointed by the Trust Chair, the Non-Executive Board member must ensure that the investigation is completed in a fair and transparent way, in line with Trust procedures and the MHPS framework. The Non Executive Board member reports back findings to Trust Board.

5

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 Mackie, 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, in Florida, since 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 44 years

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 NICA to consider taking on the role of Lead Clinician of NICA'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 NICA'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. Personal Information redacted by USI is a 63 year old 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 Personal Information redacted by USI 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 MH, 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 increasingly 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, bladder outlet obstruction. In addition, I had undertaken to defer surgery 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 surgery on 17 November 2016. Surgery went very well with the expected outcome until symptomatic deterioration one month later, due to [REDACTED]. 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 2016. I enquired whether he was aware that I was on [REDACTED] 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, recovering from [REDACTED] while on [REDACTED] 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, [REDACTED] 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 USI: Patient seen 6 times and no letters on file for any attendances.

Personal Information
redacted by was a six year old 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 Information redacted by USI 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 USI Letter done when patient was a private patient, no other letters on file.

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

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

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

As above

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

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

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

As above.

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

Has never been a urological patient

8. Personal Information redacted by 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 untrue. Instead, I submitted a formal written grievance against Mr. Mackle when I discovered that he had