

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

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

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

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

Terms of Reference

1. Triage

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

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

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

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

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

2. Patient Notes stored at Home

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

3. Undictated Outcomes

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

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

4. Private Patients

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

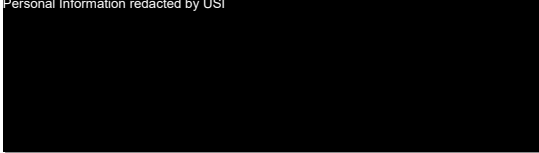
5. The Role of Management

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

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

This did not happen.

Personal information redacted by USI



Aidan O'Brien
10th July 2018

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Job plan report

Southern Health and Social Care Trust.

This job plan started 01 January 2015.

Job plan for Mr O'Brien, Aidan in Urology

Basic Information

Job plan status	Job Disruption State
Appointment	Full Time
Cycle	Spelling cycle: 14 weeks
Start week	
Report date	16 Apr 2015
Expected number of weeks in attendance	6 weeks
number of weekdays for on-call purposes	1 (Monday to Friday)
Alternate employer	None Specified
Contract	Urology
Private practice	No

Job plan stages

Job plan stages	Comment	Date stage achieved	Who by
1. Disruption State		16 Apr 2015	Mr O'Brien

PA Breakdown

	Main Employer PAs	Total PAs	Total hours
Direct Clinical Care (DCC)	10.458	10.458	3137
Supporting Professional Activities (SPA)	1.737	1.737	520
Total	12.195	12.195	3657

On-call availability

Works on-call?	No
General Settings:	
Want to ever on call tomorrow?	No
Weekend on-call work:	
Other Information:	
Emergency duty and on-call work take home?	Check on work schedule
Category	Category A (Return immediately to see or lengthy phone consultation)
PA Count:	
The number of PAs arising from your predictable on-call work is:	0.000
The number of PAs arising from your unpredictable on-call work is:	0.000
Your on-call responsibility supplement is:	0
Link your predictable on-call work to a personal or service objective?	No (link collectively)
Link your unpredictable on-call work to a personal or service objective?	No (link collectively)

Sign off

Senior Clinical Director	Senior Clinical Manager	Senior Board Member
Signature: Mr Hall, Samuel	Signature: Dr Madhav, Eduram	Signature: Mrs Preston, Heather
Date:	Date:	Date:

Threats

Week 1

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1. Webinar: Digital Marketing 9:00 - 10:00 2. Client Meeting: ABC Corp 10:30 - 11:30 3. Writing Blog Post: SEO Trends 13:00 - 14:00 4. Review Project Status 15:00 - 16:00	5. Webinar: Social Media Strategy 9:00 - 10:00 6. Client Meeting: DEF Ltd 10:30 - 11:30 7. Writing Blog Post: Content Marketing 13:00 - 14:00 8. Review Project Status 15:00 - 16:00	9. Webinar: Email Marketing Automation 9:00 - 10:00 10. Client Meeting: GHI Inc 10:30 - 11:30 11. Writing Blog Post: Analytics 13:00 - 14:00 12. Review Project Status 15:00 - 16:00	13. Webinar: Conversion Rate Optimization 9:00 - 10:00 14. Client Meeting: JKL Corp 10:30 - 11:30 15. Writing Blog Post: User Experience 13:00 - 14:00 16. Review Project Status 15:00 - 16:00	17. Webinar: Mobile App Development 9:00 - 10:00 18. Client Meeting: MNO Ltd 10:30 - 11:30 19. Writing Blog Post: Future of Marketing 13:00 - 14:00 20. Review Project Status 15:00 - 16:00		

Week 2

[illegible]

Week 5

[illegible]

Job plan report

Week 4

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Consultant at home 08:00 - 10:00 Consultant at home 10:00 - 16:00 Consultant at home 16:00 - 17:00	Consultant at home 08:00 - 12:00 Consultant at home 13:00 - 17:00	Consultant at home 08:00 - 11:00 Consultant at home 11:00 - 12:00 Consultant at home 12:00 - 14:00 Consultant at home 14:00 - 15:00 Consultant at home 15:00 - 16:00	Consultant at home 08:00 - 10:00 Consultant at home 10:00 - 12:00 Consultant at home 12:00 - 14:00 Consultant at home 14:00 - 15:00	Consultant at home 08:00 - 12:00 Consultant at home 12:00 - 13:00		

Week 5

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Consultant at home 08:00 - 10:00 Consultant at home 10:00 - 12:00 Consultant at home 12:00 - 17:00	Consultant at home 08:00 - 09:00 Consultant at home 09:00 - 10:00 Consultant at home 10:00 - 12:00 Consultant at home 12:00 - 17:00	Consultant at home 08:00 - 11:00 Consultant at home 11:00 - 12:00 Consultant at home 12:00 - 13:00 Consultant at home 13:00 - 14:00 Consultant at home 14:00 - 15:00 Consultant at home 15:00 - 16:00	Consultant at home 08:00 - 10:00 Consultant at home 10:00 - 12:00 Consultant at home 12:00 - 14:00 Consultant at home 14:00 - 15:00	Consultant at home 08:00 - 10:00 Consultant at home 10:00 - 12:00		

Week 6

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Consultant at home 08:00 - 17:00	Consultant at home 08:00 - 17:00	Consultant at home 08:00 - 17:00	Consultant at home 08:00 - 17:00	Consultant at home 08:00 - 17:00		

Week 7

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Consultant at home 08:00 - 10:00 Consultant at home 10:00 - 17:00	Consultant at home 08:00 - 09:00 Consultant at home 09:00 - 10:00 Consultant at home 10:00 - 12:00 Consultant at home 12:00 - 17:00	Consultant at home 08:00 - 11:00 Consultant at home 11:00 - 12:00 Consultant at home 12:00 - 13:00 Consultant at home 13:00 - 14:00 Consultant at home 14:00 - 15:00 Consultant at home 15:00 - 16:00	Consultant at home 08:00 - 10:00 Consultant at home 10:00 - 12:00 Consultant at home 12:00 - 14:00 Consultant at home 14:00 - 15:00	Consultant at home 08:00 - 10:00 Consultant at home 10:00 - 12:00		

Week 8

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Consultant at home 08:00 - 10:00 Consultant at home 10:00 - 16:00	Consultant at home 08:00 - 12:00 Consultant at home 12:00 - 17:00	Consultant at home 08:00 - 11:00 Consultant at home 11:00 - 12:00	Consultant at home 08:00 - 10:00 Consultant at home 10:00 - 12:00	Consultant at home 08:00 - 10:00 Consultant at home 10:00 - 12:00		

[illegible]

Normal	Premium	Activity	Employer	Location	Cat.	Name/Pt	PA	Status
Employee must have at least \$100,000 in sales								
Normal								
	Type	Normal		Premium	Cat.		PA	
Employee		10%	10%		10%			
Employee		10%	10%		10%		10%	
Employee		10%	10%		10%		10%	

Other

7

$$x_{i+1} = x_i + \Delta x_i$$

On-call Rota (PA entry)

General Information

What is your on-call service?

General PA's

Where does your on-call rota cover you for?

General PA's (own PA)

What is your on-call rota structure?

1

Weekday work

What is the frequency of your weekday on-call work?

1 in 400

Predictable Unpredictable

How many PA's are there on your weekday on-call service?

0.000 1.000

Weekend work

What is the frequency of your weekend on-call work?

1 in 400

Predictable Unpredictable

How many PA's are there on your weekend on-call service?

0.000 0.000

Other Information

Which objective does this on-call work relate to?

Comments

Sign off

Authorisation Manager

Manager: Dr. Michael O'Brien

Authorisation Director

Manager: Dr. Michael O'Brien

Manager: Dr. Michael O'Brien

Manager: Dr. Michael O'Brien

Signature

Signature

Signature

Date

Date

Date

Timetable

Hot Activities

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Week 1

There are no activities this week

Week 2

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc) 09:00 - 13:00 Review Outpatients clinic 13:30 - 17:30	Day surgery 08:30 - 13:00 New patient Clinic 13:30 - 17:30		Uroradiology meeting 08:30 - 10:00 Grand Round 10:00 - 12:00 Departmental meeting 12:00 - 14:00 Surgery MDT 14:00 - 17:30	Sub Specialty clinic 09:00 - 13:00 Continuous professional development 13:00 - 17:00		

Week 3

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Travelling time between hospitals 09:00 - 10:00 New patient Clinic	Continuous professional development 09:00 - 13:00 New patient Clinic		Uroradiology meeting 08:30 - 10:00 Grand Round 10:00 - 12:00	Sub Specialty clinic 09:00 - 13:00 Continuous professional development		

10:00 - 17:00 13:30 - 17:30
Travelling time
between hospitals
17:00 - 18:00

Departmental
meeting
12:00 - 14:00
Surgery MDT
14:00 - 17:30

13:00 - 17:00

Week 4

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc) 09:00 - 13:00 Review Outpatients clinic 13:30 - 17:30	Day surgery 08:30 - 13:00 New patient Clinic 13:30 - 17:30		Uroradiology meeting 08:30 - 10:00 Grand Round 10:00 - 12:00 Departmental meeting 12:00 - 14:00 Surgery MDT 14:00 - 17:30	Sub Specialty clinic 09:00 - 13:00 Continuous professional development. 13:00 - 17:00		

Week 5

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Review Outpatients clinic 09:00 - 13:00 Review Outpatients clinic 13:30 - 17:30	Continuous professional development. 09:00 - 13:00 New patient Clinic 13:30 - 17:30		Uroradiology meeting 08:30 - 10:00 Grand Round 10:00 - 12:00 Departmental meeting 12:00 - 14:00 Surgery MDT 14:00 - 17:30	Sub Specialty clinic 09:00 - 13:00 Continuous professional development. 13:00 - 17:00		

Week 6

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc) 09:00 - 13:00 Review Outpatients clinic 13:30 - 17:30	Day surgery 08:30 - 13:00 New patient Clinic 13:30 - 17:30		Uroradiology meeting 08:30 - 10:00 Grand Round 10:00 - 12:00 Departmental meeting 12:00 - 14:00 Surgery MDT 14:00 - 17:30	Sub Specialty clinic 09:00 - 13:00 Continuous professional development. 13:00 - 17:00		

Activities

1. HA Activity

Unstructured by location

Should be for activity

On Call Day	Day	Time	Weeks	Activity	Employer	Location	Cal. Hours/Yr	PA	Hours
							PA151: 10,340	4000	
1	Mon	09:00 - 10:00	4/5	Travelling time between hospitals	Shrewsbury and Telford Social Care Trust	Shrewsbury Hospital	1000	0.57	0.619
2	Mon	09:00 - 13:00	4/5	Review Outpatients clinic	Shrewsbury and Telford Social Care Trust	Amesbury Community Hospital	1000	0.57	0.659
3	Mon	09:00 - 13:00	4/5	Review Outpatients clinic	Shrewsbury and Telford Social Care Trust	Trageness Area Hospital	1000	0.57	0.656
4	Mon	09:00 - 17:00	4/5	Review Outpatients clinic	Shrewsbury and Telford Social Care Trust	Trageness Area Hospital	1000	0.57	0.413
5	Mon	09:00 - 17:00	4/5	Review Outpatients clinic	Shrewsbury and Telford Social Care Trust	Shrewsbury Hospital	1000	0.57	0.408

Type	Day	Time	Weeks	Activity	Employer	Location	Cal. Rate/Yr	Pct	Hours
1	Thu	13:00 - 17:00	Wks 1-46	Review Outpatient clin.	Southern Health and Social Care Trust	Craigavon Area Hospital	DEC 26.67	0.615	3:00
	Thu	17:00 - 19:00	Wk 3	Traveling Unit between hospitals	Southern Health and Social Care Trust	Donegal Hospital	DEC 7	0.642	0:10
	Fri	08:00 - 11:00	Wks 2-4, 6	Day surgery	Southern Health and Social Care Trust	Craigavon Area Hospital	DEC 30	0.506	2:00
1	Tue	07:00 - 12:00	Wks 2-5	Continues professional development	Southern Health and Social Care Trust	Craigavon Area Hospital	SPA 13.33	0.317	1:00
	Tue	09:00 - 17:00	Wk 1 6 wk cycle	Surgery on the ward	Southern Health and Social Care Trust	Craigavon Area Hospital	DEC 6.67	0.413	1:30
1	Tue	13:00 - 17:00	Wks 2-5	Neurology Clinic	Southern Health and Social Care Trust	Craigavon Area Hospital	DEC 22.33	0.797	2:10
	Wed	08:00 - 09:00		Prevalence round	Southern Health and Social Care Trust	Craigavon Area Hospital	DEC 17	0.401	0:20
	Wed	09:00 - 17:00	Wk 1 6 wk cycle	Surgery on the ward	Southern Health and Social Care Trust	Craigavon Area Hospital	DEC 6.67	0.413	1:30
	Wed	09:00 - 20:00		Provision of patient operating services	Southern Health and Social Care Trust	Craigavon Area Hospital	DEC 15.33	0.633	0:30
1	Wed	11:00 - 12:00		Prevalence round	Southern Health and Social Care Trust	Craigavon Area Hospital	DEC 16.67	0.699	0:20
1	Wed	17:00 - 20:00		Provision of patient operating services	Southern Health and Social Care Trust	Craigavon Area Hospital	DEC 16.67	0.694	0:30
1	Thu	08:00 - 13:00	Wk 1 4 wk cycle	Use of surgery equipment	Southern Health and Social Care Trust	Craigavon Area Hospital	DEC 23.33	0.748	1:10
	Thu	09:00 - 12:00	Wk 1 4 wk cycle	Surgery on the ward	Southern Health and Social Care Trust	Craigavon Area Hospital	DEC 23.33	0.744	1:30
1	Tue	13:00 - 17:00	Wks 2-6	General Clinic	Southern Health and Social Care Trust	Craigavon Area Hospital	DEC 12.33	0.577	0:30
1	Tue	13:00 - 14:00	Wks 2-6	Highly skilled practice	Southern Health and Social Care Trust	Craigavon Area Hospital	SPA 13.33	0.397	0:15
1	Tue	14:00 - 17:00	Wks 2-6	General Practice	Southern Health and Social Care Trust	Craigavon Area Hospital	DEC 13.33	0.584	2:40
1	Fri	09:00 - 12:00	Wks 2-6	Use of specialist clinic Continues the research and analysis	Southern Health and Social Care Trust	Craigavon Area Hospital	DEC 22.33	0.794	2:10
	Fri	09:00 - 17:00	Wk 1 6 wk cycle	Surgery on the ward	Southern Health and Social Care Trust	Craigavon Area Hospital	DEC 6.67	0.413	1:30
1	Fri	3:00 - 17:00	Wks 2-6	Continues professional development	Southern Health and Social Care Trust	Craigavon Area Hospital	SPA 22.33	0.794	2:10

No specified day

"I" Refers to an activity that replaces or runs concurrently

4. Hot Activity

Type	Normal	Premium	Activity	Employer	Location	Cat. Num/Yr	PA	Hours
							Total:	0,304 110
	0:00	0:00	Surgery MDT Comments: 3 hours prep + 4 hours MDT outside normal working time 12 activities shared between 2 clinics	Southern Health and Social Care Trust	Orkney and Hospital	001 17	0,304	110

Resources

Staff

Equipment

Clinical Space

Other

Additional information

Additional comments

For comments, please

8



23 March 2016

Mr Aidan O'Brien,
Consultant Urologist
Craigavon Area Hospital

Dear Aidan,

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

1. Untriaged outpatient referral letters

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

2. Current Review Backlog up to 29 February 2016

Total in Review backlog = 679

2013	41
2014	293
2015	276
2016	69

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

3. Patient Centre letters and recorded outcomes from Clinics

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

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

patient is reviewed at another Urology Clinic a new appointment slot is required due to the lack of documentation.

This lack of documentation combined with no record of clinic outcomes means further investigations/follow-up may not be organised by admin staff.

4. Patient Notes at home

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

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

Yours sincerely,

Personal Information redacted by USI

Eamon Mackle
Associate Medical Director

Personal Information redacted by USI

Heather Trouton
Assistant Director

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

9

**Witness Statement**

NAME OF WITNESS	Mrs Heather Trouton
OCCUPATION	Assistant Director of Acute, Integrated maternity women's health, cancer and clinical services
DEPARTMENT / DIRECTORATE	Directorate of Acute Services, Craigavon Area Hospital
STATEMENT TAKEN BY	Dr Neta Chada, Associate Medical Director / Case Investigator
DATE OF STATEMENT	Monday 5 June 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. My name is Mrs Heather Trouton. I am employed by the Southern Health and Social Care Trust as Assistant Director of Acute, Integrated maternity women's health, cancer and clinical services. I was appointed to this role in April 2016. I previously worked as Assistant Director of Surgery and Elective Care between September 2009 and 31 March 2016.
2. I have been asked to provide this witness statement in respect of an investigation into concerns about the behaviour and / or clinical practice of Mr Aidan O'Brien, Consultant Urologist being carried out in accordance with the Trust Guidelines for Handling Concerns about Doctors and Dentists and the Maintaining High Professional Standards Framework.
3. I agreed to answer questions specifically related to the terms of reference previously shared with me.
4. I explained that a new Director had taken up post within Acute Services in August 2015 and she decided to change the structure at a senior level within the Directorate. She wanted to have 3 clinical staff to operationally manage the Directorate. This resulted in an internal move and reduced Assistant Director roles from 7 to 5. Tracey Boyce and Anita Carroll remained in their roles. Simon Gibson went to the Medical Director's office and Barry Conway took up a role dealing with strategic reform. Anne McVey went to Medicine, I got women's services and Ronan Carroll got Surgery.
5. In respect of TOR 1, I advised that I wouldn't know the detail about un-triaged referrals but I am aware that MR O'Brien did not agree with triage and he made it clear that he didn't agree with



the 3 categories of referral. Mr O'Brien would have said red flags were important and the others were not important. He didn't agree with the system in place.

6. Many of us were aware that Mr O'Brien didn't agree with the system in place and so on weeks when he was due to do triage it was addressed with the clinical lead – his colleagues picked up the slack. It was not possible to get Mr O'Brien to do triage in a timely manner so a default position was adopted to ensure patients weren't waiting to be booked at all. I know it isn't satisfactory but it is what happened. The default position was known and agreed by the Director, the AMD, myself as AD and the Head of Service. It was felt that it was at least some safety measure.
7. I had numerous conversations with Mr O'Brien about triage, notes and his review backlog. He always disagreed with the triage. I would have said to him that that's the system in place and I would have tried to help him. Sometimes there was a change for a short period of time but then he reverted to his own way of doing things.
8. It has been a problem since I came into post, Michael Young was the Clinical Lead, Mr O'Brien the 2nd Consultant and the third person changed regularly so didn't have management input so there was not a lot of clinical challenge to Mr O'Brien. I addressed concerns about Mr O'Brien with Michael Young and he spoke to him. But it was the way it was under both Dr Rankin and Debbie Burns since 2009.
9. Did Mr O'Brien ever say he was not doing triage or clinic dictation, possibly, but it was never agreed he could not do it. There was a Urology review during this time and experts made recommendations at consultant level. Mr O'Brien did not agree with them. Mr O'Brien had his own view about things. He was clear about what he did not agree with and felt he needed more admin time generally, he handwrites everything. As an example, the way it generally works is that a Theatre list is agreed and the Consultant will ask their secretary to list the date and to organise and the secretary goes off to do that including arranging for the patient to attend. Mr O'Brien however insists on ringing every patient himself to attend but that is not what we need him to be doing. He wanted admin sessions to fit in with every aspect of what he wanted to do. He is already on a high number of PA's so to give additional time for admin is not sensible because he didn't use the admin support available to him. There was never an issue of other specialities doing triage.
10. When the issues were raised, Michael Young as the Clinical Lead would have said he would sort it out so it was left with him and he would have helped Mr O'Brien in his practice and so the issues were improved for a period of time.
11. While I was concerned about his practice I was content patients were being seen and red flags were being done. As most referrals came in as red flags I was satisfied patients were being seen. I did have a concern about upgraded referrals but there was no data to show how many were being upgraded so I felt relatively comfortable that patients coming in as red flags were being

seen. The numbers being upgraded were not that many and I felt the risk was relatively small for the one that may slip through. New urology colleagues were not willing to let him not triage.

13. I was involved in the conversation regarding the 23 March 2016 letter which was issued to Mr O'Brien. Mr O'Brien's general way of doing this is maverick. Every Director knew but nothing moved. I felt with the newly appointed Medical Director things might progress. There was a meeting held with Dr Wright on 11 January 2016 at 10 am and the concerns were outlined to him and I took his advice so we formally addressed the issues via a letter.
14. Some time ago Eamon Mackle tried to address the issues but Dr Rankin had said not to do anything further because a complaint had been received accusing Eamon Mackle of bullying and he was told he should not address further issues with Mr O'Brien. Eamon Mackle appointed Robin Brown to be a go between with Urology. Mr Brown made attempts too. Improvements were short term but then he went back to his behaviours again. There was a general view that Eamon Mackle was unable to deal with the issues because he was told not to. In my opinion Mr Young and Mr Brown felt uncomfortable holding Mr O'Brien to account.
15. I feel, their view was that he is a very intelligent man and a good doctor, therefore we could overlook smaller things. Trying to get peer and medical management support to deal with the issues was difficult to do.
16. The letter was sent to address issues regarding not triaging, his review backlog and notes at home. More recently there has been new appointments made and so there is a bigger urology team and there are members who were willing to peer challenge. The letter was given to Mr O'Brien and the expectation was that he would set out a plan as to how he was going to deal with the outstanding work.
17. I moved post on 1st April 2016, so I left it with Esther Gishkori and Ronan Carroll to deal with the action plan. I got nothing back directly from Mr O'Brien.
18. Mr O'Brien was outwith other Consultants I dealt with. I didn't come across any other surgeon who didn't agree with or partake in triage.
19. I know there was an issue with Mr O'Brien taking notes home because some were missing and Martina Corrigan had to chase these. Mr O'Brien was told he should not have notes at home. He was also told by Mr Young and Mr Brown. I shared an email of 22 January 2015 as an example of this issue which is appended to this statement. Mr O'Brien would bring them back but the process started again. I didn't know the number of charts he had or if it was a constant trickle. He should not have had any at home.
20. In respect of TOR 3, I was unaware that dictation was an issue until March 2016 when colleagues started doing validation of backlog. There has always been a review backlog in Urology but they have tended to hold on to patients to review the clinical decision. The review backlog for Mr O'Brien was particularly long. Others addressed theirs so Tony Glackin and Mark Haynes looked back to try to sort the issues. This was done on Patient Centre not via the notes. During that process they realised that nothing was on Patient Centre so that prompted my concern in March

2016. It was relatively close to when the 23 March letter went out. There was nothing recorded in the notes or on Patient Centre. This in my view was the most serious issue as we cannot have patients treated without records.

21. I cannot remember if this prompted me to look at the clinics, I'm sure Martina Corrigan did a review. Patients were still being treated but recoverable information was a problem. It was certainly outside of acceptable practice not to dictate. I don't know if there was a delay with clinical management plans for patients, he may have had his own way of managing things.
22. In respect of TOR 4, on some occasions when scrutinising lists because of pressures there were some patients on the list earlier than you would have expected but Mr O'Brien always had a clinical rationale as to why a particular patient was on the list. They were not necessarily all private patients but some were.
23. Mr Mackle, Dr Rankin, Debbie Burns, the AD, the HOS all had discussions with Michael Young and Robin Brown. The issues were repeatedly addressed but no lasting change resulted. There seemed to be no way of enforcing him to comply. I think the formal process did not happen because when the previous issue arose, Mr Mackle was warned off by Dr Rankin at that point and Mr Mackle then took a back seat.
24. From I came into post, it was very well known that Mr O'Brien did not comply with the management way of managing patients. There were repeated informal attempts to resolve with no real action happening. When addressing clinical practice we rely largely on peer support. I think he has some sympathy with some colleagues as he is really good with his patients. But more recently there is a bigger team able to stand up and say this is not good clinical practice.

This statement was drafted on my behalf by Mrs Siobhan Hynds, Head of Employee Relations and I have confirmed its accuracy having seen it in draft and having been given an opportunity to make corrections or additions.

This statement is true to the best of my knowledge. I understand that my signed statement may be used in the event of a conduct or clinical performance hearing. I understand that I may be required to attend any hearing as a witness.

SIGNATURE	
DATE	

10

Witness Statement

NAME OF WITNESS	Mr Colin Weir
OCCUPATION	Consultant Surgeon / Clinical Director
DEPARTMENT / DIRECTORATE	Directorate of Acute Services, Craigavon Area Hospital
STATEMENT TAKEN BY	Dr Neta Chada, Associate Medical Director / Case Investigator
DATE OF STATEMENT	Wednesday 24 May 2017
PRESENT AT INTERVIEW	Mrs Siobhan Hynds, Head of Employee Relations
NOTES	The terms of reference were shared prior to the date of statement.

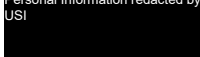
1. My name is Mr Colin Weir. I am employed by the Southern Health and Social Care Trust as a Consultant Surgeon and I am also the Clinical Director for General Surgery, Daisy Hill Hospital, ENT, Craigavon Area Hospital and Urology, Craigavon Area Hospital. I have been employed in the Clinical Director role for approximately 12 months.
2. I have been asked to provide this witness statement in respect of an investigation into concerns about the behaviour and / or clinical practice of Mr Aidan O'Brien, Consultant Urologist being carried out in accordance with the Trust Guidelines for Handling Concerns about Doctors and Dentists and the Maintaining High Professional Standards Framework.
3. I agreed to answer questions specifically related to the terms of reference previously shared with me.
4. In my role as Clinical Director, I have been Mr O'Brien's line manager for approximately 12 months.
5. In respect of TOR 1 I was asked if I was aware of if there have been any patient referrals to Mr A O'Brien which were un-triaged in 2015 or 2016 as was required in line with established practice / process. I explained that I was first made aware of issues of concerns by Dr Charlie McAlister who was Associate Medical Director for the Urology service when I was initially appointed as Clinical Director. Dr McAlister had been appointed temporarily for both ATICS and Surgery. Mr Eamon Mackle had previously held the AMD position.

6. Dr McAlister first mentioned to me that there were concerns about Mr O'Brien's triage, keeping notes at home and undictated clinics in or around August 2016. He put it in terms of there being a bit of an issue with charts, triage and clinics but it wasn't put to me as a really serious problem.
7. I met with the Head of Service, Martina Corrigan around the end of September 2016 and I got further information about charts that were tracked to Mr O'Brien but were not in the Trust, that Mr O'Brien was way behind with triage of GP referrals and a backlog needing to be addressed. At this point the intention was very much to deal with the issues informally. There was no formality about the matter. The approach to managing the issues was all informal and it was about how we could help Mr O'Brien to get him back on track. No-one knew the enormity of the problem.
8. I was appointed as Clinical Director around April 2016 and the issues of concern were not immediately brought to my attention. I recall discussions between Mark Haynes and Dr McAlister at the weekly Thursday meetings about the concerns but it was not addressed directly with Mr O'Brien because he may not have been at the meetings. I think I first became aware there were issues around the summer of last year. I discussed the concerns with Michael Young who is the clinical lead in Urology and he was aware of the concerns.
9. I remember that the intention was for Martina and Ronan to discuss with Mr O'Brien but I do recall it was always meant to be on an informal basis. This meeting didn't happen as far as I understand. I had discussed the matter with Martina and Michael Young and then I was made aware that it had gone to the Medical Director's office and that Dr Wright was looking at it.
10. I don't think people knew the enormity of the problem or how far back it was going on. I know I was told at a point not to meet with Mr O'Brien about this issue. I can't recall who said this to me, it may have been Ronan.
11. In terms of TOR 1, I know now that there is a problem with Mr O'Brien not triaging patients but I didn't know the extent of the problem at the time.
12. In respect of the issue to do with notes, again I was aware there was an issue with Mr O'Brien having notes at home but not the extent of the problem.
13. In relation to the undictated clinics I was broadly made aware of an issue by Dr McAlister but I did not know the detail or extent of the problem.
14. In relation to TOR 4, I was not aware of any issue related to private patients.
15. I know managers within the Trust were aware of the problems with Mr O'Brien and I was shown a letter dated March 2016 addressed to Mr O'Brien. Dr McAlister felt the correspondence in March 2016 had not addressed the problem and he wanted to manage it in a different way. I recall Dr McAlister saying that Mr O'Brien was a good surgeon and he felt could help him get back on track. This was all without the knowledge of the enormity of the problems.

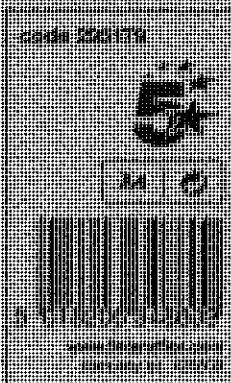
16. Since the MHPS process has commenced, I have met with Mr O'Brien to revise and agree his job plan. This is not yet agreed. Currently we are giving consideration to his SWAH clinic to ensure there is not as generous an allowance for travel etc. Mr O'Brien's productivity has been lower than others but he is working to the agreed action plan and he is now using digital dictation.

This statement was drafted on my behalf by Mrs Siabhan Hynds, Head of Employee Relations and I have confirmed its accuracy having seen it in draft and having been given an opportunity to make corrections or additions.

This statement is true to the best of my knowledge. I understand that my signed statement may be used in the event of a conduct or clinical performance hearing. I understand that I may be required to attend any hearing as a witness.

SIGNATURE	Personal Information redacted by USI 
DATE	7/6/2017

11



O'Brien, Aidan

From: Khan, Ahmed
Sent: 23 October 2018 16:57
To: O'Brien, Aidan
Cc: Wilkinson, John; Hynds, Siobhan
Subject: RE: Information Request
Attachments: Action note - 22nd December - AOB.DOCX; Appendix 27 IEAP Executive Summary April 08.doc; leto [REDACTED] advice+letter [REDACTED] pdf; NCAS Correspondence - Sept16.pdf; Return to Work Action Plan February 2017 FINAL (2).pdf

Dear Mr O'Brien,

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

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

- In respect of the note of the meeting on 24 January 2017 – as per above, Colin Weir (then Case Investigator) was satisfied with the content of the note as an accurate reflection of the meeting with Mr O'Brien on 24 January. Mr O'Brien submitted his comments on the note. Both have been appended to the final investigation report to ensure both positions could be considered. Mr O'Brien has been provided with these documents.

- Copy of the minutes of the meeting of the Oversight Group December 2016 attached.
- Copy correspondence with NCAS in September & December 2016 attached.
- Copy of the Integrated Elective Access Protocol attached. It has been previously clarified with Mr O'Brien that this is the document referred to at the outset of the investigation. It has previously been clarified with Mr O'Brien that there is no separate Southern Trust Policy or Procedure on Triage.

Aidan, I take this opportunity to ask if you are adherent to agreed MHPS action plan (attached)?

Regards,
 Ahmed

Dr Ahmed Khan
 Case Manger

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

Dear Dr. Khan,

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

I also write to advise you that I have since had the opportunity of discussing my concerns with Dr. Lynn of Practitioner Performance Advice (formerly NCAS).

I have been further concerned to be advised by her that there had been an earlier consultation with and communication from NCAS in September 2016, and about which I had not been advised.

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

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

Aidan O'Brien

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

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

Regards,
Ahmed

Dr Ahmed Khan
Case Manger- MHPS

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

Dear Dr. Khan,

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

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

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

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

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

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

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

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

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

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

Aidan.

12


National Clinical Assessment Service

NCAS
NI office
HSC Leadership Centre
The Beeches
12 Hampton Manor Drive
Belfast
Co Antrim
BT7 3EN

Tel: 028 90 690 791

www.ncas.nhs.uk
Jill.Davenny@ncas.nhs.uk

13 September 2016

PRIVATE AND CONFIDENTIAL
Sent by email only

Mr Simon Gibson
Assistant Director
Southern Health and Social Care Trust
Craigavon Area Hospital
68 Lurgan Road
Portadown
Craigavon
BT63 5QQ

NCAS ref:  (Please quote in all correspondence)

Dear Mr Gibson

I am writing following our telephone discussion on 7 September. Please let me know if I have misunderstood anything as it may affect my advice.

You called to discuss a consultant urologist who has been in post for a number of years. You described a number of problems. He has a backlog of about 700 review patients. This is different to his consultant colleagues who have largely managed to clear their backlog.

You said that he is very slow to triage referrals. It can take him up to 18 weeks to triage a referral, whereas the standard required is less than two days.

You told me that he often takes patient charts home and does not return them promptly. This often leads to patients arriving for outpatient appointments with no records available.

You told me that his note-taking has been reported as very poor, and on occasions there are no records of consultations.

To date you are not aware of any actual patient harm from this behaviour, but there are anecdotal reports of delayed referral to oncology.

The National Clinical Assessment Service is an operating division of the NHS Litigation Authority. For more information about how we use personal information, please read our privacy notice at <http://www.nhs.uk/About/PrivacyPolicy.aspx>

Please ensure that any information provided to NCAS which contains personal data of any type is sent to us through appropriately secure means.



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

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

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

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

Relevant regulations/guidance:

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

Review date:

7 October 2016.

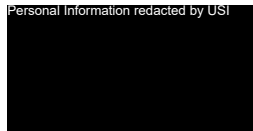
As it seems likely that further NCAS input will be required, we will keep this case file open and review the situation in about one month. If you require further advice in the meantime, please do not hesitate to contact me.

If you have any further issues to discuss, or any difficulties with these arrangements, please contact the Northern Ireland office on the direct line above.

I hope the process has been helpful to you.

Yours sincerely

Personal Information redacted by USI



Dr Colin Fitzpatrick
NCAS Senior Adviser

cc: Jill Devenney, Case Officer (N I)



Please ensure that any information provided to NCAS which contains personal data of any type is sent to us through appropriately secure means.

13

Urology PERFORMANCE – 13 October 2016

New Outpatient waiting lists

Total on waiting list – 2902 longest wait = 83 weeks

Total URGENT waiting a date is 983 (longest = 65 weeks)

Urology REFERRALS RECEIVED

Year	GP only	**Total	Red Flags
2013-2014	2980	5471	929
2014-2015	2955	5120	1227
2015-2016	2857	5147	1357
Apr 16- Sept 16	1433	2241	835

**Total includes ED, Consultant, etc

Review outpatient backlog – should have been seen by 31 October 2016

Consultant	TOTAL October	Should have been seen by
Mr Young (stones)	616	April 2014
Mr Young (general)	158	April 2013
Mr O'Brien	746	July 2013
Mr Glackin	68	December 2015
Mr Haynes	43	May 2014
Mr O'Donoghue	408	March 2015
Mr Suresh up to Aug 17	408 (289 by Oct)	July 2013
Overall total	2447	

Consultant	Inpatients Urgent	Waiting time (weeks)	Inpatients Routine	Waiting time (weeks)
Mr Young	56	111 weeks	60	146 weeks
Mr O'Brien	136	131 weeks	96	137 weeks
Mr Glackin	18	48 weeks	11	38 weeks
Mr Haynes	44	53 weeks	33	120 weeks
Mr O'Donoghue	38	36 weeks	21	110 weeks
Mr Suresh	31	41 weeks	10	70 weeks
Total	323	131 (AOB)	231	146 (MY)

116
232
29
77
59
41

Consultant	Daycases Urgent	Waiting time (weeks)	Daycases Routine	Waiting time (weeks)
Mr Young	48	115 weeks	119	138 weeks
Mr O'Brien	10	87 weeks	19	128 weeks
Mr Glackin	24	45 weeks	24	41 weeks
Mr Haynes	20	38 weeks	55	106 weeks
Mr O'Donoghue	13	45 weeks	17	78 weeks
Mr Suresh	23	25 weeks	39	67 weeks
Total	138	115 (MY)	291	138 (MY)

14

Southern Health & Social Care Trust**Oversight Committee****22nd December 2016****Present:**

Dr Richard Wright, Medical Director (Chair)

Vivienne Toal, Director of HROD

Ronan Carroll, on behalf of Esther Gishkori, Director of Acute Services

In attendance:

Simon Gibson, Assistant Director, Medical Director's Office

Malcolm Clegg, Medical Staffing Manager

Tracey Boyce, Director of Pharmacy, Acute Services Directorate

Dr A O'Brien**Context**

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

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

Issue one

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

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

Action

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

Lead: Ronan Carroll/Colin Weir

Issue two

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

Action

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

Lead: Ronan Carroll

Issue three

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

Action

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

Lead: Ronan Carroll/Colin Weir

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

Action: Tracey Boyce

Consideration of the Oversight Committee

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

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

Action: Dr Wright/Simon Gibson

The following was agreed:

Case Investigator – Colin Weir

Case Manager – Ahmed Khan

15

From: Aidan O'Brien

Personal Information redacted by USI

To: Siobhan.Hynds

Personal Information redacted by USI

AOB-15138

Subject: Formal Investigation

Date: Mon, 31 Jul 2017 10:06

Siobhan,

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

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

Thank you,

Aidan O'Brien

From: Aidan O'Brien

Personal Information redacted by USI

To: Siobhan.Hynds

Personal Information redacted by USI

Subject: Re: FORMAL INVESTIGATION

Date: Mon, 31 Jul 2017 13:16

Siobhan

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

Aidan O'Brien.

16

Subject: RE: MR O'BRIEN AND CHARTS AT HOME

From: O'Brien, Aidan

Personal Information redacted by USI

To: Corrigan, Martina

Personal Information redacted by USI

Sent: 14/11/2016 21:32:12

Martina,

I have already asked Noleen to return Personal Information redacted by USI chart to Pamela Lawson, who has requested it.

Thank you,

Aidan.

From: Corrigan, Martina

Sent: 14 November 2016 17:49

To: O'Brien, Aidan

Subject: RE: MR O'BRIEN AND CHARTS AT HOME

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 Personal Information redacted by USI 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

Martina Corrigan
 Head of ENT, Urology, Ophthalmology and Outpatients
 Craigavon Area Hospital
 Telephone: [Personal Information redacted by USI]
 Mobile: [Personal Information redacted by USI]

From: O'Brien, Aidan
Sent: 14 November 2016 16:09
To: Corrigan, Martina
Subject: RE: MR O'BRIEN AND CHARTS AT HOME

Martina,

As I will be having [redacted] 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 the 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.

From: Corrigan, Martina
Sent: 14 November 2016 07:15
To: O'Brien, Aidan
Subject: FW: MR O'BRIEN AND CHARTS AT HOME

Further emails Aidan.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: [Personal Information redacted by USI]
Mobile : [Personal Information redacted by USI]

From: Lawson, Pamela
Sent: 10 November 2016 14:41
To: Corrigan, Martina
Cc: Gibson, Simon
Subject: FW: MR O'BRIEN AND CHARTS AT HOME

Martina – is there any way we can get these charts.

I am looking one at the moment for [Personal Information redacted by USI] if you could possibly action??

Thanks very much

Pamela

From: Lawson, Pamela
Sent: 17 October 2016 11:40
To: Nelson, Amie
Cc: Forde, Helen
Subject: FW: MR O'BRIEN AND CHARTS AT HOME

Amie – in Martina's absence.

Pamela

From: Lawson, Pamela
Sent: 17 October 2016 11:39
To: Forde, Helen
Cc: Corrigan, Martina
Subject: MR O'BRIEN AND CHARTS AT HOME

Hi Helen

I just learnt this morning that Mr O'Brien is going from mid-November possibly until January 2017.

I would like to get any charts back into Records from his home. Martina is on leave until 31 October.

Is there anything we could do in the meantime? I think if he started to bring a few in each day we could cope with it better.

Thanks

Pamela

Pamela Lawson

Health Records Manager

CAH

Personal Information redacted by
 USI

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 USI

17

DATE	CLINIC	CLINIC CODE	PATIENTS	COMPLETED	UNDONE
24/11/2014	SWAH	EUROAOB	RETURNED BEFORE 30TH DECEMBER 2016		
22/12/2014	SWAH	EUROAOB	RETURNED BEFORE 30TH DECEMBER 2016		
12/01/2015	SWAH	EUROAOB	RETURNED BEFORE 30TH DECEMBER 2016		
23/02/2015	SWAH	EUROAOB	RETURNED BEFORE 30TH DECEMBER 2016		
09/03/2015	SWAH	EUROAOB	RETURNED BEFORE 30TH DECEMBER 2016		
13/04/2015	SWAH	EUROAOB	15	8	7
11/05/2015	SWAH	EUROAOB	17	10	7
22/06/2015	SWAH	EUROAOB	16	7	9
06/07/2015	SWAH	EUROAOB	15	5	10
28/09/2015	SWAH	EUROAOB	15	6	9
19/10/2015	SWAH	EUROAOB	15	8	7
02/11/2015	ARMAGH CLINIC	AAOBU1	RETURNED BEFORE 30TH DECEMBER 2016		
06/11/2015	URODYNAMICS CLINIC	CAOBUDS	RETURNED BEFORE 30TH DECEMBER 2016		
24/11/2015	NEW CLINIC	CAOBTDU	RETURNED BEFORE 30TH DECEMBER 2016		
30/11/2015	SWAH	EUROAOB	16	9	7
04/12/2015	URODYNAMICS CLINIC	CAOBUDS	RETURNED BEFORE 30TH DECEMBER 2016		
06/12/2015	ARMAGH CLINIC	AAOBU1	RETURNED BEFORE 30TH DECEMBER 2016		
22/12/2015	NEW CLINIC	CAOBTDU	7	4	3
08/01/2016	UROONCOLOGY CLINIC	CAOBUO	RETURNED BEFORE 30TH DECEMBER 2016		
11/01/2016	SWAH	EUROAOB	17	10	7
15/01/2016	UROONCOLOGY CLINIC	CAOBUO	RETURNED BEFORE 30TH DECEMBER 2016		
08/02/2016	SWAH	EUROAOB	18	10	8
07/03/2016	SWAH	EUROAOB	16	5	11
21/03/2016	ARMAGH CLINIC	AAOBU1	16	13	3
01/04/2016	UROONCOLOGY CLINIC	CAOBUO	9	8	1
04/04/2016	REVIEW CLINIC - CAH	CAOBT DUR	13	7	6
08/04/2016	UROONCOLOGY CLINIC	CAOBUO	RETURNED BEFORE 30TH DECEMBER 2016		
15/04/2016	UROONCOLOGY CLINIC	CAOBUO	7	5	2
18/04/2016	ARMAGH CLINIC	AAOBU1	13	8	5
19/04/2016	NEW CLINIC	CAOBT DU	6	3	3
22/04/2016	UROONCOLOGY CLINIC	CAOBUO	5	4	1
27/04/2016	URODYNAMICS CLINIC	CAOBUDS	RETURNED BEFORE 30TH DECEMBER 2016		
27/04/2016	UROONCOLOGY CLINIC	CAOBUO	9	3	6
29/04/2016	URODYNAMICS CLINIC	CAOBUDS	3	1	2
03/05/2016	REVIEW CLINIC - CAH	CAOBT DUR	RETURNED BEFORE 30TH DECEMBER 2016		
06/05/2016	HOT CLINIC		2	0	2
23/05/2016	REVIEW CLINIC - CAH	CAOBT DUR	16	12	4
27/05/2016	UROONCOLOGY CLINIC	CAOBUO	10	8	2
27/05/2016	URODYNAMICS CLINIC	CAOBUDS	5	4	1
03/06/2016	URODYNAMICS CLINIC	CAOBUDS	RETURNED BEFORE 30TH DECEMBER 2016		
10/06/2016	UROONCOLOGY CLINIC	CAOBUO	12	11	1
13/06/2016	ARMAGH CLINIC	AAOBU1	15	7	8
20/06/2016	SWAH	EUROAOB	21	13	8
04/07/2016	REVIEW CLINIC - CAH	CAOBT DUR	17	10	7
22/07/2016	UROONCOLOGY CLINIC	CAOBUO	12	11	1
26/07/2016	NEW CLINIC	CAOBT DU	7	4	3
09/08/2016	NEW CLINIC	CAOBT DU	10	6	4
12/08/2016	UROONCOLOGY CLINIC	CAOBUO	9	7	2
19/08/2016	URODYNAMICS CLINIC	CAOBUDS	3	2	1

19/08/2016	UROONCOLOGY CLINIC	EUROAOB	5	4	1
22/08/2016	SWAH	EUROAOB	16	4	12
19/09/2016	SWAH	EUROAOB	18	7	11
07/10/2016	URODYNAMICS CLINIC	CAOBUDS	3	2	1
11/10/2016	NEW CLINIC	CAOBTDU	9	8	1
14/10/2016	URODYNAMICS CLINIC	CABOUDS	3	2	1
14/10/2016	UROONCOLOGY CLINIC	CAOBUO	5	3	2
21/10/2016	URODYNAMICS CLINIC	CAOBUDS	4	2	2
28/10/2016	URODYNAMICS CLINIC	CAOBUDS	RETURNED BEFORE 30TH DECEMBER 2016		
28/10/2016	UROONCOLOGY CLINIC	CAOBUO	RETURNED BEFORE 30TH DECEMBER 2016		
04/11/2016	URODYNAMICS CLINIC	CAOBUDS	RETURNED BEFORE 30TH DECEMBER 2016		
04/11/2016	UROONCOLOGY CLINIC	CAOBUO	RETURNED BEFORE 30TH DECEMBER 2016		
			PATIENTS	COMPLETED	NOT PROCESSED
	TOTAL OF 41 CLINICS		450	261	189

BREAKDOWN OF UNPROCESSED	REVIEW	DISCHARGES	DNA	THORNDALE	DAY SURG	INPATIENT W/L
189	110	35	10	13	7	14

18



Southern Health
and Social Care Trust

6th January 2016

STRICTLY PRIVATE & CONFIDENTIAL

Mr Aidan O'Brien

Personal Information redacted by USI

Dear Mr O'Brien

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ

Tel: [REDACTED] / Email: [REDACTED]
Personal Information redacted by USI

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

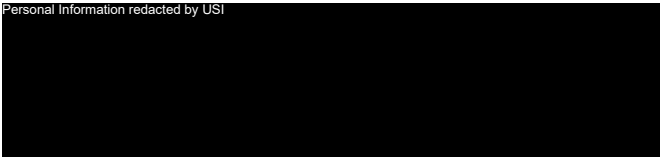
This 4 week exclusion period should allow sufficient time to determine a clear course of action, including the need for formal exclusion. Any decisions made will, of course, be communicated to you. I would refer you to the MHPS Framework document, Section 1, Paragraphs 18 – 27 and Section II, Page 13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

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

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

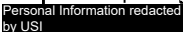
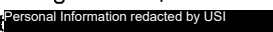
In the meantime, should you have any queries in relation to the content of this letter, please do not hesitate to contact me.

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Dr Richard Wright
Medical Director

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ

Tel:  / Email: Richard.wright@

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17 January 2017.

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

Dear Dr. Wright,

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

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

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

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

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

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

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

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

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

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

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

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

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

Yours sincerely,

Aidan O'Brien.

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Southern Health
and Social Care Trust

Quality Care - for you, with you

20 January 2016

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Mr Aidan O'Brien

Personal Information redacted by USI

Dear Mr O'Brien

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

I write further to Dr Richard Wright's letter to you dated 6 January 2017 and to our telephone discussion yesterday afternoon.

As you are aware, I am the Case Investigator assigned to your case under the MHPS Framework. Mrs Siobhan Hynds, Head of Employee Relations has been assigned to assist me with the investigation.

As discussed, Mr John Wilkinson, Trust Non-Executive Director is the nominated Board member for your case. Mr Wilkinson can be contacted via the Trust Chair's office on Personal Information redacted by USI

A current period of immediate exclusion is in place effective from 30 December 2016 to allow for further preliminary information to be gathered in respect of the concerns identified, to determine the scope of the investigation and to inform the Terms of Reference for the investigation.

In line with the MHPS Framework, I wish to now meet with you to discuss the concerns identified. Our meeting will provide you with an opportunity to state your case and propose alternatives to formal exclusion. I would be grateful if you could

meet with myself and Mrs Hynds Tuesday 24 January 2017 at 2.30pm in Mrs Vivienne Toal's Office, 1st Floor, Trust Headquarters, Craigavon Area Hospital.

You are entitled to be accompanied to all meetings during the course of the investigation as per Section 1, Paragraph 30 of the MHPS Framework.

I understand this is a difficult process and therefore please be advised that the services of the Trust's Occupational Health or the staff counselling service, Care Call are available to you.

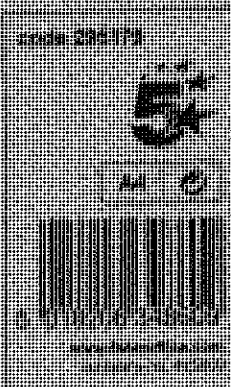
Yours sincerely

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USI

MR COLIN WEIR
Case Investigator

Copy to: Siobhan Hynds

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Southern Health
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Quality Care - for you, with you

Medical Directorate

23 January 2016

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Mr Aidan O'Brien

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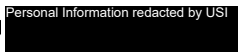


Dear Mr O'Brien

Re: Letter of 17th January 2017

I am writing in response to your letter dated 17th January, which I received on 18th January. Dealing with the specific requests within your letter, I note that you have sought three items of information:

1. Details of the Non-Executive Director (NED)

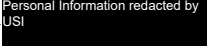
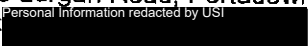
I believe these have been provided to you under separate correspondence, confirming that Mr Wilkinson is the NED identified for this case. Should you have any issues in future regarding progress in this case, then these should be raised with Mr Wilkinson in future. Mr Wilkinson can be contacted via the Chairs office on 

2. Minutes of the meeting – 30th December

These had been progressed, and I approved these on the same day I received your letter, sending them to you on 18th January.

3. Details of meeting with Case Investigator

I understand that the Case Investigator has been in touch, and a date for a meeting with the Investigating Team has been proposed.

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel:  / Email: Richard.Wright@

I hope that this addresses the issues you have raised. I recognise your desire to address other concerns we discussed, and assure you that you will have the opportunity to do this with the Investigating Team as part of their investigations.

I would take this opportunity to highlight that any decision to commence an investigation under the terms of MHPS is never undertaken lightly, as it is recognised that there will be complexities in ensuring a thorough investigation is completed. Whilst the guidance creates an expectation that investigations are completed within 4 weeks, it is my experience, and that of local NCAS colleagues, that this rarely is the case and I would hope that you would recognise that our priority – to you and to the organisation – is the completion of a fair and accurate consideration of issues identified.

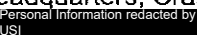
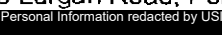
As highlighted previously, I do understand this is a difficult process and therefore please be advised that the services of the Trust's Occupational Health or the staff counselling service, Care Call are available to you.

Yours sincerely

Personal Information redacted by USI

DR RICHARD WRIGHT
Medical Director

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ

Tel:  / Email: Richard.Wright@

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

Mr O'Brien (accompanied by his son, Mr O'Briens son)

Dr Colin Weir, Case Investigator

Mrs Siobhan Hynds, Head of Employee Relations

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

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

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

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

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

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

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

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

The update position as at 24 January is:

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

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

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

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

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

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

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

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

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

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

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

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

Proposals for alternatives to exclusion

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

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

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

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

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

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

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

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

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

Amendments

In Page 1, Paragraph 2, it states that Mr. Weir outlined that 'we had asked to meet with Mr. O'Brien to provide him with an opportunity to discuss the next steps in the process, to state his case at this point of the process should he wish to and to provide an opportunity to hear from Mr. O'Brien his proposals for alternatives to formal exclusion'.

It was not proposed at the meeting of 24 January 2017 that the meeting was an opportunity for me to state my case. In that regard, the Note is not an accurate record, and reference to it being an opportunity to state my case should be deleted.

The second purpose of the meeting was to propose alternatives to exclusion, i.e., the exclusion which was in place at that time and not formal exclusion.

In Page 1, Paragraph 5, it states that, from June 2015, 318 GP referrals had not been triaged 'in line with the agreed / known process for such referrals'. No reference was made during the course of the meeting to the triage of letters in line with an *agreed / known process*. Therefore, reference to such a process should be deleted from the Note.

Similarly, in Page 2, Paragraph 2, it refers to 783 GP referrals which had not been triaged in line with 'the agreed / known process for such referrals'. Again, as no reference was made to an agreed / known process, this reference should be deleted from the Note.

Page 2, Paragraph 4, refers to the issue of triage of referrals. It does make reference to my having validated referrals which had not been triaged by me, up to June 2015. It has omitted to include the detailed explanation, which I gave at the meeting, of the origin of the inclusion of triage in the duties of the Urologist of the Week, that I had found it impossible to conduct the triage of non-red flag referrals whilst being Urologist of the Week and in the context of the additional work undertaken by me, of my having advised personnel that I had found it impossible to do, and of my views concerning the risks posed to inpatient care by the triage of all referrals by the Urologist of the Week.

Page 2, Paragraph 5, referred to the issue of the 13 missing charts tracked to me. It omitted to relate that I provided to the meeting a written synopsis of each of the 13 patients, relating that nine of them had never been my patients.

Of the remaining four, that I had no recollection of one who last attended an outpatient clinic in 1995, that the chart of another deceased patient had been returned to Medical Records in 2005, that the chart of another had been returned for letter typing in August 2016 and was not made available for her last outpatient clinic attendance in September 2016, and that the chart of the fourth patient had been returned to my office from my home on Tuesday 03 January 2017.

Page 3, Paragraph 1 finishes with 'Mr. O'Brien reported that Mr. Mackle didn't respond but rolled his eyes'. I did not report that Mr. Mackle rolled his eyes, as he did not. I reported that, on asking what I was supposed to do and what they wanted me to do, that enquiry was met with silence and a shrug of the shoulders. The reference to Mr. Mackle rolling his eyes should be deleted.

Page 3, Paragraph 2, it refers to my having spoken about my concerns regarding my workload with a number of Clinical Directors over the years with no change. In fact, I reported that I had raised my concerns, orally and in writing, on many occasions to a Lead Clinician, Clinical Directors, Medical Directors and a Chief Executive.

Page 3, Paragraph 3, in respect of the issues of concern, it states that Mr. O'Brien 'stated that he was surprised by the number of undictated clinics in SWAH, i.e., 272'. I do presume that the Note intended to refer to the number of patients attending clinics in SWAH whose consultations had not been dictated, as there have not been 272 clinics held in SWAH since urology clinics commenced there in January 2013. Similarly, this Paragraph referred to 289 other clinics. Both of these references require to be corrected.

Page 3, Paragraph 4, refers to the issue of private patients. It omits to refer to Mr. O'Brien's expressed concern regarding the claim that this issue had emerged from a scoping of the original three issues of concern, as that is not possible, as they are unrelated. It omits reference to Mr. O'Brien's enquiry as to the identity of the person(s) who initially raised this issue, and the assurance given that there would be no problem in having the identity of the person(s) made available to him. It omits Mr. Weir's own expressed view that he did not consider this fourth issue to be an issue of concern. It omits to relate that Mr. O'Brien enquired whether there had been or would be an investigation of NHS patients who had their TURP procedures performed after a significantly shorter period than other patients. These omissions should be included in the Note. Lastly, I made no reference to concern about reputational damage in relation to this matter.

Page 3, Paragraph 5, refers to the timeframe of the investigation. It omits to make any reference to our expression of concern regarding the investigation's breach of Trust Guidelines and the implications of that breach.

The Note omitted any reference to the issue of the large number of patients awaiting admission for surgery, and more particularly, those patients awaiting readmission for surgery. It omitted to relate my contention that this cohort of patients is the cohort at greatest risk of suffering poor clinical outcomes as a consequence of delay in admission or readmission. It omitted to make any reference to the additional numbers of elective operating sessions undertaken by me in recent years in attempting to minimise the numbers of poorer clinical outcomes and the severity of those outcomes. It omitted to refer to the extent by which the arrangement and conduct of additional operating sessions impacted upon the capacity to deal with the other issues of concern. It omitted to refer to the inequity of waiting lists and times between consultants. It omitted to refer to my request of 07 November 2016, addressed to my colleagues and to the Head of Service, to have the ten most urgent cases admitted during my planned Personal Information redacted by USI leave, and that only two of those patients had been admitted. Lastly, it omitted to refer to my contention that this issue of greatest clinical priority would not appear as an issue or concern for investigation.

Personal Information redacted by USI



Aidan O'Brien.
27 March 2017.

23

Concerns Regarding the Investigation Process

7th February 2017

1. A letter dated 23rd March 2016 was provided to Mr O'Brien at a meeting on or around that date by Mr Mackle and Ms Corrigan. The letter raises a number of issues which are now the subject of a formal investigation. There are a number of concerns arising from this letter.

- It does not constitute a formal or informal process under MHPS or any other Trust Guidelines. It included no local action plan to resolve the problems or any suggestions regarding a plan.
- It was provided by Mr Mackle, an individual in respect of whom Mr O'Brien has extant though stayed formal grievance. Mr O'Brien had previously been provided an assurance by both Dr. Gillian Rankin and Mr Mackle that Mr Mackle would have no further meetings with him.
- At the meeting Mr O'Brien asked what he should do to resolve the matter. The only response received was a shrug and silence from Mr Mackle.

The letter of 23rd March 2016, gives rise to a number of questions:

- What was the nature of the complaint that led to this letter being issued?
- What investigation occurred prior to the letter being completed?
- Who completed this investigation?
- How have the suggested numbers of untriaged patients and the review backlogs been arrived at?
- Was there a decision taken by a Clinical Manager that the concerns should be approached by the issue of the letter of 23rd March 2016 or by any other individual? In any case, who took this decision?
- Was this decision taken with reference to MHPS?
- Was this decision taken in consultation with the Medical Director, the Director of Human Resources or any other individual?

2. The origin of this current investigation remains unclear. It has been suggested that this investigation arises out of an ongoing Serious Adverse Incident (SAI) investigation. The following concerns arise

- The issues of concern have been reported before the completion of the report of Serious Adverse Incident Investigation and before Mr O'Brien had even been afforded the opportunity to comment on the SAI. It is therefore concerning that it is premature to commence a formal investigation.
- Insofar as the SAI relates to Mr O'Brien's practice, it is only with reference to triaging referrals whilst urologist of the week. The other issues regarding administrative practices are entirely unrelated. It is therefore unclear how the other concerns became a part of the investigation.
- It is concerning that the initial correspondence regarding the investigation from Dr Wright refers to the letter of 23rd March 2016 as an informal attempt to resolve the issues under investigation when the letter of 23rd March 2016 did not constitute any such process. It seems likely that the erroneous presumption that an informal attempt had been made to resolve the issues and that this attempt had failed has had an effect on the decision to commence a formal investigation.

Therefore, the following questions arise out of the decision to commence a formal investigation.

- Who made the complaint to the Trust that gave rise to this investigation?
- To whom was the complaint made?
- When was the complaint made?
- In what form was the complaint made?
- What was the nature of the concerns brought to the attention of the Trust?

- What investigation had been completed prior to the 30th December 2016, which resulted in the data that was presented at that meeting relating to untriaged referrals and a backlog in dictation?
- Who completed the above investigation?
- What consideration was given to handling this matter through an informal approach?
- If consideration was given to proceeding with an informal approach, why was this deemed inappropriate?
- What effect, if any, did the letter of 23rd March 2016 have on the decision to proceed with a formal investigation?
- What was the rationale for the immediate exclusion? What alternatives were considered?
- As the SAI, insofar as it concerns Mr O'Brien, only relates to triage, why was the investigation launched into the entirety of the administrative practices?

3. The conduct of the investigation is also concerning.

- The Trust Guidelines mandate that an investigation must be completed within four weeks. We are now in the sixth week of this investigation. This is a breach of contract and this was acknowledged by the HR representative at the meeting of 24th January 2017.
- It has been stated that all of these investigations take longer than the four weeks required and therefore there has been no justification offered as to why this investigation must take longer than four weeks.
- At this point, there is no end date in sight for this investigation whatsoever.
- The Non-Executive Director was not appointed until at least two weeks had passed in the investigation, half of the permitted time for completion of the investigation.
- At the meeting of the 24th January 2017, Mr O'Brien was advised that there is a team of investigators attached to this investigation. It is

concerning that any chance of confidentiality being maintained within the investigation is now lost as an unknown number of unidentified people are involved.

- The investigation has now expanded beyond administrative practices and encompasses an alleged issue that private patients have been receiving preferential treatment in having their procedures completed more quickly than NHS patients. It is unclear how this issue can arise out of an investigation into administrative practices.

The following questions arise.

- How long is the investigation expected to take?
- What justification is there for the investigation continuing in breach of the contractual term contained in the guidelines that an investigation must be completed within 4 weeks?
- How many people are now involved in the investigation and what are the identities of the investigators?
- How does the Trust propose to ensure confidentiality and the rights to privacy given the number of professionals involved in this investigation?
- What has given rise to the addition of Mr O'Brien's private practice becoming the subject of investigation?

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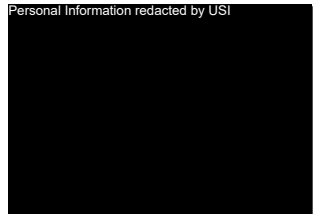
13 February 2017

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BY E-MAIL ONLY

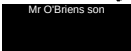
Mr Aidan O'Brien

Personal Information redacted by USI

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Dear Mr O'Brien

Re: Process under Maintaining High Professional Standards Framework (MHPS)

Thank you for meeting with me on Tuesday 7 February 2017 along with your son . I welcomed the opportunity to meet with you and I hope you felt our meeting was helpful.

I have shared the submission you provided to me with the Oversight Committee and I have also shared my notes of our meeting. I feel it is important that I take time to properly consider all of the representations you have made to me and to discuss fully with the relevant individuals involved in this process.

I am intending to undertake these discussions next week however some difficulties are presenting in that this coincides with planned annual leave of some key individuals and therefore I am writing to advise you that it will likely be the early part of week commencing 20 February 2017 when I am in a position to come back to you to respond to the points you have raised.

I understand you are already concerned about the timescales to date for this process however I trust you can appreciate the importance of ensuring the matters are fully considered in order to determine the appropriate way forward.

I thank you for your continued patience while we work through these matters.

Yours sincerely

Mr John Wilkinson
Non-Executive Director

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24 February 2017

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BY E-MAIL ONLY

Mr Aidan O'Brien

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Dear Mr O'Brien

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

Mr John Wilkinson Non-Executive Director has shared with me details of representations you have recently made to him at a meeting on 7 February 2017 about the formal investigation under the Maintaining High Professional Standards (MHPS) Framework.

Following due consideration of the issues you have raised, I wish to respond to you on these matters.

1. The letter of 23 March 2016

I have considered the representations you have made in respect of the letter of 23 March 2016. It is important that I state at the outset, that I was not involved in the conversations or discussions that took place at that time. I understand that concerns were identified by managers within the Acute Services Directorate and the purpose of the March 23rd letter was to set out to you those concerns on an informal basis in order to enable you to put in place measures to rectify the concerns. The issues of concern did not result from a specific complaint.

The letter was not set out to you in the context of an informal process under the Maintaining High Professional Standards Framework but rather was an informal attempt at local resolution of the issues, sent to you through normal line management channels. 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 to rectify the identified problems.

You state in your submission to Mr Wilkinson that an agreement was in place that formal contact or meetings would not take place between you and Mr Mackle due to a prior grievance process. I am not aware of this background or the agreement referred to. I understand the Medical Director, Dr Wright is also unaware of this matter. As you will be aware, Dr Gillian Rankin has retired from the Trust. I feel this is a matter best dealt with via the formal investigation process and I would ask that you raise this with the Case Investigator to fully explore the background and history of what preceded the management of the concerns under the MHPS Framework as is relevant to the current investigation.

2. Formal Investigation

You have raised the matter of the circumstances which led to the decision to manage the concerns under the formal process of the MHPS Framework. As you know, there were concerns raised with you in March 2016 about your administrative practices and the impact on patient management and care.

Management follow up is not clear to me at present. It is not my role to investigate the detail of this and I believe this is again a relevant matter for the formal investigation process. I am however aware that Mr Colin Weir was in post as Clinical Director in the period following March 2016 and given your representations to Mr Wilkinson, I feel it is likely Mr Weir may be required to provide information to the investigation on this issue. Therefore I have asked Mr Weir to step down from his role as Case Investigator and I have asked Dr Neta Chada, Associate Medical Director to undertake the role of Case Investigator. Dr Chada will be in contact with you in due course.

The SAI process you refer to in your submission, alerted the Trust to a very serious issue of concern which indicated harm had come to a patient who had not been properly triaged by you as was required. The issue was one of the same issues alerted to you informally in March 2016. You have noted that a decision was made to immediately exclude you from work prior to the finalised report on the SAI. The reason for this decision was due to the very serious nature of the concern. The Trust must ensure patient safety is properly safeguarded and when matters of serious concern arise, consideration is given to any necessary action to immediately ensure the safety of patients. It is for this reason, a decision was made to exclude you and to move to a formal investigation of the concerns.

You suggest the formal investigation has resulted because of an erroneous presumption that an informal attempt at resolution of the issues had failed. The Trust does not always manage issues of concern through an informal process, the seriousness of issues will always be considered. However an informal attempt to address concerns with you in March 2016 was made.

When a very serious issue of concern came to the attention of the Trust, i.e. the harm of a patient, it was necessary for the Trust to take action deemed necessary and proportionate to manage such a concern. This is the current formal investigation process.

A decision was initially taken to exclude you, this decision has since been reviewed taking into consideration the representations you made for alternatives to exclusion and you have returned to work with effect from 20 February pending conclusion of the formal investigation.

As discussed at our meeting on 9 February, you will be returning to work with a clear management plan for supervision and monitoring of key aspects of your work. An immediate priority is to ensure your job plan is reviewed and agreed to ensure a manageable and comparable workload with your other Consultant colleagues. I have asked for this to be completed as a matter of urgency.

3. Timescales of Investigation

The matter of the timescales for the investigation has also been raised by you with Mr Wilkinson and I understand this was also raised by you at a meeting with Colin Weir and Siobhan Hynds on 24 January.

The timescale for a formal investigation as set out in the MHPS Framework states: *'The Case Investigator should, other than in exceptional circumstances, complete the investigation within 4 weeks of appointment and submit their report to the Case Manager within a further 5 working days.'*

Given the vast scale of the concerns, the numbers of patients involved, the time period over which the concerns stretch, the records which need to be reviewed and the scale of facts to be gathered, a 4 week turnaround time is not practicable in these circumstances. These are exceptional circumstances.

I can assure you that the investigation process will be concluded as expeditiously as possible ensuring that it is fully and properly completed. I will ensure you are kept informed on an on-going basis as to the status of the investigation and the likely timescale for completion.

Your understanding that there is a team of case investigators looking at this case is not correct. The case investigator assigned to your case is Dr Chada, who will be assisted by Siobhan Hynds. However a review of the un-triaged patients must be completed to consider what, if any, impact there has been on patient care. A similar review must also be undertaken in respect of the undictated clinics. This can only be done from within the service directorate by individuals with the requisite expertise. This work will inform the case investigator's investigation.

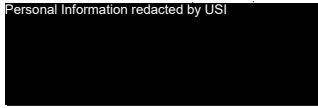
I wish to assure you that all matters pertaining to these concerns will be kept strictly confidential and any individuals involved are wholly bound by their obligations of confidentiality in line with Trust Policy and contract of employment.

I trust this address the issues you have raised and provides assurance to you of my commitment to ensuring the investigation process is concluded as quickly, thoroughly and robustly as possible.

I have shared a copy of this letter with Mr Wilkinson for his information.

Yours sincerely

Personal Information redacted by USI



Dr Ahmed Khan
Associate Medical Director &
Case Manager

Copy to: Mr John Wilkinson

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Questions to be Asked

In Paragraph 1.5 of the Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance (23 September 2010), it states that, 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.

Question 1:

How was it possible to ascertain what had happened and why it had happened without speaking with and enquiring of Mr. O'Brien?

Question 2:

Who made the decision not to speak to or enquire of Mr. O'Brien?

Question 3:

When was that decision made?

In Paragraph 2.2 of the Trust Guidelines, it states that concerns should be raised with the practitioner's Clinical Manager – this will normally be either the Clinical Director or Associate Medical Director.

Question 4:

Who was the Clinical Manager with whom concerns were raised?

Question 5:

When were concerns raised with that Clinical Manager?

Question 6:

Who raised the concerns with the Clinical Manager at that time?

In Paragraph 2.2 of the Trust Guidelines, it states that, 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.

The Medical Director advised at the meeting of 30 December 2016 that the concerns had been brought to his attention during the course of an investigation into a Serious Adverse Incident.

Question 7: Who brought these concerns to his attention?

Question 8: When were these concerns brought to his attention?

Question 9: Did he refer the matter to the relevant Clinical Manager?

Question 10: If so, who was that Clinical Manager?

Question 11: When did he refer the matter to the Clinical Manager?

Question 12: If not, why not?

In Paragraph 2.4 of the Trust Guidelines, it states that the Clinical Manager will immediately undertake an initial verification of the issues raised.

Question 13: Did a Clinical Manager undertake an initial verification of the issues raised?

Question 14: If so, who was that Clinical Manager?

Question 15: If so, when did the Clinical Manager undertake the initial verification?

Question 16: If so, what methods or means was used to verify the issues?

Question 17: If so, did other persons assist in the verification process?

Question 18: If so, who were those persons?

Question 19: If so, why did the verification process not include a consultation with Mr. O'Brien?

Question 20: If an initial verification was not undertaken, why not?

Question 21: If an initial verification was not undertaken, who made the decision not to do so?

Question 22: If an initial verification was not undertaken, when was the decision made not to do so?

In Paragraph 2.6 of the Trust Guidelines, it states that 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.

Question 23: Did a Clinical Manager and a nominated HR Case Manager investigate the concerns raised?

Question 24: If so, who was that Clinical Manager?

Question 25: If so, who was that nominated HR Case Manager?

Question 26: If so, when did the investigation begin?

Question 27: If so, when did the investigation end?

Question 28: If so, what methods or means were used to conduct the investigation?

Question 29: If so, did other persons assist in the investigation?

Question 30: If so, who were the other persons?

Question 31: If so, why did the investigation not include a consultation with Mr. O'Brien?

Question 32: If a Clinical Manager and nominated HR Case Manager did not conduct an investigation, why not?

Question 33: Who made the decision not to conduct an investigation?

Question 34: When was that decision made?

Question 35: Why was that decision made?

In Paragraph 2.6 of the Trust Guidelines, it states that 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.

Question 36: Did the Clinical Manager or the HR Case Manager take advice from NCAS in determining their assessment of action to be taken in response to the concerns raised?

Question 37: If so, who sought the advice from NCAS?

Question 38: If so, what information was given to NCAS?

Question 39: If so, who provided that information?

Question 40: If so, what advice was given by NCAS?

Question 41: Why was advice not sought from the Occupational Health Department in determining the assessment of action to be taken in response to the concerns raised, particularly as Mr. O'Brien was on sick leave following surgery?

Question 42: Who made the decision not to seek advice from the Occupational Health Department?

Question 43: When was that decision made?

In Paragraph 2.7 of the Trust Guidelines, it states that 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.

Question 44: Why was a local action plan not agreed with Mr. O'Brien?

Question 45: Why was Mr. O'Brien not consulted in determining whether a local action plan and resolution were possible and appropriate?

Question 46: Who made the decision not to consult with Mr. O'Brien or agree an action plan with Mr. O'Brien?

In accordance with the Trust Guidelines, all of the above constituent parts of the process of Handling Concerns should have been conducted prior to the decision of formal investigation and immediate exclusion. The constituent parts are screening, verification, investigation and an informal action plan with the objective of resolution if possible and appropriate. It is my concern that some of these constituent parts have not been conducted properly and fully, if at all. I have concerns regarding the accuracy of the evidence provided to date, and I would possibly have concerns regarding the sources of that evidence. Above all, I have found it remarkable and unjust that I was not consulted at any stage of the above process when I should have been.

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Aidan O'Brien

06 March 2017.

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30 March 2017

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Mr Aidan O'Brien

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Dear Mr O'Brien

RE: Correspondence dated 6 March 2017 to Mr John Wilkinson

Mr John Wilkinson has passed a copy of a document to me containing a number of questions to which you have requested a response. It is appropriate that I, as Medical Director, respond to these questions.

I can confirm that I was verbally made aware of an ongoing SAI in late 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 by you to undertake the triage of the GP referral. Part of this SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason. I was also aware that at this stage you had been on a period of sick leave and that you were due to return to work on 2 January 2017.

You will know that I was aware that you had been met with previously by senior management in March 2016 regarding your administration practices relating to un-triaged referral letters, review backlogs, patient centre letters /recorded outcomes and patient notes being retained at home. These concerns were still present at the point you commenced sick leave. Given the indications provided to me from the ongoing SAI in December 2016, as Medical Director, I could not let these concerns go on any further unaddressed.

Prior to Christmas 2016, I had been advised by Acute Services, that there were 318 un-triaged cases, there was a backlog of over 60 undictated clinics, with over 600 patients, going back over 18 months, and that patient notes were not available in the hospital with the view that these notes were located in your home. This information was collated initially as a result of the concerns emanating from the ongoing SAI.

Question 1:

Given the likely scale of the patients / notes involved as outlined above, it was necessary to fully understand the extent of the issues and ensure that there was a management plan in place to review the status of each patient, as there was a strong possibility from the information available at that stage that patients may have come to harm. It was necessary for further scoping information to be collated to verify the numbers of patients / notes involved, and this had to be undertaken by the Acute Services management team, including Mr Ronan Carroll and Mrs Martina Corrigan using the necessary clinical systems. It was necessary to collate this information before speaking with you.

Question 2:

There was never a decision made that you would not be spoken with. The decision was made to place you on immediate exclusion 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. During the period of immediate exclusion you were met with by Mr Colin Weir, Clinical Director and Mrs Siobhan Hynds, Head of Employee Relations, in compliance with Maintaining High Professional Standards.

Question 3:

See above.

Questions 4, 5 & 6:

I, as the Medical Director, had been advised in relation to the concerns raised as a result of the ongoing SAI. Mr Colin Weir as Clinical Director is the Clinical Manager. Mr Weir had been on a period of Personal Information redacted by USI leave in December following [REDACTED] I advised Mr Weir by telephone on 28 December 2016 of the concerns, and advised him that I would require him to act as Case Investigator.

Question 7:

Mrs Esther Gishkori, Director of Acute Services

Question 8:

Week commencing 19th December 2016

Questions 9, 10, 11, 12:

See response to Questions 4, 5 & 6

Question 13:

This was not necessary as Mr Ronan Carroll and Mrs Martina Hogan were collating the information from the patient systems to confirm the extent of the concerns and patients affected, as outlined in response to Question 1.

Questions 14 – 18:

See response to Question 1

Questions 19 - 22

Prior to you being placed on immediate exclusion it was clear from initial checks made by Mr Carroll and Mrs Corrigan that there were at least 318 un-triaged cases, a backlog of over 60 undictated clinics, with over 600 patients, going back over 18 months, and that patient notes were not available in the hospital with the view that these notes were located in your home. During the period of immediate exclusion further scoping was undertaken to determine the full extent, and you were met with during the 4 week period of immediate exclusion.

Questions 23 – 35

During the initial 4 week period following your immediate exclusion, 30 December 2016 to 27 January 2017, Mr Weir and Mrs Hynds through discussions with Mr Ronan Carroll and Mrs Martina Corrigan established the extent of the concerns. The further scoping exercise identified that there were 783 un-triaged referrals and not 318 as initially identified. Scoping of the concern relating to notes being kept at your home identified initially 27 sets of notes tracked out to you were missing, further investigation of this matter led to a final number of 13 sets of notes missing. Mr Weir

and Mrs Hynds sought your response to each of the 13 sets of notes during this period to determine if any further sets of notes could be found.

The 4 week period also allowed for further scoping of the number of patients who did not have a dictated outcome from a clinic. This was determined to be 668 patients in total. It was also 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. The screening process established that further investigation of this matter was required.

On establishing the extent of the concerns, Mr Weir and Mrs Hynds met with you on 24 January 2017, during the initial 4 week immediate exclusion period, to update you on the extent of the concerns, to seek your initial response to the concerns and to discuss with you your proposals for alternatives to formal exclusion. A case conference meeting was then held in line with MHPS Framework to determine if continued exclusion was required and for the a decision to be made with regards to the need for further formal investigation of the matters of concern.

Question 36 – 40

NCAS advice was sought on 28 December 2016 by myself, in the absence of Mr Weir.

I notified NCAS of my concerns in respect of a consultant urologist and increasing performance concerns. I notified NCAS of my concerns about poor record keeping, slowness of triaging referrals and arranging reviews, removal of a very substantial number of charts from the Trust without returning them despite request to do so and patients who were seen by you where there were no notes available.

I also notified NCAS of the SAI which caused concern that there is potential for patients to have been harmed due to your practices and I explained that I believed the Trust needed to undertake an investigation into the concerns. Furthermore I advised that consideration was being given to your exclusion from work.

I was advised by NCAS with regards to the need to follow a robust investigation process in line with the MHPS Framework, our obligations to appoint the necessary persons under that process and some general advice on Data Protection. I was advised of the option of immediate exclusion for a 4 week period to allow for further information to be collated and to take account of your comments before deciding on the need for formal exclusion.

I was advised to encourage you to contact your defence organisation or BMA for help and advice and also of the Trust's staff care services.

Question 41-43

My initial consideration, given the serious nature of the concerns known to me in December 2016, was regarding investigation and possible exclusion to enable an assessment of the issues to be completed. Given the serious nature of the initial concern/s in particular the SAI process, consideration of a local action plan in these circumstances was not appropriate. Therefore seeking advice from Occupational Health to determine the assessment of action to be taken was not required at that point.

You were referred to Occupational Health by Mrs Martina Corrigan, Head of Service and were assessed by Dr Alan Black on 9 February 2017. By this time a decision had been made not to proceed with formal exclusion. The advice from Occupational Health was followed in respect of your fitness to return to work at that time.

Question 44

It was determined by Dr Khan that there was a case to answer and that the formal investigation should proceed as the most appropriate course of action given the extent of the concerns. A local action plan was agreed in respect of your return to work following the lifting of the immediate exclusion. You received a copy of this from Dr Khan on 9 February 2017.

Questions 45, 46 & 47:

It is the decision of the Case Manager to determine the course of action in accordance with MHPS page 15 Section II para 10. Dr Khan made this decision on 26 January 2017.

It is noted that you feel all constituent parts of the MHPS Framework should have been conducted prior to the decision to investigate and exclude. Your contention is that this also should have included an informal action plan. Given the very serious nature of the concerns identified and the potential that a patient has come to harm as a result of those concerns, it is my firm belief that formal investigation is the most appropriate action. This belief, following initial screening and verification of the scale of the concerns was also held by Mr Khan, Case Manager.

If you have concern regarding the accuracy of the evidence or the source of the concerns you will have a full opportunity to address these matters as part of the formal investigation and have these considered.

The investigation process is currently underway and you will be kept advised of its progress periodically.

Yours sincerely

Personal Information redacted by USI

A large black rectangular redaction box covers the signature area.

DR RICHARD WRIGHT
Medical Director

28



National Clinical Assessment Service

NCAS

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

Website: www.ncas.nhs.uk

General Enquiries and Advice Line: 020 7811 2600

Direct Fax: 020 7931 7571

Email: casesupport@ncas.nhs.uk

29 December 2016

SENT VIA EMAIL ONLY

PRIVATE AND CONFIDENTIAL

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

NCAS ref: [Personal Information redacted by the] Please quote in all correspondence)

Dear Dr Wright

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

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

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

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

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Any formal investigation should be undertaken to robust and specific Terms of Reference (ToR) and in line with the guidance in paragraphs 28-40 of MHPS Section II. The Case Manager should write to Dr [Personal Information redacted by the USI] as per paragraph 35 informing him of the name of the Case Investigator and Designated Board Member; any objections by Dr [Personal Information redacted by the USI] to the appointment of nominated individuals should be given serious consideration. The investigation should not be an unfocused trawl of Dr [Personal Information redacted by the USI] 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 [Personal Information redacted by the USI] comments) may be helpful in deciding the scope of the investigation and therefore the ToR.

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

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

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

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

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

Relevant regulations/guidance:

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

Review date:

27 January 2017

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

I hope the process has been helpful to you.

Yours sincerely

Personal Information redacted by USI

Grainne Lynn
NCAS Adviser

cc Case Support Team

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Southern Health
and Social Care Trust

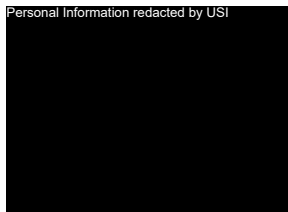
Quality Care - for you, with you

23 January 2017

STRICTLY PRIVATE & CONFIDENTIAL

Mr Aidan O'Brien

Personal Information redacted by USI

A large black rectangular redaction box covering the address and contact details of Mr Aidan O'Brien.

Dear Aidan

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

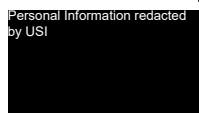
Further to our planned meeting on Tuesday 24 January.

As you are aware, part of the preliminary investigations relate to concerns about the location of patient's notes. I would take this opportunity to ask whether you know of the whereabouts of the 13 sets of notes listed below. These notes are traced out on PAS to yourself, but they are not located in your office or your secretary's office, and they were not contained within the 307 sets of notes returned from your home in early January.

Any information you may have in relation to these 13 sets of notes would be much appreciated.

Yours sincerely

Personal Information redacted
by USI

A black rectangular redaction box covering the signature of Mr Colin Weir.

MR COLIN WEIR
Case Investigator

Copy to: Siobhan Hynds

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

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Personal Information redacted by USI

I have no recollection of this man whatsoever. According to PAS, he attended my clinic in Banbridge on 07 September 1995. He was discharged from review at the clinic that day as he was placed on the waiting list for admission. I do not have any means of determining whether I or a Registrar had the consultation with the patient. His chart would have been returned to Records following his clinic attendance in 1995. He was subsequently cancelled from or taken off the waiting list on 06 July 1998. I have not had patient's chart since, or at all, and have no knowledge of its whereabouts.

Personal Information redacted by USI

This man would appear to have attended the Nurse Led Haematuria Clinic on 06 August 1999. He was then reviewed at and discharged from my review clinic in Craigavon Area Hospital on 09 November 1999. I have no recollection of this patient. I do not know whether the patient was reviewed by me or by another doctor. In any case, I have not had the patient's chart since then, or at all, and have no knowledge of its whereabouts.

Personal Information redacted by USI

I recall this patient intimately as he was

Personal Information redacted by USI

He was

At his request, I performed a radical orchiectomy for testicular tumour in 1996. I reviewed him regularly at my office in the hospital, last doing so in May 2001. He subsequently developed acute bowel obstruction due to a caecal carcinoma for which he had a right hemicolectomy in the . He died of metastatic disease in 2006. I definitely returned his chart to Records on the diagnosis of his colonic carcinoma.

Personal Information redacted by USI

There is no record on PAS of this person ever having been my patient, and I have no record of him having attended privately. He last attended Mr. Mulligan's clinic in February 1993.

Personal Information redacted by USI

There is no record of this man having had any clinical episodes on PAS. He does not even have a H&C number. He has not attended me privately.

Personal Information redacted by USI

This person has never been my patient, either NHS or privately. Her last clinical episode was in July 1988, under the care of Mr. Wallace, four years before I was appointed to Craigavon Area Hospital!

Personal Information redacted by USI

This person was born on 14 February 1993 and discharged from hospital one week later, on 21 February 1993. There have been no clinical episodes since then. He does not have a H&C number. He has not been my patient.

Personal Information redacted by USI

This person has not had any clinical episodes since discharge from hospital, under the care of Mr. Mackle, in November 1992. This person has not been my patient at any time.

Personal Information redacted by USI

There is no record on PAS of this person having had any clinical episodes. She does not have a H&C number. She has not been my patient at any time.

Personal Information redacted by USI

This person has not been my patient at any time. I have not had his chart.

Personal Information redacted by USI

There is no record of this patient having been my patient. She has not attended privately. I have not had her chart.

Personal Information redacted by USI

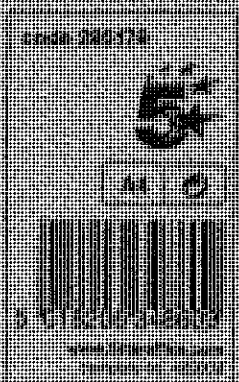
I know this patient very well, [REDACTED]
Southern Trust well known to all doctors. I dictated correspondence regarding [REDACTED] in August 2016. It was typed by an audiotypist in 16 August 2016. I presume it was then returned to Records. Her chart was not available when I reviewed her at my clinic at South West Acute Hospital on 19 September 2016. I have not had her chart since August 2016.

Personal Information
redacted by USI

Personal Information redacted by USI

I have known this patient, known as [Personal Information redacted by USI] personally for many years. He attended privately on 21 November 2015. His chart was **definitely** returned to my office on Tuesday 03 January 2017. I have kept a meticulous record of all the charts of private patients that were returned. I have retained duplicate clinical records for all these private patients.

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Meeting with Mr Aidan O'Brien
Tuesday 24 January 2017

Update from preliminary investigation

Issue one - Untriaged referrals

It is determined that, from June 2015, there are 783 untriaged referrals, all of which need to be tracked and reviewed to ascertain the status of these patients in relation to the condition for which they were referred.

4 consultants will be participating in this review, which is not yet complete.

There are 4 letters which hadn't been recorded on PAS which have been handed over by Dr O'Brien (consultant to consultant referrals).

Issue two – Notes being kept at home

It is determined that:

307 notes were returned by Mr O'Brien from his home.

88 sets of notes located within Mr O'Briens office

13 sets of notes, tracked to Mr O'Brien, are still missing, going back to 2003. Work is continuing to validate this list of missing notes.

Mr O'Brien has been provided with a copy of this list for comment.

Issue three – Undictated outcomes

It is determined that 668 patients have no outcomes formally dictated from Mr O'Briens outpatient clinics.

272 From the SWAH clinic Due Times 115 unprocessed

39 From other clinics. Due Times 96 unprocessed.

The remaining 107 patients are still being investigated

Issue four – private patients

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.

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<u>Patient</u>	<u>Hosp No.</u>	<u>Date of Surgery</u>	<u>Waiting Time</u>
Personal Information redacted by the USI	Personal Information redacted by USI	13/07/16	19 days
		18/07/16	115 days
		25/07/16	833 days
		27/07/16	33 days
		27/07/16	61 days (Attended Privately 30/04/16)
		27/07/16	28 days
		16/08/16	25 days (Attended Privately 23/07/16)
		17/08/16	292 days (Attended Privately 20/12/14)
		22/08/16	643 days
		24/08/16	421 days
		25/08/16	414 days
		26/08/16	74 days
		07/09/16	424 days
		20/09/16	382 days
		21/09/16	61 days
		21/09/16	427 days (Attended Privately 20/07/15)
		21/09/16	785 days
		04/10/16	53 days
		12/10/16	777 days
		01/11/16	241 days
		02/11/16	25 days (Attended Privately 08/10/16)
		02/11/16	99 days
		09/11/16	79 days

TURP 2016

<u>Patient</u>	<u>Hosp No.</u>	<u>Date of Surgery</u>	<u>Waiting Time</u>
Personal Information redacted by the USI	Personal Information redacted by USI	27/01/16	12 days (Attended Privately 28/02/15)
		27/01/16	705 days
		10/02/16	23 days
		10/02/16	12 days
		24/02/16	26 days
		26/02/16	14 days
		09/03/16	32 days
		09/03/16	83 days
		16/03/16	23 days
		16/03/16	155 days (Attended Privately 07/03/15)
		23/03/16	24 days
		13/04/16	400 days
		13/04/16	14 days
		04/05/16	54 days
		04/05/16	58 days
		17/05/16	581 days
		18/05/16	15 days
		25/05/16	61 days
		01/06/16	17 days
		15/06/16	65 days
		15/06/16	443 days (Attended Privately 01/11/14)
		29/06/16	427 days
		06/07/16	305 days (Attended Privately 15/08/15)

Summary

Private TURP Patients x 9

- Mean time on Waiting List 202 days
- > 500 days :
- 100 – 500 days: 5 Patients 56%
- < 100 days: 4 Patients 44%

Remaining TURP Patients x 37

- Mean time on Waiting List 219 days
- > 500 days: 6 Patients 16%
- 100 – 500 days 8 Patients 22%
- < 100 days 23 Patients 62%

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Bunmi Ogunseye

From: Grainne Lynn
Sent: 27 January 2017 09:44
To: Richard.Wright [Personal Information redacted by USI]
Cc: CST-C
Subject: case 18665 confidential

Categories: [Personal Information redacted by USI] UPLOADS no action

Morning Richard,

I was hoping for an update on this case. If there is anything you wish to discuss, I am available today and on Wed/Thurs/Fri of next week on [Personal Information redacted by USI]; alternatively, if you prefer, I am happy to be updated by email.

Kind regards,
Grainne

Grainne Lynn
Adviser
National Clinical Assessment Service (NCAS)

[Personal Information redacted by USI]

The National Clinical Assessment Service (NCAS) has moved. Our new address is:
National Clinical Assessment Service
NHS Litigation Authority
2nd Floor, 151 Buckingham Palace Road
London
SW1W 9SE
General Enquiries: 020 7611 2600 | Fax: 020 7931 7571

NCAS NI office: HSC Leadership Centre, The Beeches, 12 Hampton Manor Drive, Belfast BT7 3EN
Tel: 028 90 690 791

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Website: www.ncas.nhs.uk

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Bunmi Ogunseye

From: Grainne Lynn
Sent: 30 March 2017 13:28
To: 'Richard.Wright' [Personal Information redacted by USI]
Cc: CST-C; 'norma.thompson' [Personal Information redacted by USI]
Subject: CASE [Personal Information redacted by the USI] confidential

Hi Richard,

I called for an update on this case but you were unavailable.

As I understand it, there is to be an investigation and there are restrictions on the practitioner's practice.

If there is anything you (or the Case Manager) wish to discuss, I am available on [Personal Information redacted by the USI].

Kind regards,
Grainne

Grainne Lynn
Adviser
National Clinical Assessment Service (NCAS)

[Redacted]
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NHS Litigation Authority
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Tel: 028 90 890 791

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Website: www.ncas.nhs.uk

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Bunmi Ogunseye

From: Grainne Lynn
Sent: 30 May 2017 10:42
To: Richard.Wright Personal Information redacted by USI
Cc: CST-C
Subject: Case 18665 confidential

Categories: Personal Information UPLOADS no action

Hi Richard,

I was hoping for an update on this case. If you don't need further NCAS input I can close the file; it can easily be reopened at any stage

Kind regards,
Grainne

Grainne Lynn
NCAS Adviser

Personal Information redacted by USI

NHS Resolution
2nd Floor, 151 Buckingham Palace Road, London, SW1W 9SZ

NI Office
HSC Leadership Centre, 12 Hampton Manor Drive, Belfast BT7 3EN

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Quality Care - for you, with you

06 February 2017

STRICTLY PRIVATE & CONFIDENTIAL

BY E-MAIL ONLY

Mr Aidan O'Brien

Personal Information redacted by USI



Dear Mr O'Brien

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

The purpose of this correspondence is to put on record the decision of the case conference on 26 January 2017.

As per our telephone discussion on Thursday 26 January 2017, a case conference meeting to review your immediate exclusion from work which had been in place from 30 December 2016 took place on 26 January.

Mr Weir, Case Investigator provided the case conference with an update from the preliminary scoping exercise into 4 concerns previously notified to you. Based on this information, I have determined that you do have a case to answer in respect of the 4 concerns and that a formal investigation of the issues of concern is required.

The matter of your immediate exclusion from clinical duties was also discussed in detail and a decision was taken to lift the immediate exclusion with effect from 27 January 2017 as a formal exclusion is not required at this time. However this may be implemented at any time if all monitoring requirements are not met after you return to work. This is to ensure patient safety, to safeguard the investigation and to ensure you are protected from any further allegation of concern during the investigation process.

Please note you will be returning to work with a clear management plan for supervision and monitoring of key aspects of your work. The case conference members are satisfied that you can return to your full role with safeguards in place.

To discuss the detail of the monitoring arrangements, I would be grateful if you could meet with Siobhan Hynds and I, on Thursday 9 February at 4pm in the meeting room, Clanrye House, Daisy Hill Hospital.

I understand you are also due to be assessed by the Trust's Occupational Health department on the same date and we can therefore discuss your fitness for work when we meet.

If this date is not suitable, please contact Siobhan on Personal Information redacted by USI or via e-mail at Siobhan.HyndsPersonal Information redacted by USI to arrange an alternative date.

Yours sincerely

Personal Information redacted by USI

Dr Ahmed Khan
Associate Medical Director &
Case Manager

Copy to: Colin Weir, Siobhan Hynds

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TERMS OF REFERENCE FOR INVESTIGATION

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

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



TERMS OF REFERENCE FOR INVESTIGATION

	clinics. (c) To determine if there have been delays in clinical management plans for these patients as a result. 4. To determine if Mr O'Brien has seen private patients which were then scheduled with greater priority or sooner outside their own clinical priority in 2015 or 2016. 5. To determine 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.
Case Investigator:	Dr Neta Chada, Associate Medical Director supported Mrs Siobhan Hynds, Head of Employee Relations Personal Information redacted by USI
Case Manager: Designated	Dr Ahmed Khan, Associate Medical Director (Paediatrics), Daisy Hill Hospital Personal Information redacted by the USI
Board Member	Mr John Wilkinson, Non-Executive Director (contactable via the Chair's Office)

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Witness Statement

NAME OF WITNESS	Mr Ronan Carroll
OCCUPATION	Assistant Director, Anaesthetics and Surgery
DEPARTMENT / DIRECTORATE	Directorate of Acute Services, Craigavon Area Hospital
STATEMENT TAKEN BY	Dr Neta Chada, Associate Medical Director / Case Investigator
DATE OF STATEMENT	Thursday 6 April 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. My name is Ronan Carroll. I am employed by the Southern Health and Social Care Trust as Assistant Director for Anaesthetics and Surgery. I have been in this position since 1st April 2016. Prior to this date, I was employed as Assistant Director for Cancer and Clinical Services between 2007 and 2016 within the Southern HSC Trust. I came into my recent position following a restructure with the Acute Services Directorate.
2. I have been asked to provide this witness statement in respect of an investigation into concerns about the behaviour and / or clinical practice of Mr Aidan O'Brien, Consultant Urologist being carried out in accordance with the Trust Guidelines for Handling Concerns about Doctors and Dentists and the Maintaining High Professional Standards Framework.
3. I agreed to answer questions specifically related to the terms of reference previously shared with me.
4. I have always been aware of issues of concern in respect of Mr O'Brien's practice. I previously had responsibility for cancer performance within the Trust as well as the booking centre / cancer unit. Referrals to urology went to the Consultant of the week and would be sent to the relevant Consultant secretary for triage. Staff within the booking centre would expect to receive the referrals the next day or relatively soon thereafter and so would arrange a pre-determined time to go to collect the triaged referrals. On and off since 2007 I would have been made aware of problems with Mr O'Brien's triage. The booking centre staff wouldn't get the referrals back in the time scales needed.

5. There are 2 different cancer pathways, 31 day pathway and 62 day pathway. Staff would have struggled to get the referral back within the timescales needed from Mr O'Brien. There was not the same problem with the other Urologists.
6. I am aware the problem was discussed with Mr O'Brien and I would have been aware from senior management meetings that both Gillian Rankin and Debbie Burns discussed the matter with Mr O'Brien. At one time Mr O'Brien told me he didn't agree with the cancer standards and would continue to practice as he had always practised. This would be going back to 2007. I was never in a meeting when discussions with Mr O'Brien took place but I was aware the discussions were had.
7. I took up post in April 2016 which brought with it responsibility for Urology. I was unaware of the issue of the routine un-triaged referrals until I received a letter from Mr Glackin. (I knew previously about the red flag issues when I worked in cancer services.) Mr Haynes had raised an IR1 in respect of a particular patient (MH) who he had seen at his outpatient clinic. The patient had been seen as a routine patient but has been referred a considerable time before to the service. On review of the patient and the referral to the service, he felt the patient should have been upgraded to red flag based on the symptoms.
8. The issue resulted in a Serious Adverse Incident (SAI) investigation Chaired by Mr Glackin. There were several issues with the care of the patient. There were issues regarding diagnostic images not having been correctly reported on etc. From a urology perspective Mr Glackin discovered that Mr O'Brien was the urologist of the week. It was felt that the symptoms recorded by the GP on the referral letter should have resulted in the referral being regraded to red flag. This referral had not been triaged. This led to a "look back exercise" to see if there were other untriaged referrals that same week, there were a number and in turn this led to a review of all referrals.
9. It came to my attention through this that because referrals from the booking centre were not coming back from Mr O'Brien's office, it had been agreed that if referrals didn't come back, the secretary would put them onto the system according to the GP triage so they would not be lost in the system. Mr Glackin wrote to myself and Esther Gishkori expressing concern about what he had found and that process has taken us to the point of this investigation, I believe that may have been November 2016.
10. At some point after my appointment I was made aware of the letter to Mr O'Brien in March 2016 from Eamon Mackle and Heather Trouton outlining concerns which were to be addressed by Mr O'Brien. I didn't see the matter as being anything new, just another attempt at trying to manage Mr O'Brien. The issues in March 2016 related to his review backlog and notes being kept at home. The SAI issue was not known at that time.
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.

12. We also discovered clinics were not being dictated.
13. When all of the issues of concern were looked at, I admit to being very shocked at the magnitude of it. I don't think anyone appreciated the magnitude of the issues of concern.
14. I shared this with Dr Wright, Medical Director and Esther Gishkori, Director of Acute Services and a meeting was set up under the Maintaining High Professional Standards process where the outcomes of what had been found were shared.
15. During this period of time (Nov/Dec 2016) Mr O'Brien was on sick leave due to a matter unrelated to these concerns. Dr Wright met with Mr O'Brien in late December 2016 to advise him of the concerns and to explain the process for investigation.
16. In terms of TOR and affected patients, we know there are 5 patients who it felt should have been upgraded if triaged, who now have a cancer diagnosis. The Consultant Urologists within the Trust have completed a full review of all patients and in total 24 they felt should have been upgraded. A peer assessment was done on the 24 cases and then is agreed with by at least one other colleague.
17. We work to IEAP standards which sets out 72 hours for an outcome of referrals. All of the Consultants know every day they must triage prioritising the red flags. The Consultants can make a decision to keep to the GP triage category or to upgrade.
18. Mr O'Brien never said he was not doing triage. I was unaware he was finding it difficult to fit in with his other work and would have raised this as an issue but he never said he wasn't doing it. There are no issues with the other Consultants completing their triage. Mr O'Brien's outpatient workload was lighter than some of his colleagues and his theatre time was comparable.
19. In terms of patient notes, I knew this was an issue when I took up post. It was Mr O'Brien's practice to have notes at home. I had no idea of the scale of the problem. I understand there were previous conversations between Mr O'Brien, Mr Mackle and Dr Wright about these concerns. I don't know if someone was looking at the scale of the problem or if it was known and no-one choose to address it.
20. Mr O'Brien is a respected Consultant and it is difficult to address such issues. Everyone knew you would need to be prepared for a fight. He likes to do things his own way. The scale of this epitomises this. I don't know any other Consultant who would think it is OK to work this like this.

21. With NICER the issue re patient notes has become less and so people have found ways around missing notes. There are still 13 sets of notes missing and he has been asked about them. I have no recollection of anyone using IR1's to document missing notes.
22. The Consultants working through the notes and undictated clinics have some concern that other appointments to other specialities have been missed as the letters were not dictated. There are no significant patient complaints regarding Mr O'Brien. The waiting lists are now so long so we have complaints generally about waiting times. Mr O'Brien does not use digital dictation and therefore it is not possible to monitor when clinics haven't been dictated. All of the other Consultants use digital dictation which allows for every clinic to be linked on PAS. If a clinic is not dictated this would highlight it. Consultants are using digital dictation 3 to 4 years now. While there is nothing specifically documented, my expectation would be that Mr O'Brien's secretary should have been flagging if outcomes were not dictated. I am now aware there are hundreds of letters from clinics not dictated by Mr O'Brien.
23. Mr O'Brien knows his patients really well but has kept a lot of the information relating to his patients retained in his head. It is not safe clinical practice.
24. An issue which concerned me this week is that when I checked regarding bed pressures, Mr O'Brien has no clinical priority noted on the theatre list. He said they are all urgent and 'they will all be done'. We need to be able to prioritise patients when there are bed pressures so we know who can be cancelled if absolutely necessary. The only person who knows the priority is Mr O'Brien.
25. In respect of TOR 4 – I was notified via e-mail from Mr Haynes about concerns relating to Mr O'Brien's private patients. Currently checks are ongoing on all patients in 2015 and 2016. The current waiting time for a routine procedure in Urology is 170 weeks. There does appear to be patients taken out of chronological order and operated on sooner. This is being looked into further to see if there were specific reasons for clinical priority in these cases.
26. Mr O'Brien says he has 4 categories of prioritisation; semi urgent, urgent, soon and routine, or something like that. This Trust has 2 categories urgent or routine. The rest of the urologists follow that.

This statement was drafted on my behalf by Mrs Siobhan Hynds, Head of Employee Relations and I have confirmed its accuracy having seen it in draft and having been given an opportunity to make corrections or additions.

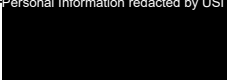
This statement is true to the best of my knowledge. I understand that my signed statement may be used in the event of a conduct or clinical performance hearing. I understand that I may be required to attend any hearing as a witness.



Southern Health
and Social Care Trust

Quality Care - for you, with you

INVESTIGATION UNDER THE MAINTAINING HIGH PROFESSIONAL STANDARDS FRAMEWORK
Witness Statement

SIGNATURE	Personal Information redacted by USI 
DATE	17.8.17

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Dr Ahmed Khan

Medical Director (Interim)

Case Manager -MHPS

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

Dear Dr Khan,

Thank you for your email of 23 October 2018.

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

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

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

It is now of the utmost importance that all correspondence and Minutes are shared as a matter of urgency.

Accordingly, I request that you provide me with the following documents within seven days of the date hereof:

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

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

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

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

Yours Sincerely,

Aidan O'Brien.

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Personal Information redacted by USI



30 July 2017.

Dr. Ahmed Khan,
Associate Medical Director,
Southern Health and Social Care Trust,
Trust Headquarters,
Craigavon Area Hospital,
Craigavon,
BT63 5QQ.

Dear Dr. Khan,

Re: Formal Investigation.

As you may know, I have been invited to interview by Dr. Chada, the Case Investigator, on Thursday 03 August 2017. I therefore wish to take this opportunity to register the cumulative concerns which I have had regarding the above investigation, the events leading to it and its conduct to date.

First amongst these is the relationship between 'Maintaining High Professional Standards in the Modern HPSS' issued by the Department of Health, Social Services & Public Safety (DHSSPS) in November 2005 and the 'Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance' issued by the Southern Health and Social Care Trust (SHSCT) in September 2010. 'Maintaining High Professional Standards in the Modern HPSS' (MHPS) is a framework for the handling of concerns about doctors and dentists in the HPSS. In Paragraph 3 of the Framework, the DHSSPS obliges HPSS organisations to notify the Department of the action they have taken to comply with the framework. In response to that obligation, the SHSCT formulated and issued its Guidelines in September 2010.

Paragraph 1.5 of the Trust Guidelines states that the 'guidance, in accordance with the MHPS framework, establishes clear processes for how the Southern Health & Social Care Trust will handle concerns about its doctors and dentists,

to minimise potential risk for patients, practitioners, clinical teams and the organisation'. Therefore, I believe that it is evident that the procedure by the SHSCT handles concerns about its doctors and dentists should be by and in accordance with its Guidelines, as obliged by the DHSSPS. Yet, this investigation has and continues to be conducted under MHPS, rather than under the Trust Guidelines.

In its Introduction, MHPS states that numerous ways exist in which concerns about a practitioner's performance can be identified, through which remedial and supportive action can be quickly taken before problems become serious or patients harmed, and which need not necessarily require formal investigation or the resort to disciplinary procedures. Paragraph 1.2 of the Trust Guidelines states that the 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 patients harmed.

In your letter of 24 February 2017 to me, you advised that the letter of 23 March 2016 given to me was not in the context of an informal process under the MHPS Framework but rather an informal attempt at local resolution of the issues, sent to me through normal line management channels. Apart from the fact that it was given to me rather than sent to me, it should not have been in the context of the MHPS Framework in any case. Instead, SHSCT management should have discussed with me and taken remedial and supportive action to resolve the issues of concern, in accordance with the Trust Guidelines.

In your letter, you stated that it was your understanding that concerns were identified by managers within the Acute Services Directorate and that the purpose of the March 23rd letter was to set out to me those concerns on an informal basis in order to enable me to put in place measures to rectify the concerns. Your understanding would infer that I had not been aware of those concerns prior to being given the letter. I had been burdened with the same concerns prior to being given the letter, and still am. I fail to understand how receipt of a letter outlining concerns of which I had long been aware, was itself enabling, without the remedial and supportive assistance obliged of those who wrote and gave the letter. Instead, it was expected that the letter was sufficient to ensure that I took all necessary steps to address the concerns and to rectify the identified problems.

Without the support which should have been given, it would have required the displacement of other work, and particularly operative activity. The numbers of patients severely suffering while awaiting surgery, at risk of suffering poorer clinical outcomes and actually doing so, remained my greatest clinical priority before and after receipt of the letter of 23 March 2016. During the months after March 2016, I deferred [REDACTED] which I should have had earlier, and did not take any leave on operating days or on the operating days vacated by colleagues, in order to maximise operating capacity, so as to minimise the poor outcomes suffered by scores of patients. To have attempted to address and rectify the concerns, on my own without support, would certainly have displaced all of the additional operating carried out during the remainder of 2016.

There were 280 patients awaiting admission for surgery in November 2016, excluding those awaiting admission to the Day Surgical Unit. Patients were waiting as far back as February 2014. That number included some thirty patients requiring admission as soon as was possible. The numbers suffering due to delay in admission, at risk of poor clinical outcomes and actually suffering poor clinical outcomes, have been and remain my greatest clinical concern. So far as I am aware, these outnumber many times over, those identified by the investigation as at risk of suffering poor clinical outcomes. When I advised Mr. Weir and Mrs. Hynds of this greatest clinical concern at my meeting with them on 24 January 2017, I was asked whether I had raised this issue with management previously. In addition to advising that I had done so numerous times with all tiers of management, I also asserted that I was doing so again, there and then, and that I predicted that my doing so would not appear in any record of the meeting. It did not! On 27 March 2017, I included this omission in a written request for the Note of the meeting to be amended, and returned to me. Four months later, I still await receipt of the amended Note.

I believe that I, and the patients about whom management claimed to have been concerned, were failed by management's failure to discuss the concerns which they had and which I shared, with a view to agreeing a remedial and supportive course of action over a period of time in order to rectify the problems, as obliged by Trust Guidelines. I would have so welcomed that support. Instead, when I asked what they wanted me to do, there was no advice or support offered.

I believe that the deliverance of a letter to me on 23 March 2016 by members of Trust management, identifying concerns which they expected me to address and rectify, on my own, without remedial action and support, in breach of Trust Guidelines, is untenable, particularly when those same concerns were deemed to be so grave as to merit a Formal Investigation and Immediate Exclusion nine months later.

In your letter of 24 February 2017, you related how the SAI investigation had alerted the Trust to a very serious issue of concern which indicated harm had come to a patient who had not been properly triaged by me as was required. I had indeed previously raised my concern that a decision had been made to proceed with a formal investigation and immediate exclusion, prior to even a draft final report of the investigating panel having been compiled. I was provided with that draft final report on 13 January 2017. I returned my comments upon the report on 25 January 2017. In doing so, I concluded that the terms of reference for the SAI investigation were prejudicial in that the investigation concerned itself with the period of time beginning with CT scanning on 24 June 2014 and ending with the patient's first urological consultation on 06 January 2016. The SAI investigation therefore failed to include that the renal lesion of concern could have been identified on CT scanning as early as December 2012. Most importantly, the patient did not come to any harm as a consequence of the delay in urological consultation. I believe that it was improper and prejudicial to have concluded that harm had been suffered by a patient before the investigation of the case had even reported. I believe that it was even more improper and prejudicial to have used that presumption of harm, which did not exist, to justify Formal Investigation and Immediate Exclusion, as you asserted.

It is also noteworthy that you made reference to my not having 'properly' triaged the letter of referral. I do believe that there is indeed a distinct difference between triage and proper triage. I believe that most, if not all, clinicians would agree that 'triage' is a process to allocate 'red flag', 'urgent' or 'routine' status to any referral in accordance with the information provided in the letter of referral. As I reported in my response to the draft final report of the SAI investigation, the patient had been a routine referral for assessment of a large, simple, right renal cyst, associated with right renal angle pain. Based upon this information, I asserted that I would have retained the routine referral status. The waiting time then for a routine urological outpatient consultation was then 66 weeks. At present, I believe it to be some 84 weeks.

I believe that 'proper' triage would have resulted in the referral status having been amended to 'Red Flag'. This would have required a review of the patient's entire history by access to NIECR. However, crucially, it would also have required a review of the digitalised imaging on NIPACS. I believe that it is a modest proposal that this would have taken some 15 to 20 minutes to undertake. We receive 120 to 160 referrals per week. Even if the mean time required to 'properly' triage were ten minutes each, that would require 20 to 27 hours during a week when one is responsible for all inpatient care of all urological patients, including emergency and urgent surgery, and all emergency and urgent referrals from elsewhere in Craigavon Area Hospital, Daisy Hill Hospital and South West Acute Hospital. Indeed, as reported in my comments upon the draft final report of the SAI investigation, on the day upon which the referral of the case was delivered for triage, I had additionally spent three hours previewing the cases for MDM discussion that afternoon when I spent a further three hours chairing MDM, followed by further time that evening proof reading and signing letters emanating from MDM, addressed to GPs. The following day, I reviewed ten oncology patients in addition to the continued responsibilities of being urologist of the week. It was precisely for this reason that I had previously advised that I had found it impossible to conduct triage on urgent and routine referrals, as there simply was inadequate time to do so. Indeed, in March 2015, as lead clinician of MDT, I had been unable to secure the commitment of my colleagues to conduct such triage on 'Red Flag' referrals alone, as they found it too time consuming and that there was not enough time as urologist of the week to do so, as documented in the minutes of the Urology MDT Business Meeting of 02 April 2015, and even though Red Flag referrals constitute only 15% to 20% of all referrals.

Also, in relation to triage, you referred in your letter to my having failed to properly triage *as was required*. I have twice requested a copy of, or a link to, the Trust's Policy and Procedure regarding triage, and to which reference has been made. I still await a reply, a copy or a link. Moreover, the ultimate reason why any patient had to wait 66 weeks for a routine consultation following referral is because the Trust provides such an inadequate service. It is worthy of note that the SAI investigation panel did not include that inadequacy at all as a factor in the patient's delay in diagnosis. Lastly, in relation to that SAI investigation, I have yet to receive a copy of the final report of the investigating panel. I have written to the Director of Acute Services requesting a copy.

Finally, in relation to triage, one of my colleagues luckily discovered during April 2017 that a decision had been made by some person(s) in management not to place patients on a waiting lists for outpatient consultations at all, if investigations had been requested during triage, until it had been determined whether appointments were required, following receipt of the results or reports of the investigations. This had been decided without any consultation with clinicians, never mind their agreement. Following protest, this practice has since been abandoned. So much for the 'agreed / established procedure' so often referred to, during the course of this investigation!

During 2016, I had deferred my own surgery for as long as possible, in order to operate on as many patients as I possibly could, so as to minimise the numbers suffering while awaiting admission, and suffering poor clinical outcomes, as already related. During 2016 alone, I carried out an additional 22 operating sessions, and an additional 17 Urodynamics and Oncology Review sessions. I continued to do so until my symptoms, and particularly pain, rendered it increasingly difficult to travel, to conduct clinics and to operate. In addition, I deferred my own surgery until after the departure from the Trust of a colleague who required support following concerns regarding his competence when urologist of the week.

As indicated previously, prior to my taking Personal Information redacted by the USI leave, I had identified thirty patients awaiting admission, and whom I believed required to be admitted as soon as was possible. On 07 November 2016, I advised the Head of Service and my four colleagues of the ten of those patients waiting the longest periods of time, requesting that they be admitted during my Personal Information redacted by the USI leave. Personal Information redacted by the USI on 17 November 2016. During the subsequent weeks following discharge, I had arranged operating lists and clinic sessions to be undertaken by me during January 2017. By mid-December 2016, I had become so increasingly concerned by the outcome of my Personal Information redacted by the USI that Personal Information redacted by the USI

Personal Information redacted by the USI This proved to be so effective that there was no need for readmission, though it was equally evident that I needed to Personal Information redacted by the USI Personal Information redacted by the USI I felt well enough to have my secretary notify patients of their planned admissions and reviews in January 2017. I felt all the more compelled to do so as only two of the above ten patients had been admitted, by 31 December 2016.

Perhaps, the one aspect of this investigative process which I have found most incomprehensible was the decision to proceed to Formal Investigation and Immediate Exclusion without having consulted with me in the first instance. If I had been Medical Director and received such information, I would have certainly wanted to assess its veracity, accuracy and reliability, not only with those who had provided and delivered the information, but also with the clinician involved. I would certainly have wanted to explore with the clinician involved the reasons for the concerns raised. It would have been for me a matter of common sense, of courtesy and of natural justice. When requested to provide an explanation for this failure, the Medical Director, in his written reply of 30 March 2017, advised that it was not necessary as the required information was being collated by the Assistant Director of Acute Services and by the Head of Service. Instead, I was presented on 30 December 2017 with the fait accompli of Formal Investigation and Immediate Exclusion. Both were inflicted by a Medical Director, on behalf of an Oversight Group, upon a colleague recovering from [REDACTED] even though he claimed to be unaware of the nature of the [REDACTED] or of the pathology for which it was performed. The consequences of both upon my health have been the most severe I have suffered in my lifetime, some permanently, and without enquiry since.

When I met with the Medical Director and Ms. Hainey on 30 December 2017, it did appear that the greatest issue of concern was that of 'missing' hospital charts at my home. I did advise that I had never mislaid a patient's chart and that the only patients' charts that I had ever known to have been mislaid, were mislaid by the Trust. Nevertheless, all charts were returned from my home, as directed, on 03 January 2017, so that the Medical Director could advise the Chief Medical Officer of the status of 'missing' charts. I was subsequently presented with a list of 13 patients' charts, tracked out to me, and which were still missing. These included one who had never been my patient, two who never had clinical episodes at Craigavon Area Hospital and who did not even have a Health & Care numbers, one discharged following his birth in 1993 and who had had no episodes since then and who did not have a Health & Care Number, and one who last attended in 1988, four years before my appointment. It also included a patient whose chart had been returned to Medical Records, but which remained tracked out to me, but who is currently an inpatient with her chart intact, provided by Medical records, of course!

It was reported that there were over 600 patients who had attended as outpatients at over 60 clinics, and whose outcomes were unclear. I have yet to be advised of the source of this information, though there has been a belief

that it may have been an extrapolation of an audit of seven outpatient attendances conducted in October 2016. In fact, 349 of 560 patients (62%) who had attended 51 clinics, had already had outcomes dictated and implemented because of their clinical priority. There were 211 patients whose outpatient consultations had neither been dictated or outcomes returned. At the meeting of 30 December 2016, as I had been advised that I would not be able to return to work as intended, I requested a period of two weeks to process these remaining patients, explaining that I would review all of these patients by telephone, to ensure that their current clinical status was up to date. That would have ensured that all of these patients would have been effectively reviewed, relevant correspondence dictated, charts and clinical outcomes returned and implemented, during January 2017. Instead, I was advised that the Oversight Group had directed that the utmost priority was to have the charts returned, by 03 January 2017, so that the Medical Director could see them and report to the Chief Medical Officer of the status of the 'missing' charts.

The Medical Director advised me in his letter of 06 January 2017 that he understood that the charts had been returned as directed, and that their return would be recorded, and their location tracked on PAS, back to filing, to my office or to my secretary's office, in line with Trust procedures. However, charts were not returned to my office or to my secretary's office. Having attended a meeting in the Associate Medical Directors' office on 09 March 2017, I was concerned to find the charts still there. Nevertheless, I had consoled myself that I had been able to document all of the clinical outcomes intended for each patient before returning the charts on 03 January 2017. All of these outcomes were returned, upon request, on Monday 09 January 2017. However, I was advised in June 2017, five months later, that the outcomes had not yet been registered on PAS, never mind implemented. I find it remarkable and contradictory that a Trust purporting to be so concerned about patient safety, harm and potential harm, could have considered it appropriate to insist that 'missing' charts be imminently returned so that they could be declared 'unmissing', having been advised by me that doing so would prevent the processing of those patients in the manner which I have described, and yet allow a further five months to elapse before the returned outcomes were implemented.

Even though it is clearly stated in the Trust Guidelines that the investigation must be completed within four weeks, I still had not received any communication from the appointed Case Investigator, by 16 January 2017,

never mind any notification of a meeting with the appointed Case Investigator, to provide me with an opportunity to state my case and to propose alternatives to exclusion, as required by the same Trust Guidelines, within the four week period permitted. I had to resort to contacting the Case Investigator myself, on 16 January 2017, to be advised that he had a meeting scheduled to take place on Thursday 26 January 2016, the penultimate day of the four week period, with Mrs. Hynds, the Human Resources person appointed to assist him in the investigation, and that no meeting with me had been scheduled to take place at all, within the four week period.

In addition, I had not been provided with the Terms of Reference for the investigation on the day on which it was initiated, in breach of NCAS guidelines. I had not been provided with a copy of correspondence or communication with NCAS. I had not been provided with the minutes of the meeting of the Oversight Group. I had not been provided with a Record of the meeting of 30 December 2016. I had not been advised of the identity of the non-executive Board member appointed to ensure momentum was maintained, to ensure that the investigation was completed in a fair and transparent way, and to consider any representations regarding exclusion or any other aspect of the investigation.

I had to write to the Medical Director on 17 January 2017 requesting to be advised of the identity of the non-executive Board member and requesting all minutes, records and documentation pertaining to the meeting of 30 December 2017. I expressed my concern that a date had not been set for me to meet with the Case Investigator within the four week period, as required by the Trust Guidelines. I also requested the Medical Director to inform me in more detail of the reasons and justifications for immediate exclusion, so that I may be able to adequately respond to them, and to consider proposals for alternatives.

The Medical Director wrote to me on 18 January 2017, enclosing a Note of Meeting of 30 December 2016. In a later letter of 23 January 2017, the Medical Director advised that he had approved the Note of the Meeting on 18 January 2017. I wrote to the Medical Director on 14 February 2017, detailing factual errors and omissions in the Note of the Meeting. I found it most egregious that the Note included a statement, in parenthesis, attributed to my wife who had accompanied me to the meeting, and which she did not make. I received an email from Mrs. Hynds on 01 March 2017, acknowledging receipt of my letter of 14 February 2017 to the Medical Director, and undertaking to arrange for an

amended Note to be sent to me, taking consideration of my comments. I sent a further email to Mrs. Hynds on 19 April 2017, advising her that I still awaited receipt of an amended Note of the meeting of 30 December 2016. I have yet to receive a reply, or an amended Note.

As a consequence of my contacting the Case Investigator on 16 January 2017, and of my letter to the Medical Director on 17 January 2017, I was advised by the Case Investigator, by telephone on 19 January 2017, that a meeting was arranged with him and with Mrs. Hynds on 24 January 2017. I was advised that the purpose of the meeting was to discuss alternatives to exclusion. I was then advised by the Case Investigator, in writing on 20 January 2017, that the purpose of the meeting was two-fold, an opportunity to state my case and to propose alternatives to formal exclusion, even though I had not yet been provided an opportunity to discuss alternatives to immediate exclusion. On 23 January 2017, the Medical Director confirmed in writing that a date for the meeting had been proposed. The Medical Director did not advise me of any specific reasons or justifications for immediate exclusion as requested. He did however avail of the opportunity to opine that the Trust Guidelines created an expectation that investigations are completed in four weeks, even though the Guidelines explicitly assert that investigations must be completed within four weeks. That the investigation was in breach of Trust Guidelines was acknowledged at the meeting with the Case Investigator and with Mrs. Hynds on 24 January 2017. That acknowledgement was not included in the Note of the Meeting.

At that meeting, I asked for specific reasons for my immediate exclusion. None could be given. I asked for specific reasons why exclusion should be continued. None could be given. That none could be given was not included in the Note of the Meeting.

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 this fourth concern.

On 06 February 2017, I received from Mrs. Hynds a Note of the Meeting of 24 January 2017, inviting me to advise her of any amendments required to the factual accuracy of the Note. On 28 March 2017, I submitted to Mrs. Hynds amendments to be made as a consequence of factual errors and omissions. I still have not received an amended Note.

I was provided with the Terms of Reference for the investigation on 16 March 2017, though NCAS guidelines stipulate that the terms of reference be provided to the practitioner when advised of the formal investigation. On the same date, I was provided with a list of seven witnesses. Dr. Chada advised in her letter of 14 June 2017 that I will have received a witness list from her at an earlier date. I have not received any such list from Dr. Chada. I have not been provided with the testimonies of any witnesses. I have not yet been provided an opportunity to see all relevant correspondence, as obliged by Trust Guidelines.

I had considered deferring this record of my concerns until after interview by Dr. Chada. However, I have decided to do so at this time after a recent experience. I had taken annual leave the week commencing Monday 10 July 2017, but had agreed upon request to be on call on Saturday 15 July and Sunday 16 July 2017. On Friday 14 July 2017, I received calls from colleagues advising me of patients acutely admitted for surgery over the weekend. There were a total of eight patients requiring urgent surgery but I was only able to operate on four due to lack of theatre capacity. Some days later, I was approached by a member of staff whom I presume has not known of this investigation but was concerned enough to advise me that an investigation was being conducted into the cases upon whom I had operated, as it had been reported that I had arranged for one or more of these patients to be admitted electively. I was shocked by this revelation. I reported this experience when I

met with the Assistant Director of Acute Services, the Clinical Director and the Head of Service on Tuesday 25 July 2017. It was evident that this investigation was known to one or more of them, if not instigated by one or more of them. I find this a matter of grave concern.

I have very much appreciated the flexibility demonstrated by Dr. Chada in facilitating her interviewing me on a date which did not further compromise patient management and outcomes. I approach that interview with integrity, sincerity, accountability and with some apprehension. However, I do so convinced that there was a safer and less traumatic way of dealing with the concerns identified by management in March 2016, and which I had shared before and since. I should have been offered and provided with remedial action and support to address and resolve those concerns at that time. I believe that I was failed by management, as were the patients I care for. In December 2016, I should then have been offered remedial action and support to address those same concerns. An investigation of untriaged referrals could have been conducted by my colleagues, without my involvement, as I provided all of those referrals in chronological order, upon request. All of the undictated outcomes could have been completed, with updated reviews, by mid-January 2017, as described above. All of the 'missing' charts would have been returned by then. I do believe that there was no need whatsoever for immediate exclusion to be imposed in December 2016, no more than was considered necessary to be continued in January 2017, thereby avoiding the consequences upon my health suffered since, and which have been further exacerbated by the administrative conduct of an investigation into my administrative practices.

Yours Sincerely,

Personal Information redacted by USI



Aidan O'Brien.

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

Casenote	Consultant Name	Date on Waiting List	Date Operation	Days between Added to WL to Operation Date	Is there a clinical reason why they should have waited such a short time
Personal Information redacted by USI	O'Brien A Mr	22/02/2016	22/03/2016	29	No
	O'Brien A Mr	25/04/2016	04/05/2016	9	Reasonable – Red Flag
	O'Brien A Mr	11/04/2016	15/04/2016	4	No
	O'Brien A Mr	01/04/2016	27/04/2016	26	No
	O'Brien A Mr	08/07/2016	09/08/2016	32	No
	O'Brien A Mr	29/07/2016	21/09/2016	54	No
	O'Brien A Mr	04/12/2015	24/02/2016	82	Reasonable
	O'Brien A Mr	11/07/2016	17/08/2016	37	No
	O'Brien A Mr	08/10/16	02/11/16	25	No
	O'Brien A Mr	31/10/16	04/11/16	5	No
	O'Brien A Mr	16/02/2016	24/02/2016	8	No

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

Casenote	Consultant Name	Date on Waiting List	Date Operation	Days between Added to WL to Operation Date	Is there a clinical reason why they should have waited such a short time
Personal Information redacted by USI	O'Brien A Mr	~~22/02/2016~~ 20.02.16	22/03/2016	~~29~~ 31	No
	O'Brien A Mr	~~25/04/2016~~	04/05/2016	~~9~~ 46	Reasonable – Red Flag
	O'Brien A Mr	~~11/04/2016~~	15/04/2016	~~4~~ 349	No
	O'Brien A Mr	~~01/04/2016~~	27/04/2016	~~26~~ 25	No
	O'Brien A Mr	08/07/2016	09/08/2016	32	No
	O'Brien A Mr	~~20/07/2016~~ 20.07.15	21/09/2016	~~54~~ 428	No
	O'Brien A Mr	~~04/12/2015~~ 21.11.15	24/02/2016	~~82~~ 94	Reasonable
	O'Brien A Mr	~~11/07/2016~~ 23.07.16	17/08/2016	~~37~~ 25	No
	O'Brien A Mr	08/10/16	02/11/16	25	No
	O'Brien A Mr	~~31/10/16~~ 01.10.16	04/11/16	~~5~~ 34	No
	O'Brien A Mr	~~10/02/2016~~ 30.01.16	24/02/2016	~~8~~ 25	No

PRIVATE PATIENTS

Patient 114

Personal Information redacted by
USI

This man attended privately on 20 February 2016. I found him to be a very anxious man concerned, if not convinced, that his right scrotal swelling was an indication of cancer. His concern at that time was in the context of his mother being gravely ill in hospital, requiring laparotomy for bowel obstruction. He was her main carer. I am unaware of her outcome. I was unable to convince him that the right scrotal swelling was benign, and felt that it was justified in the context of his anxieties and his mother's illness to be able to eliminate his concern by arranging his admission to the Day Surgical Admission for hydrocoelelectomy **(after 31 days)**.

Even though I did so on 22 March 2017, he returned again on 25 June 2017, his persistent concern regarding cancer centred on persistent left abdominal pain for which reason I arranged for him to have a CT scan of his abdomen and pelvis on 20 July 2017, finding no evidence of any such pathology. Instead, it was evident that he had significant degenerative pathology throughout his thoracolumbar spine. I believe that he was then adequately relieved of his anxiety. However, I note that he has been urgently referred to Mental Health in August 2017 because of worsening depression. I have attached my review letter of 16 August 2016.

Patient 115

Personal Information redacted by
USI

Patient 115

was an 86 year old lady brought to see me privately by her daughters on 19 March 2016 as they were concerned by their mother's visible haematuria. She was found on CT scanning to have a bladder tumour obstructing her right ureter resulting in a deterioration of her global renal function. She was admitted on 04 May 2017 **(after 46 days)** for resection of the bladder tumour and ureteric stenting. Following subsequent stent removal and intravesical chemotherapy, she has had no recurrence of carcinoma since.

Patient 116

Personal Information redacted by
USI

Patient 116

had been referred by his GP in December 2014 for assessment of troublesome urinary symptoms, and later referred by a Dermatologist in February 2015 for assessment of balanitis. He attended privately on 02 May 2015 when he reported that he was most troubled by urgency and urge incontinence. Even though anticholinergic therapy reduced the severity of the incontinence, the persistent urgency made it very difficult for him to care for and visit his terminally ill wife. It was for that reason that I expedited his further assessment by flexible cystoscopy and urodynamic studies on 15 April 2016 **(after 349 days)** and as an additional patient in SPA time.

Patient 117

This 82 year old lady was referred on 24 March 2016 for assessment and management of intermittently severe, left loin pain, microscopic haematuria and a left renal stone found on ultrasound scanning. As suspected, CT scanning confirmed that the 1.2 cm stone had become impacted in her upper left ureter, causing renal outlet obstruction. She was admitted on 27 April 2016 (**after 25 days**) for left ureteroscopic laser lithotripsy and ureteric stenting.

Patient 118

This 34 year old man was twice referred by his GP, in February and in June 2016, for assessment and management of increasingly severe urinary symptoms including urge incontinence and nocturia. In fact, when I met him on 25 June 2016, with some significant difficulty, he advised me that he additionally had nocturnal enuresis, causing him and his wife to sleep in separate rooms, and resulting in significant marital strain. He advised that he had not advised his GP. It was for that reason that I expedited further investigation of his symptoms by flexible cystoscopy and urodynamic studies on 08 July 2016 (**after 45 days**), and without including that reason in my letter to the GP. For the same reasons, I believed that it was reasonable to expedite his admission to the Day Surgical Unit on 09 August 2017 for hydrostatic dilatation of his bladder (**after a further 32 days**).

Patient 119

This 62 year old man attended privately as an outpatient on 20 July 2015 for further assessment and management of severe lower urinary tract symptoms, due to bladder outlet obstruction, resulting in chronic urinary retention, necessitating self-catheterisation. I advised him then that he would be best served by having his prostate resected. I arranged his admission on 21 September 2016 (**after 428 days**).

Patient 120

This man was 73 years old when he attended privately on 21 November 2015 for assessment of severe urinary symptoms, including urinary incontinence, accompanied by microscopic haematuria. CT urography on 30 November 2015 revealed that he had a large bladder stone, measuring 3.5 cm in diameter. I arranged his admission on 24 February 2016 for endoscopic bladder lithotripsy (**after 94 days**).

Patient 121

This frail, 80 year old man was found to have urinary retention, accompanied by hyponatraemia, requiring catheterisation, following his acute admission in June 2016. He failed a trial removal of the catheter. He was brought to see me privately on 23 July 2016 due to his discomfort due to indwelling catheterisation. It was for that reason that I believed it reasonable to admit him on 16 August 2016 (**after 25 days**) for TURP on 17 August 2016.

Patient 122

This 90 year old man was acutely admitted in July 2016 in acute urinary retention, resulting in bilateral upper tract obstruction and acute renal injury, urinary infection and coliform bacteraemia. He attended privately on 08 October 2016 due to urethral discomfort caused by continued catheterisation. He was found to have recurrence of coliform infection on urinary culture. I therefore expedited his admission on 02 November 2017 (**after 25 days**) to minimise the risk of recurrence of the previous morbidity.

Patient 123

This 78 year old man attended privately on 01 October 2016 for assessment of severe urinary symptoms. Even though he had had a satisfactory outcome following TURP in 2013, by 2016 he had to strain to pass urine and had to rise up to hourly each night to pass urine. Because of the severity of his symptoms, I arranged for him to attend on 04 November 2016 (**after 34 days**) for flexible cystoscopy and urodynamic studies, which confirmed that he was in chronic urinary retention due to detrusor hypocontractility, and for which he was taught to practise self-catheterisation.

Patient 124

is the 25 year old daughter of Personal Information redacted by the USI who not only has been one of my closest friends Personal Information redacted by the USI

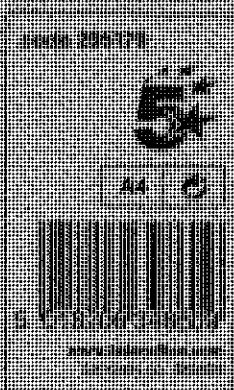
closely with our department in the

Patient 124

has suffered left flank pain of the nature of ureteric colic throughout 2012 until she was found to have stenosis of the intramural segment of her left ureter in February 2013. Dilatation of the intramural segment resulted in complete resolution of pain until Christmas

2015, since when she had constant pain throughout January 2016, when Personal
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redacted by the
USI asked me to review her. On doing so on 30 January 2016, I found her to have recurrence of the same ureteric pain as previously. However, I was also struck by the severity of her lower tract symptoms, having to rise 4 or 5 times each night to pass urine. I was therefore keen for her to have urodynamic studies performed prior to left ureteroscopy. Jenny Mc Mahon, Clinical Nurse Specialist, offered to do so on Tuesday 16 February 2016 (**after 17 days**) whilst I was doing a New Patient clinic, and without displacing any patient on a scheduled session of urodynamic studies. Finding that she had a moderately severe hypersensitivity of her bladder enable me to perform effective hydrostatic dilatation of her bladder, in addition to left ureteroscopy on an additional operating session on 24 February 2016 (**after a further 8 days**).

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Witness Statement

NAME OF WITNESS	Mr Michael Young
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 23 March 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. My name is Mr Michael Young. I am employed by the Southern Health and Social Care Trust as a Consultant Urologist. I was appointed in 1998 as a Consultant in Craigavon Area Hospital and have held my current position with the Southern Trust since 2002.
2. I have been asked to provide this witness statement in respect of an investigation into concerns about the behaviour and / or clinical practice of Mr Aidan O'Brien, Consultant Urologist being carried out in accordance with the Trust Guidelines for Handling Concerns about Doctors and Dentists and the Maintaining High Professional Standards Framework.
3. I agreed to answer questions specifically related to the terms of reference previously shared with me.
4. Mr O'Brien and I were the Trust's only two Consultant Urologists up until 2005 when a third Consultant was appointed. Around 2005, the urology service with Mr O'Brien and I as the two Consultants were under significant pressure due to workloads. We were only able to do emergency work at that time. In fact our 'doors closed' for a short period of time in 2005 – around 80% of our work at that point was emergency work.
5. I recall meetings about the service and being asked by John Templeton if the service was working, it clearly wasn't. An action plan was put in place and it was at that point that Mr Batstone came to work with us for 6 months and then Mr Akthar joined the team. In 2010 there was a Urology review in Northern Ireland and from this work it was determined that the area a unit would cover was to be based on population. A unit covering 400,000 to 500,000 people required 5 Consultants



on a rota. In addition to Craigavon clinics, we also needed to cover outreach clinics in Armagh, Banbridge and more recently in the South West Acute Hospital Hospital. The compliment of staff increased with Mr Glackin joining the team followed by Mr Suresh. Mr Haynes and Mr O'Donoghue then replaced two other consultants who only stayed a short period. Although Mr Suresh has left within the last year, our team has remained stable in its compliment.

6. A new format was developed for triaging and assessing patients. This was based on the Guys Model which involved trying to aim for a one stop clinic principle. This involved either xrays being carried out before or at the clinic appointment along with investigations being performed at the clinic attendance where possible. We also followed the Surgical model and moved to a Consultant Urologist of the week in approximately October 2015. This was to incorporate triaging of letters as well as looking after the emergencies during that week. 2017
7. As many as possible decisions within the service are led by committee, in others words, I as lead clinician bring topics to discuss at departmental meetings. We all discuss any changes and agree them within the team of Consultants. All Consultants in the unit were involved in decision making about how the unit was going to run. Meetings were held each Thursday regarding the running of the service and all Consultants were invited to attend, along with managers and senior nurses.
8. Prior to the new service model, our on-call week involved done triage, attending our normal clinics and theatre in addition to the on-call commitment. At that time triage of referrals was into several categories - routine, semi-urgent, urgent and red-flag. There was a long waiting list and there were an excessive amount of referrals. We hoped that moving to the new system would improve matters. Since we have moved to the new model, we have noted that patient's stay in hospital has shortened because Consultants are involved in the day to day decisions about their care.
9. Advanced triage took extra work to carry out but it was good to have some tests performed prior to patients attendances. Mr O'Brien was an advocate of the Advanced triage principle. All Consultants 'bought into the change' and felt it was a good system. When we moved to Consultant of the Week, we introduced Advance triage. Although not a necessity, it was useful for patients to have tests done before they came to clinic.
10. It was always clear that Consultants triaged the referral. Referrals primarily come from GP's and internal referrals. In the past, letters may have gone directly to secretaries but when the Referral and Booking Centre opened all referrals went through their department. If I received a direct referral I may have got my secretary to log it on the system but certainly it always was sent to the Referral and Booking Centre.
11. Since the new system came into place, all letters should go to the booking office. Once or twice per day they will be delivered to the Thorndale unit for triage by the Consultant of the Week, as agreed by the service. Routine and Urgent referrals are separate from Red Flag referrals. Red Flag referrals will be delivered 3 to 4 times per day by the cancer tracking service.



12. The Consultants may process the triage letters in the Thorndale unit, some take them to their offices to sort and some may take them home. The triaged referrals are returned and any new referrals lifted. The on-call week is Thursday to Thursday and triage is done during this week. Each Consultant is supposed to keep on triaging until Thursday morning when they come off Consultant of the Week. Referrals should all be done by the end of the on-call week. Personally, by midnight on the Wednesday I like to have them all done. Occasionally some are put into the next week if it has been a particularly busy week as consultant of the week, but usually they are done during the week. There is an issue with delivery of letters to the Thorndale unit late on a Wednesday, as these will usually only be picked up by the next Consultant.
13. Red Flag referrals should be processed by the next day.
14. I was asked if I felt triage was important and I explained that I personally don't necessarily look at the GP prioritisation. I read the information on the referral and make triage decision myself. Sometimes a GP may not realise the significance of symptoms as potentially more sinister and therefore triage is important. The service has decided that triage is the main process that defines a patient pathway and as such it is extremely important that the Consultant performs the triage. There has always been a team approach to this and although it was felt advanced triage was best, some of the Consultants I sensed were more engaged with it than others, however all do agree with it. Mr O'Brien was very much in favour of advanced triage.
15. I find I regularly have to change GP triage ratings and I have upgraded referrals from routine to red-flag. It can work the other way around too where you change a referral from urgent to routine.
16. Advanced Triage is involved and can be time consuming. Some complete the task at different rates. Prior to the Consultant of the Week model it was very onerous but regardless, all letters should have been triaged. However I am not aware that there were reasons for not completing triage.
17. Mr O'Brien, I sense may work at a different pace to others. He has previously commented upon problems within the system and I interpret a common theme to this as the volume and time to process the workload to his satisfaction as being too much.
18. The process is that the booking centre takes a copy of the referral letter and then the original letter goes to the Consultant. Up until recently I was not aware of triage not being completed. I knew Mr O'Brien had prior issues with triage and in 2014 I did his triage for a period of time. At that time he was undertaking the role of NI Lead Clinician for an oncology peer review. So I told him to focus on that and I did his triage. I felt the work he was doing was important for both the Trust and Northern Ireland Urology. I think I did this for approximately 6 months until his project was completed.



19. I know Mr O'Brien finds triage arduous and he would often say he had difficulty completing triage on a timely basis. Mr O'Brien would raise issues at departmental meetings however I was unaware that the triage was not being done. I knew he didn't necessarily agree fully with all of the new introductions to the service but it was the process within the Department that we had all agreed to at prior meetings. He never said he was not going to do triage, he was very much part of the meetings when it was agreed. Mr O'Brien was very much an advocate of advanced triage and complained that others may not have done it properly. The level of triage he was aspiring to achieve was difficult to attain possibly, some may comment that he was almost trying to do it in too much detail, and as such the totality took too long.
20. My experience of Mr O'Brien is that if he was not wanting to do something he wouldn't be pushed into doing it. Mr O'Brien would be the first to politely say when he didn't agree with something. I am not aware of Mr O'Brien saying he wasn't doing triage. I knew he may have been behind with triage but not that he wasn't doing it.
21. It was only in December 2016 that I became aware of the extent to which Mr O'Brien was behind on doing triage. Again as commented upon before I appreciate that he was vocal about saying he had difficulty and didn't have enough time. I know he felt he didn't have time to do advanced triage in the way he wished. He however did not say the extent to which he was behind. I recall seeing the bundle of referrals which were not triaged in December 2016 and being particularly surprised by the volume.
22. I would have expected Mr O'Brien to have come to me and alerted me about the referrals not being triaged. I hadn't spotted that it was such an issue. I'm not in charge of his practice but I thought he would have afforded me the opportunity to speak to him. There was no reason why he couldn't approach me. I had helped him in the past. We have always had a good relationship and speak openly about a wide variety of things. We have had only 'two cross words' in the 20 years we've worked together.
23. In respect of TOR 1, I was unaware of the scale of the issue and was not told by Mr O'Brien or anyone else that triage was not being done, just that there was a delay in it being done. I was informed in late December 2016 that there was approximately 700 letters dating back to June 2015 that had not been triaged.
24. I was involved, along with my urology colleagues, in reviewing the referrals that hadn't been triaged. Of those I triaged several were upgraded to red flag. Some were clearly red-flag referrals. I am also aware my colleagues also upgraded some referrals.
25. All un-triaged referrals had the potential for patients to come to harm. During the look back exercise, I didn't see any GP coded red-flag referrals among the un-triaged referrals. i.e. it seems the red flag letters were triaged. These are printed on yellow paper to make them stand out. I'm not sure if Mr O'Brien screened the routine letters, this is not for me to comment upon. However if he had, it is unlikely he would have missed an evident red-flag referral. I am not sure if he



triaged some but ran out of time and didn't do the rest for that week. Again this is my supposition only and really not for me to officially comment upon.

26. Basic triage would not have taken any significant time, other than when there is a high volume of referrals. Advanced triage is however much more time consuming. If things are busy in the week, you do the basic triage and do the advanced version to the best of your ability in the time allocated. Its common sense in my mind and is the approach I take. In saying that the vast majority of triage I do is of the advanced version despite being busy. I suspect Mr O'Brien would not agree with the mix and match approach to basic /advanced triage so as to clear the weeks work. I have absolutely no concern about Mr O'Brien's clinical competence, in fact I and my family would go to him personally if needed. He is very capable of reading a letter and knowing what action was necessary.
27. Mr O'Brien is very fastidious about what he does, I sense he looks at the letters in detail, the minutiae is important. However the quantum in combination with the detail I think is his issue. I think it might be regarded that he does small amounts very well, whereas others can get through a larger volume.
28. All Urology Consultants, including Mr O'Brien, accept the Consultant of the Week model and what was required in the new model.
29. I am not aware of the issue regarding notes in Mr O'Brien's home. This is a Trust issue. I was unaware of charts being stored at his home. We do outreach clinics in Banbridge, Armagh, and South Tyrone. The notes are available when we go there.
30. When the new SWAH clinic started there was no transport between the two Trusts to take the charts and so files were taken to the clinic by Martina Corrigan. I bring the notes home in the back of my car and then bring them back to the Trust the next day. There is no reason to keep them longer than the time taken to do dictation of the clinic.
31. I believe Mr O'Brien works differently. I dictate at the time of the clinic, usually after each patient or at the end of the clinic. I write on the 'outcome sheet' the requirements for the patients and this is kept separate from the patient notes. I return all to my secretary the next day. The notes, dictation and outcome sheet are stored in my car / home over night before their return to the hospital the following day. There is generally a dictated letter on every encounter with a patient.
32. Mr O'Brien always requested the following Tuesday morning after the Erne clinic to be free to do his administration. (on other Tuesdays he does day surgery, but not the week of the Erne clinic). There was no indication that this was not enough time. We hold a scheduling meeting on the last Thursday of the month to define the activity for the month ahead. The schedule was sent out ahead of time to ensure everyone could plan the number of patients attending specific clinics. I run this meeting and everyone is present including the secretaries, junior medical staff and Consultants. Mr O'Brien was always very clear that he wanted to be free for admin work the day



after the Erne clinic. A further point noted in relation to the clinic administration is that I was unaware that outcome sheets had not been returned either. We had previously agreed that charts, dictation and outcome sheets should be regarded as separate in case something got lost.

Mr Young was unable to complete his interview on Thursday 23 March 2017 and it was agreed to re-schedule to complete the interview. Mr Young met again with Dr Chada on Monday 3 April 2017.

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.

35. In respect of patients with no dictated outcome letters, I was involved in the 'look back' exercise and I have completed 3 to 4 clinics so far. I was asked to review charts to work out the outcome of the patients. I reviewed the chart on its own without the 'outcome sheet'. I was asked to see if I could determine what action was required and if an outcome could be assessed from the available written documentation. The initial priority however was to clear up the un-triaged letters and that work is now complete.

36. On review of the clinics there was a mix of things in terms of outcomes. The vast number had no dictated letter to cover the attendance at clinic. The GP certainly and the hospital doctors would therefore have had no outcome from the consultation / referral. If the chart was available, working out what had happened with the patient could be possible as Mr O'Brien does generally write a lot of information in the chart so as to determine a care pathway. This would be the case in most but not all the cases.

37. Because of the lack of communication, I suspect there would probably have been GPs sending another referral. One example I came across had 5 consultations with an individual without any outcome letters from any of the contacts. Even without a letter the Outcome sheets would have allowed a secretary to action any plans.

38. I found out about the issue of undictated outcomes on 14 December 2016. Mr O'Brien's secretary hadn't received an outcome sheet for a period of time. It appears to me that Mr O'Brien seems to

like one letter to complete the whole episode of treatment. However I would have thought that this creates the problem of the GP and hospital system not knowing what is going on in the meantime. This creates unreasonable delays. I feel that outcomes should be dictated within a reasonable period of time. I think that actions required from the clinics were indeed undertaken by Mr O'Brien despite the lack of a letter to back this up.

39. Of the clinics I reviewed, the clinical management was fine from the documentation supplied. Actions did appear to have been carried out e.g. scans ordered, but the GP would not have been aware of that, nor his secretary if an outcome was not returned. There was the odd concern but nothing significant. I am not aware of harm to any patient. Some patients have now returned to catch up clinics and the previous information re attendances was not available. It is like starting all over again, almost like dealing with a new patient. There is no doubt there have been delays with clinical management plans for some patients because people have had to start again.

40. In respect of TOR 5, I was aware that triage was taking longer than it should have but I always thought it was being done. I knew there was some cajoling of Mr O'Brien to get referrals back. More recently Mr O'Brien was not keen to take new patients as he wanted to deal only with his waiting list. I knew about the concerns in the latter part of last year. Mr O'Brien had said something to me about a communication from the Trust about several issues. He felt the oncology review was the most important issue and so he was concentrating on that.

41. Prior to the last 6 months, I was not aware of letters not being triaged. I had helped him before but I completely unaware of the scale of the issue. I am not Mr O'Brien's line manager and so I wasn't aware of the detail of the March 2016 discussions. Managers didn't discuss those concerns with me. I am however now aware that there were prior issues of concern.

42. Having carried out Mr O'Brien's appraisal and he raised the difficulties about the volume of his work. However he never indicated he wasn't doing all his triage. Job planning is a separate issue to his appraisal and I officially don't do his job plan. We did have discussions about his scheduling, SPA and administration time. Other aspects of his job appeared satisfactory. I know Mr O'Brien had comparable or perhaps more favourable admin time than the rest of the Urologists. Mr O'Brien does extra oncology clinics on Friday afternoons. It has been offered to remove these if he doesn't want to do them.

(I would like to add that this document is logged in a series of points. This is as a series of questions put to me hence appearing a little disjointed in places and repetitive in areas)

This statement was drafted on my behalf by Mrs Siobhan Hynds, Head of Employee Relations and I have confirmed its accuracy having seen it in draft and having been given an opportunity to make corrections or additions.



This statement is true to the best of my knowledge. I understand that my signed statement may be used in the event of a conduct or clinical performance hearing. I understand that I may be required to attend any hearing as a witness.

SIGNATURE	M. Young
DATE	5 th October 2017

42

AIDAN O'BRIEN FRCSI
Consultant Urologist

Personal Information redacted by USI

Patient 124

23rd February 2016

DR MCSHANE
 Moy Medical Centre
 Charlemont Street
 Dungannon
 BT71 7SL

Dear Personal Information redacted by USI

Patient 124

DOB Personal Information redacted by USI
 UN Personal Information redacted by USI

30th Jan 16?

5 Feb u/s

12 Feb u/s

16 Feb urology

24th Feb water + 1 hydro

3/52 turn around.
 Diet 3/52. 4 water.
 on admission bi 12 F.
 7. urgent.

I write to you regarding Patient 124 who presented with persistent left flank pain in 2012. The pain was consistent with ureteric colic but it had not been possible to determine whether small opacities seen in the left hemi-pelvis were indicative of left lower ureteric calculi. As a consequence, Patient 124 was admitted in February 2013 for left ureteroscopy when I found her to have a stenosis of the intramural segment of her ureter, above which the ureteric lumen was dilated, containing urothelial debris. The stenosed intramural segment was effectively dilated by advancement of the ureteroscope.

Dilatation of the intramural segment resulted in complete relief of the left flank pain. She had a recurrence of that same pain in October 2014. There was no evidence of any left ureteric calculi or of left upper tract dilatation on CT scanning of her urinary tract at that time. The pain then was not as severe as it had been in 2012. Urinary microscopy and culture then were both normal, though later she did have a coliform infection in December 2014.

Patient 124 has had recurrence of the same pain since January 2016. She had remained effectively free of pain during 2015. When I reviewed her on 30th January 2016, she reported that the pain radiated from her left loin to her left labium majus. I noted that she had been found to have pyuria and bacteriuria on urinary microscopy on 12th January 2016. However, both were normal when repeated on 30th January 2016. In any case, I had empirically prescribed Trimethoprim 200mgs to be taken twice daily for a period of 3 weeks.

I arranged for Patient 124 to have ultrasound scanning of her urinary tract performed on 5th February 2016. Ultrasound scanning was normal. As the pain persisted, I had intravenous urography performed on 12th February 2016. Whilst this was also normal, there was just a hint that there may have been a mild degree of left ureteric dilatation. By then, her pain was increasingly localised to the left lower abdominal area, and was increasingly accompanied by lower urinary tract symptoms, which included hesitancy of micturition, a reduced urinary flow and post micturitional incontinence in addition to urgency and quite severe nocturia, having to rise 4 or 5 times each night to pass urine. Prior to considering any endoscopic reassessment, I had Patient 124 attend on 16th February 2016 for urodynamic studies when she was found to have a hypersensitivity of her bladder resulting in a compromised cystometric capacity of 190mls. There was no evidence of detrusor muscular overactivity.

AIDAN O'BRIEN FRCSI
Consultant Urologist

Personal Information redacted by USI

31st October 2016

DR ALLEN
 Rathkeeland House
 1 Blaney Road
 Crossmaglen
 BT35 9JJ

Dear Dr Allen

Patient 123

DOB
 UN

Personal Information
 redacted by USI

Patient 123

1-10-16
 26-10-16 4/5 - erect w/pen
 4-11-16 flex + wedy

12-11-16 flex + wedy

in line

Thank you for referring back to me this 77 year old gentleman with lower urinary tract symptoms. Patient 123 had been found to have similar symptoms in 2012 when urodynamic studies confirmed that he had bladder outflow obstruction of significance, resulting in chronic urinary retention. He underwent prostatic resection in March 2013. There was no evidence of any prostatic adenocarcinoma on pathological examination of resected tissue. Perhaps somewhat importantly, pathological examination did confirm that he had mild chronic prostatitis in addition to benign prostatic hyperplasia. When he returned for review in April 2013, he was very satisfied with the symptomatic outcome of prostatic resection, and was discharged from review.

When I met Patient 123 as an outpatient on 1st October 2016, he reported very significant symptoms of both a voiding and storage nature. He reported that he has to strain to micturate, and is frequently dissatisfied with bladder emptying on doing so. He reported having urgency of micturition, increased diurnal frequency and severe nocturia. He reported that he has to rise at least 3 times each night to pass urine, but frequently would have to do so hourly. On clinical examination, I found him to have a balanitis for which I prescribed Fucidin hydrocortisone cream to be applied topically. I also found him to have a moderately enlarged and clinically benign prostate gland. I was pleased to note that his biochemical renal function has remained normal as has his serum total PSA at 0.71 ng/ml.

I arranged for Patient 123 to have ultrasound scanning of his urinary tract performed on 26th October 2016. He was reported to have a small echogenic focus within his right kidney, possibly indicative of a small right renal stone. He was also reported to have simple left renal cysts, the largest of which measured 2.5cms in diameter. Apart from these findings, both upper urinary tracts were normal. He was reported to have a mildly enlarged prostate gland with a volume of 33.6mls, and to have adequate bladder voiding with a residual volume of 50mls.

I advised Patient 123 to remain on Tamsulosin as you had prescribed. I added Oxybutynin in the modified release formulation 5mgs to be taken once daily. I advised him to remain on both until he would return to our Department on Friday 4th November 2016 for flexible cystoscopy and urodynamic studies that day. I will advise you of the findings and of any plans for his further management in due course.

AIDAN O'BRIEN FRCSI
Consultant Urologist

Personal Information redacted by USI

28th October 2016

DR COLLINS
 20 Upper Main Street
 Roslea
 Enniskillen
 BT92 7LT

Dear Dr Collins

Patient 122

DOB
 UN

Personal
 Information
 redacted by USI

*8/10/16 Dr Collins - F. Hydronephrosis
 due to significant morbidity
 assigned admission 2.11.16.
 12.10.16 - TURP for Catheterisation*

I write to you regarding this 89 year old gentleman who was admitted to the Emergency Department of the Hospital in Enniskillen in July 2016 in urinary retention. He had significant urinary tract dilatation, acute deterioration in renal function, urinary infection and coliform bacteraemia. He was managed very successfully with urethral catheterisation, intravenous hydration and antibiotic therapy. By the time of his discharge on 28th July 2016, his biochemical renal function had returned to the normal range.

Patient 122 remained well when I met him as an outpatient on 8th October 2016, apart from discomfort associated with continued indwelling urethral catheterisation. In view of the significant morbidity suffered as a consequence of bladder outlet obstruction, I have arranged for him to be admitted to our Department on Wednesday 2nd November 2016 for prostatic resection that day.

Yours sincerely

dictated but not signed by

Mr Aidan O'Brien
Consultant Urologist

Date dictated: 28th October 2016

Date typed: 28th October 2016/LH

AIDAN O'BRIEN FRCSI
Consultant Urologist

Personal Information redacted by USI

16th August 2016

DR CATHCART
 The Health Centre
 Erne Road
 Enniskillen
 BT74 6NN

Dear Dr Cathcart

Patient 121

DOB
 UN

Personal Information
 redacted by USI

I write to you regarding this 79 year old gentleman who accompanied by hyponatraemia during his admission to South West Acute Hospital in June 2016 due to increasing erythema affecting his left foot. He required catheterisation. He was discharged on 16th June 2016 with an indwelling urethral catheter. He subsequently failed a trial removal of the catheter on 27th June 2016 when he was recatheterised.

When I met Patient 121 as an outpatient on 23rd July 2016, he reported that he found the indwelling urethral catheter to be particularly uncomfortable. I have therefore arranged for him to be admitted to our Department on Tuesday 16th August 2016 for prostatic resection on Wednesday 17th August 2016.

Yours sincerely

dictated but not signed by

Mr Aidan O'Brien
Consultant Urologist

Date dictated: 16th August 2016

Date typed: 16th August 2016/LH

AIDAN O'BRIEN FRCSI
Consultant Urologist

Personal Information redacted by USI

22nd February 2016

DR MCAULEY
 87/89 William Street
 Lurgan
 Co Armagh
 BT66 6JB

Dear Dr McAuley

Patient 120

DOB
 UN

Personal
 Information
 redacted by USI

*Jumped
 Queue but
 reasonable.*

Patient 120

*21.11.15 6.8 ng/ml
 24.2.16 Bladderstone 3.5cm*

*Diagnose
 in clinic Reasonable*

I write to you regarding this 73 year old gentleman who previously lived in Eglinton who has recently moved to live in Lurgan so that he could be near to his daughter who cares for him. He had initially been referred to my colleague, Mr MacLeod, Consultant Urologist at Altnagelvin Area Hospital for assessment of lower urinary tract symptoms, biochemical haematuria and an elevated serum PSA level. However, before investigation could be undertaken, Patient 120 had moved to Lurgan.

When I met him as an outpatient on 21st November 2015, I noted that his serum PSA level had been 2.9 ng/ml in 2011, increasing to 6.8 ng/ml by July 2015, then decreasing to 6.5 ng/ml by September 2015. I also noted that he had had an intracranial aneurysm in 1999.

He reported having a poor urinary flow and was quite severely troubled by urinary incontinence related to urgency. He was already taking Tamsulosin. He had been found to have pyuria, haematuria and bacteriuria on urinary microscopy but urinary culture was negative.

I found him to have a moderately enlarged prostate gland with some minimal induration of the right lateral lobe.

I arranged for Patient 120 to have a CT urogram performed on 30th November 2015 on account of the finding of microscopic haematuria. The dominant finding was that of a large bladder stone measuring 3.5cms in diameter. He was coincidentally found to have a large, incarcerated, hiatus hernia, to have chronic inflammatory changes in the basis of both lungs, to have colonic diverticulosis and more importantly, to have an infra-renal, abdominal aortic aneurysm, measuring 5.2cms in diameter, and which extended into the right common iliac artery.

I also arranged for him to have ultrasound scanning of his urinary tract performed on 2nd December 2015 when he was reported to have small, bilateral renal cysts, and to have minimal enlargement of his prostate gland.

I had prescribed Finasteride, 5mgs daily, when I met Patient 120 in November 2015, advising him to remain on Finasteride and Tamsulosin until further review. When I spoke with his daughter more recently, she reported that the addition of Finasteride had not resulted in any improvement in his

AIDAN O'BRIEN FRCSI
Consultant Urologist

Personal Information redacted by USI

5th September 2016

DR J M MCCONVILLE
 The Health Centre
 Erne Road
 Enniskillen
 BT74 6NN

Dear Dr McConville

Patient 119

DOB
 UN

Personal
 Information
 redacted by USI

Patient 119

July 15-
 20-15 u/s.
 LUTS
 TURP 21.9.16
 2/12 for LUTS
 symptoms
 *

I write to you regarding this 60 year old man whom you referred to Contingence Nurse Specialist in 2015 for assessment of severe, lower urinary tract symptoms which he had had for several years, and which had not been significantly improved as a consequence of having remained on Tamsulosin for some time. When assessed by Personal Information redacted by USI in May 2015, he reported a poor and intermittent urinary flow usually followed by a sensation of inadequate voiding, post micturitional incontinence and severe nocturia, having to rise at least 3 times each night to pass urine and not unfrequently having to rise up to 5 times. She found him to have a poor, maximum flow rate of 6 mls/sec and to have a post micturitional, residual urine volume of 170mls. He had then been recently prescribed Finasteride in addition to Tamsulosin. She initiated clean, intermittent, self catheterisation.

When I met Patient 119 as an outpatient in July 2015, his urinary symptoms had improved since the addition of Finasteride. His flow remained reduced, he still did have a sensation of unsatisfactory voiding following micturition, but the nocturia was less severe, he having to rise once or twice each night to pass urine. On clinical examination I found him to have a moderately enlarged and clinically benign prostate gland, in keeping with very normal serum total PSA levels of 1.1 ng/ml in 2013 and 1.4 ng/ml in 2015. I was also pleased to note that his biochemical renal function was normal in April 2015.

Patient 119 had ultrasound scanning of his urinary tract performed on 20th July 2015 when both upper urinary tracts were found to be normal and when bladder voiding was found to be much improved and normal with a residual volume of 14mls only.

I advised Patient 119 in July 2015 that he would be better served by having his prostate gland resected. As you may be aware from recent correspondence from Personal Information redacted by USI she has found his flow rate to remain very poor, even though bladder voiding has remained satisfactory. I have therefore arranged for Patient 119 to be admitted to our Department on Wednesday 21st September 2016 for endoscopic resection of his prostate gland later that day.

dictated but not signed by

Mr Aidan O'Brien
 Consultant Urologist

Date dictated: 5th September 2016
 Date typed: 5th September 2016/LH

«PTFNAMES» «PTSNAME» DOB: «PTDOB» H+C: «PTNHS»

Page 1 of 1

AIDAN O'BRIEN FRCSI
Consultant Urologist

Personal Information redacted by USI

29th June 2016

DR O'LOUGHLIN
 Parkview Surgery
 South Tyrone Hospital Site
 Carland Road
 Dungannon
 BT71 4AU

Dear Dr O'Loughlin

Patient 118

Personal Information redacted by the USI

Patient 118

25.6.16
 5.7.16 Flat + woody
 24. ok w/flat w/dyn
 but 1/2.

I write to you regarding this 34 year old man who had been found to have a cystic mass located in his left anatomical hemi-pelvis on CT scanning in October 2010. The cystic mass measured almost 10cms in its maximum diameter, and was seen to displace the urinary bladder significantly to the right. On surgical exploration in November 2010, the mass was found to be an extra-peritoneal, haemorrhagic cyst which was evacuated. Part of the mass was submitted for histopathological examination. There was no evidence of any malignancy. There has been no reassessment of the possibility of any recurrence since then.

For several years prior to then, Patient 118 had had significant lower urinary tract symptoms predominantly of a storage nature. It may have been assumed that his symptoms are attributable to the presence of the pelvic mass compressing and displacing his urinary bladder. However, in retrospect, evacuation of the cystic mass did not appear to have any significant or lasting benefit with regard to his lower urinary tract symptoms. In fact, in more recent years, those symptoms have progressively increased in severity. Following his recent referral, I met Patient 118 as an outpatient on 25th June 2016 when he reported troublesome urinary symptoms of a mixed nature. He reported urgency and urge incontinence in addition to nocturia, having to rise 2 or 3 times each night to pass urine. However, in addition, he reported voiding symptoms in the form of hesitancy, a reduced urinary flow and a sensation of unsatisfactory voiding following micturition in addition to dysuria. He has derived no benefit from having been prescribed Tamsulosin. I noted that his serum total PSA level was very normal at 0.43 ng/ml in September 2015. In fact, his progressive lower urinary tract symptoms had caused him more recent concern regarding the prospect of he having prostatic carcinoma, and particularly in light of an uncle having recently undergone radical prostatectomy for prostatic carcinoma. On clinical examination, I felt that Patient 118 had a minimally enlarged and clinically benign prostate gland.

I hopefully have been able to reassure Patient 118 that there is no clinical or biochemical reason to suspect the presence of prostatic carcinoma. I have requested a CT scan of his pelvis in order to determine whether there is any evidence of recurrence of the cystic lesion, and I have arranged for him to attend our Department on Friday 8th July 2016 for flexible cystoscopy and urodynamic studies.

dictated but not signed by

«PTFNAMES» «PTSNAME» DOB: «PTDOB» H+C: «PTNHS»

Page 1 of 2

AIDAN O'BRIEN FRCSI
Consultant Urologist

20th April 2016

DR O'DONNELL
 The Medical Centre
 15 Barrack Street
 Coalisland
 BT71 4LS

Dear Dr O'Donnell

Patient 117

DOB
 UN

Personal Information
 redacted by USI



2.4.16
 19.4.16 CT
 27.4.16 (L) uroscopy
 20.4.16
 not known but renal
 stone for surgery 1/12

I write to you regarding this 82 year old lady whom you referred on 24th March 2016 following a 2 month history of left flank pain which, at times, has been severe. She was reported to have a stone, measuring 1.2cms in diameter, within her left kidney when she had ultrasound scanning performed on 26th February 2016.

When I met Patient 117 as an outpatient on 2nd April 2016, she reported that she continued to have intermittent left flank pain. I did note that she did have microscopic haematuria on urinary microscopy on 9th February 2016. On reviewing the digitalised images of the ultrasound scan of February 2016, I felt that this stone could very well be located within her left renal pelvis rather than within the lower pole calyceals, and as a consequence, maybe causing intermittent renal outlet obstruction resulting in ureteric colic.

I arranged for Patient 117 to have CT scanning of her urinary tract performed on 19th April 2016, and I have arranged for her to be admitted to our Department on Wednesday 27th April 2016 for left ureteroscopy with a view to ensuring that she does not have any additional ureteric calculi, and ideally with a view to achieving laser lithotripsy of the left renal stone. She may require ureteric stenting. In any case, you will be advised of the outcome and of plans for any further management in due course.

dictated but not signed by

Mr Aidan O'Brien
Consultant Urologist

Date dictated: 20th April 2016

Date typed: 20th April 2016/LH

AIDAN O'BRIEN FRCSI
Consultant Urologist

Personal Information redacted by USI

11th April 2016

DR THOMPSON
 Northland Surgery
 79 Cunninghams Lane
 Dungannon
 BT71 6BX

Dear Dr Thompson

Patient 116

DOB
 UN

Personal Information
 redacted by USI

Patient 116

2.5.15
 11.4.16 letter
 15.4.16 flex + wedy
 not swa of time lined
 accept.

I write to you regarding this 70 year old gentleman who was referred by your colleague, Dr Paisley, in December 2014, for assessment and management of troublesome urinary symptoms. By the time that I met ^{Patient 116} as an outpatient in May 2015, he had additionally been referred by Dr McMillan, Locum Consultant Dermatologist, for assessment of a balanitis.

When ^{Patient 116} attended on 2nd May 2015, the only symptoms which he reported to be of significance were those of urgency and urge incontinence. As Dr Paisley had indicated, ^{Patient 116} had been taking Dutasteride and Tamsulosin for some time. With regard to the erectile dysfunction, ^{Patient 116} reported that he had been taking Tadalafil 10mgs daily for some time, and with a degree of effectiveness that was just about satisfactory. On clinical examination, I found him to have minimal preputial adhesions and associated balanitis. I felt that he had a moderately enlarged, clinically benign prostate gland. I noted that ^{Patient 116} biochemical renal function has been normal to date and that his serum PSA had been very normal at 0.26 ng/ml in December 2014.

In any case, I advised him to discontinue taking Dutasteride to see whether its discontinuation with further enhance the efficacy of Tadalafil in the management of his erectile dysfunction. As his dominant urinary symptoms were storage in nature, I prescribed Oxybutynin in the modified release formulation, 10mgs to be taken once daily. I advised him to remain on Oxybutynin and Tamsulosin and Tadalafil until further review. I also arranged for him to have ultrasound scanning of his urinary tract which was performed in September 2015 when he was found to have a simple right renal cyst measuring 2.5cms in diameter, a mildly enlarged prostate gland with a volume of 35mls and very adequate bladder voiding, with a residual volume of 26mls.

I spoke with ^{Patient 116} by telephone recently when he reported that the Oxybutynin had probably contributed significantly to his avoidance of urge incontinence. However, he still does have severe urgency of micturition and to the extent that it severely compromises his quality of life to the extent that he does not allow himself to be far from a toilet at any time. The only other urinary symptom was that of nocturia, having to rise once each night to pass urine. I therefore felt that it would be reasonable to proceed with urodynamic studies. I have therefore arranged for him to attend our Department on Friday 15th April 2016 for urodynamic studies and flexible cystoscopy. I will advise you of the findings and of plans for his further management in due course.

Yours sincerely

«PTFNAMES» «PTSNAME» DOB: «PTDOB» H+C: «PTNHS»

Page 1 of 2

AIDAN O'BRIEN FRCSI
Consultant Urologist

Personal Information redacted by USI

26th April 2016

DR MCCONAGHY
 The Health Centre
 Tavanagh Avenue
 Portadown
 BT62 3BU

Dear Dr McConaghy

Patient 115

DOB
 UN

Personal Information
 redacted by USI

Patient 119

19.3.16 Haem-
 4.5.16 Bladder WB
 no Cancer

I write to you regarding this 86 year old lady who came to see me as an outpatient on 19th March 2016 following the recent onset of visible haematuria. The only other urinary symptom which she reported was that of nocturia, having to rise once each night to pass urine. I noted that she had had a total abdominal hysterectomy and bilateral salpingo-oophorectomy performed some 30 years ago and I also noted that there was a possibility of her having had a bladder prolapse in the past.

I noted that she has had chronic renal functional impairment for some time, her mean glomerular infiltration rate being 51mls/min during 2014. However, more recently, her glomerular infiltration rate has been found to have decreased to 43mls/min. There had been no evidence of infection on urinary culture during recent months, though she was found to have significant pyuria, haematuria and bacteriuria on urinary microscopy.

In any case, I arranged for Patient 115 to have a CT urogram performed on 20th April 2016 when she was found to have an enhancing, soft tissue mass with all of the characteristic appearances of a bladder tumour, arising from the right posterolateral wall of her bladder, obstructing the right ureteric orifice, resulting in marked dilatation of her right upper urinary tract. Undoubtedly obstruction of her right upper urinary tract has contributed to the recent decline in her biochemical renal function.

Importantly, Patient 115 was also reported to have a 6mm stone in her left kidney. On reviewing the digitalised images, this opacification is indeed either a left renal stone or an area of cortical calcification, particularly as it is closely related to a focal area of cortical scarring. However, if it were a stone, and if Patient 115 did have the misfortune of having that stone migrate into her left ureter, she could suffer catastrophic, anuric renal failure.

The only other lesions or pathology noted on her recent CT scan were those of simple, bilateral renal cysts, gallstones, colonic diverticulosis and degenerative changes affecting her thoracolumbar spine.

I have advised Patient 115 of the findings of CT scanning and I have arranged for her to be admitted to our Department on Wednesday 4th May 2016 for resection of the bladder tumour and possibly right ureteric stenting. I have also arranged for her to attend for pre-operative assessment prior to her admission. You will be advised of the findings and of our plans for her further management in due course.

«PTFNAMES» «PTSNAME» DOB: «PTDOB» H+C: «PTNHS»

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AIDAN O'BRIEN FRCSI
Consultant Urologist

Personal Information redacted by USI

3rd March 2016

DR CARSON
 Campbell Surgery
 10 Quarry Lane
 Dungannon
 BT70 1HX

Dear Pauline

Patient 114

DOB
 UN

Personal
 information
 redacted by USI

Patient 114

seems to be 3.3.16

22.3.16 scrotal
 surgery

2 1/2 weeks !!

I write to you regarding this Personal Information redacted by USI gentleman Patient 114 for assessment and management of a large right scrotal swelling. I noted that Patient 114 had been assessed by Mr McKnight, Consultant Urological Surgeon at the Ulster Hospital Dundonald in October 2015 when ultrasound scanning indicated that he had a large, septated, right hydrocele in addition to having probable right epididymal cysts. Mr McKnight advised that surgical intervention was not urgently indicated at that time.

I also note that Mr Patient 114 had been attending the Department of Urology as an outpatient at Lagan Valley Hospital, because of lower urinary tract symptoms. When he was reviewed in January 2016, he reported that he did not feel that he was able to empty his bladder completely on passing urine, that he had increased diurnal frequency of micturition in addition to having to rise once or twice each night to pass urine. I note that Mr Patient 114 did not have any prostatic enlargement on ultrasound scanning in April 2012 when his prostatic volume was 20mls only and when he had virtually complete bladder voiding on micturition. However, when ultrasound scanning of his urinary tract was repeated on 29th February 2016, his post micturitional, residual urine volume was 114mls.

Thirdly, Mr Patient 114 has been complaining of some left loin pain for some time. When he had ultrasound scanning of his urinary tract performed in 2012, he was reported to have a left renal cyst measuring 1cm in diameter. However, there was no left renal cyst evident on ultrasound scanning in February 2016 when, in fact, he was reported to have a right renal cyst measuring 1.1cm in diameter.

In any case, his more pressing issue is the large right hemiscrotal swelling. I have arranged for him to be admitted to the Day Surgical Unit at Craigavon Area Hospital on Tuesday 22nd March 2016 for right hydrocelectomy and right epididymal cystectomy. I will also avail of the opportunity of performing flexible cystoscopy in order to assess his lower urinary tract endoscopically.

dictated but not signed by

Mr Aidan O'Brien
 Consultant Urologist

Date dictated: 3rd March 2016

Date typed: 3rd March 2016

«PTFNAMES» «PTSNAME» DOB: «PTDOB» H+C: «PTNHS»

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L-3

Inpatient Operating 2013 - 2016

2013:	Job Plan	70 sessions
	Actual done	113
2014:	Job Plan	70 sessions
	Actual done	101.25
2015:	Job Plan	70
	Actual done	95.5
2016:	Job Plan	61
	Actual done	83.25

All of this additional operating was directed to those patients in most need.

All of this additional operating resulted in scores of patients having less poor outcomes than they would have had otherwise.

There remain 30 patients on my waiting list at risk of suffering poorer clinical outcomes as a consequence of their delayed admissions.

Elective Inpatient Operating 2013

			Sessions
Wednesday	02 January	9 am – 5pm	2.0
Wednesday	09 January	9 am – 7pm	2.5
Wednesday	16 January	9 am – 1pm	1.0
Friday	18 January	9 am – 5pm	2.0
Saturday	19 January	9 am – 5pm	2.0
Wednesday	23 January	9 am – 7pm	2.5
Wednesday	30 January	1 pm – 7pm	1.5
Wednesday	06 February	9 am – 7pm	2.5
Wednesday	13 February	9 am – 7pm	2.5
Saturday	16 February	9 am – 5pm	2.0
Wednesday	27 February	1 pm – 7pm	1.5
Wednesday	06 March	9 am – 7pm	2.5
Saturday	09 March	9 am – 5pm	2.0
Wednesday	13 March	Professional Leave: Interviews	
Wednesday	20 March	9 am – 1pm (Audit in afternoon)	1.0
Saturday	23 March	9 am – 1pm	1.0
Wednesday	27 March	9 am – 7pm	2.5
Wednesday	03 April	9 am – 7pm	2.5
Saturday	06 April	9 am – 5pm	2.0
Wednesday	10 April	9 am – 7pm	2.5
Wednesday	17 April	1 pm – 7pm	1.5
Wednesday	01 May	9 am – 7pm	2.5
Wednesday	08 May	9 am – 7pm	2.5
Saturday	11 May	9 am – 5pm	2.0
Wednesday	15 May	1 pm – 7pm	1.5
Wednesday	22 May	1 pm – 7pm	1.5
Wednesday	29 May	9 am – 7pm	2.5
Saturday	01 June	9 am – 5pm	2.0
Wednesday	05 June	1 pm – 7pm	1.5
Wednesday	12 June	9 am – 7pm	2.5
Wednesday	26 June	9 am – 7pm	2.5
Wednesday	03 July	9 am – 7pm	2.5

Wednesday	10 July	1 pm – 7pm	1.5
Wednesday	17 July	9 am – 7pm	2.5
Wednesday	24 July	9 am – 7pm	2.5
Wednesday	31 July	9 am – 7pm	2.5
Wednesday	28 August	9 am – 7pm	2.5
Wednesday	04 September	9 am – 7pm	2.5
Friday	13 September	1 pm – 5pm	1.0
Wednesday	18 September	9 am – 7pm	2.5
Wednesday	02 October	9 am – 7pm	2.5
Friday	04 October	1 pm – 5pm	1.0
Wednesday	09 October	9 am – 7pm	2.5
Wednesday	16 October	1 pm – 7pm (Audit in morning)	1.5
Wednesday	23 October	1 pm – 7pm	1.5
Wednesday	30 October	9 am – 7pm	2.5
Friday	01 November	1pm – 5pm	1.0
Saturday	02 November	9 am – 5pm	2.0
Wednesday	06 November	9 am – 7pm	2.5
Wednesday	13 November	9 am – 7pm	2.5
Friday	22 November	1 pm – 5pm	1.0
Wednesday	27 November	9 am – 7pm	2.5
Wednesday	04 December	9 am – 7pm	2.5
Saturday	07 December	9 am – 5pm	2.0
Wednesday	11 December	9 am – 7pm	2.5
Wednesday	18 December	9 am – 7pm	2.5

Total = 113 sessions

Plus 1.5 hours of perioperative patient care on each date = 82.5 hours

Total = 20.625 sessions

Plus 1 hour of administration time per session = 113 hours

Total = 28.25 sessions

Total = 161.875 sessions

Elective Inpatient Operating 2014

			Sessions
Friday	03 January	1 pm – 5 pm	1.0
Monday	06 January	1 pm – 5 pm	1.0
Wednesday	08 January	9 am – 7 pm	2.5
Wednesday	15 January	9 am – 7 pm	2.5
Wednesday	29 January	9 am – 7 pm	2.5
Saturday	01 February	9 am – 5 pm	2.0
Wednesday	05 February	9 am – 7 pm	2.5
Wednesday	12 February	9 am – 7 pm	2.5
Saturday	15 February	9 am – 5 pm	2.0
Wednesday	19 February	9 am – 1 pm (Audit in afternoon)	1.0
Wednesday	26 February	1 pm – 7 pm	1.5
Wednesday	05 March	9 am – 7 pm	2.5
Wednesday	19 March	9 am – 7 pm	2.5
Saturday	22 March	9 am – 5 pm	2.0
Wednesday	26 March	9 am – 7 pm	2.5
Wednesday	02 April	9 am – 7 pm	2.5
Wednesday	09 April	9 am – 7 pm	2.5
Saturday	12 April	9 am – 5 pm	2.0
Wednesday	16 April	9 am – 1 pm (Audit in afternoon)	1.0
Wednesday	23 April	9 am – 7 pm	2.5
Wednesday	07 May	9 am – 7 pm	2.5
Wednesday	14 May	9 am – 7 pm	2.5
Wednesday	28 May	9 am – 7 pm	2.5
Wednesday	04 June	9 am – 7 pm	2.5
Wednesday	11 June	Charing NICaUrology	
Wednesday	18 June	9 am – 7 pm	2.5
Wednesday	25 June	9 am – 7 pm	2.5
Tuesday	01 July	9 am – 1 pm	1.0
Wednesday	02 July	9 am – 7 pm	2.5
Wednesday	09 July	9 am – 7 pm	2.5

Wednesday 16 July	M&M / Audit in afternoon	
Wednesday 23 July	9 am – 7 pm	2.5
Wednesday 30 July	9 am – 7 pm	2.5
Wednesday 06 August	9 am – 7 pm	2.5
Wednesday 13 August	9 am – 7 pm	2.5
Wednesday 27 August	9 am – 7 pm	2.5
Wednesday 03 September	9 am – 7 pm	2.5
Wednesday 10 September	9 am – 7 pm	2.5
Wednesday 17 September	9 am – 1 pm	1.0
Wednesday 01 October	9 am – 7 pm	2.5
Wednesday 08 October	1 pm – 5 pm	1.0
Wednesday 15 October	1 pm – 8 pm	1.75
Monday 20 October	9 am – 1 pm	1.0
Wednesday 22 October	8 am – 8 pm	3.0
Wednesday 12 November	9 am – 7 pm	2.5
Wednesday 19 November	1 pm – 7 pm	1.5
Wednesday 26 November	1 pm – 7 pm	1.5
Wednesday 03 December	12 noon – 8 pm	2.0
Wednesday 17 December	12 noon – 8 pm	2.0
Wednesday 31 December	9 am – 5 pm	2.0

Total = 101.25 session

Plus 1.5 hours of perioperative care on each date = 72 hours

Total = 18 sessions

Plus 1 hour administrative time per session = 101.25 hours

Total = 25.31 sessions

Total = 144.56 sessions

Elective Inpatient Operating 2015

			Sessions
Wednesday	07 January	12 noon – 8 pm	2.0
Wednesday	14 January	12 noon – 8 pm	2.0
Wednesday	28 January	12 noon – 8 pm	2.0
Wednesday	11 February	12 noon – 8 pm	2.0
Wednesday	18 February	12 noon – 8 pm	2.0
Wednesday	25 February	12 noon – 8 pm	2.0
Wednesday	04 March	8 am – 8 pm	3.0
Wednesday	11 March	12 noon – 8 pm	2.0
Saturday	14 March	9 am – 1 pm	1.0
Wednesday	18 March	5 pm – 8 pm	0.75
Wednesday	25 March	8 am – 8 pm	3.0
Tuesday	31 March	8 am – 12 noon	1.0
Wednesday	01 April	12 noon – 8 pm	2.0
Wednesday	15 April	12 noon – 8 pm	2.0
Wednesday	29 April	12 noon – 8 pm	2.0
Wednesday	06 May	8 am – 8 pm	3.0
Friday	22 May	1.30 pm – 5.30 pm	1.0
Wednesday	27 May	9 am – 5 pm	2.0
Wednesday	03 June	9 am – 5 pm	2.0
Tuesday	09 June	12 noon – 8 pm	2.0
Wednesday	10 June	12 noon – 8 pm	2.0
Wednesday	24 June	9 am – 7 pm	2.5
Wednesday	08 July	9 am – 8 pm	2.75
Wednesday	15 July	9 am – 5 pm	2.0
Wednesday	22 July	12 noon – 8 pm	2.0
Wednesday	29 July	9 am – 7 pm	2.5
Wednesday	19 August	9 am – 1 pm	1.0
Friday	21 August	9 am – 5 pm	2.0
Wednesday	26 August	2 pm – 8 pm	1.5

Wednesday	09 September	9 am – 7 pm	2.5
Monday	14 September	9 am – 8 pm	2.75
Wednesday	16 September	12 noon – 8 pm	2.0
Wednesday	23 September	12 noon – 8 pm	2.0
Wednesday	30 September	12 noon – 8 pm	2.0
Wednesday	14 October	9 am – 7 pm	2.5
Wednesday	21 October	12 noon – 8 pm	2.0
Tuesday	27 October	8 am – 1 pm	1.25
Wednesday	28 October	12 noon – 8 pm	2.0
Wednesday	04 November	12 noon – 8 pm	2.0
Wednesday	11 November	8 am – 8 pm	3.0
Wednesday	25 November	9 am – 8 pm	2.75
Wednesday	02 December	12 noon – 8 pm	2.0
Wednesday	09 December	12 noon – 8 pm	2.0
Wednesday	16 December	12 noon – 8 pm	2.0
Wednesday	23 December	12 noon – 8 pm	2.0
Wednesday	30 December	9 am – 8 pm	2.75

Total = 94.5 sessions

Plus 1.5 hours of perioperative patient care on each date = 69 hours

Total = 17.25 sessions

Plus 1 hour of administration time per session = 94.5 hours

Total = 23.625 sessions

Total = 135.375 sessions

Elective Inpatient Operating 2016

			Sessions
Wednesday	06 January	Urologist of the Week	
Wednesday	13 January	9 am – 8 pm	2.75
Wednesday	20 January	12 noon – 8 pm	2.0
Wednesday	27 January	12 noon – 8 pm	2.0
Wednesday	03 February	12 noon – 8 pm	2.0
Wednesday	10 February	12 noon – 8 pm	2.0
Wednesday	17 February	Urologist of the Week	
Wednesday	24 February	9 am – 8 pm	2.75
Friday	26 February	1.30 am – 5.30 pm	1.0
Saturday	27 February	9 am to 1 pm	1.0
Wednesday	02 March	Professional Leave: expert witness	
Wednesday	09 March	12 noon – 8 pm	2.0
Saturday	12 March	9 am – 1 pm	1.0
Wednesday	16 March	9 am – 8 pm	2.75
Wednesday	23 March	12 noon – 8 pm	2.0
Wednesday	30 March	Urologist of the Week	
Wednesday	06 April	12 noon – 8 pm	2.0
Wednesday	13 April	9 am – 8 pm	2.75
Wednesday	20 April	Audit	
Wednesday	27 April	12 noon – 8 pm	2.0
Wednesday	04 May	12 noon – 8pm	2.0
Wednesday	11 May	Urologist of the Week	
Wednesday	18 May	12 noon – 8 pm	2.0
Wednesday	25 May	12 noon – 8 pm	2.0
Wednesday	01 June	12 noon – 8 pm	2.0
Wednesday	08 June	Urologist of the Week	
Wednesday	15 June	12 noon – 8 pm	2.0
Wednesday	22 June	Professional Leave: expert witness	
Wednesday	29 June	9 am – 8 pm	2.75

Wednesday	06 July	9 am – 8 pm	2.75
Wednesday	13 July	9 am – 8 pm	2.75
Monday	18 July	1.30 pm – 5.30 pm	1.0
Wednesday	20 July	9 am – 1 pm	1.0
Wednesday	27 July	9 am – 8 pm	2.75
Wednesday	03 August	Urologist of the Week	
Wednesday	10 August	9 am – 8 pm	2.75
Wednesday	17 August	12 noon – 8 pm	2.0
Wednesday	24 August	9 am – 8 pm	2.75
Friday	26 August	9 am – 5 pm	2.0
Saturday	27 August	9 am – 1 pm	1.0
Wednesday	31 August	9 am – 8 pm	2.75
Wednesday	07 September	12 noon – 8 pm	2.0
Wednesday	14 September	Urologist of the Week	
Wednesday	21 September	9 am – 8 pm	2.75
Wednesday	28 September	9 am – 8 pm	2.75
Wednesday	05 October	12 noon – 8 pm	2.0
Wednesday	12 October	12 noon – 8 pm	2.0
Wednesday	19 October	Audit	
Wednesday	26 October	Urologist of the Week	
Wednesday	02 November	9 am – 8 pm	2.75
Wednesday	09 November	9 am – 8 pm	2.75

Total = 83.25 sessions

Plus 1.5 hours of perioperative patient care for each date: 58.5 hours

= 14.625 sessions

Plus 1 hour of administration time per session: 83.25 hours

= 20.8125 sessions

Total = 118.6875 sessions

Number of elective inpatient sessions contracted at per Job Plan = 58

Elective Day Case Surgery 2012 – 2016

The obligation defined in my Job Plan has been to undertake two Elective Day Surgical Sessions per calendar month, with the expectation that four cases would be admitted per session.

Performance

2012:	Job Plan	42 weeks 19.38 elective day case sessions
	Actual	25 sessions
2013:	Job Plan	42 weeks 19.38 elective day case sessions
	Actual	20 sessions
2014:	(Urologist of the Week introduced in September 2014)	
	Job Plan	39.5 weeks 18.23 elective day case sessions
	Actual	23 sessions
2015:	Job Plan	35 weeks 16.15 elective day case sessions
	Actual	20 sessions
2016	(Until commencement of Sick Leave on 16 November 2016)	
	Job Plan	30.5 weeks 14.07 elective day case sessions
	Actual	17 sessions

Job Planned Sessions:	87.21 elective day case sessions
Actual Sessions:	105 sessions

Additional sessions = 17.79

Job Planned Patients:	349 patients
Actual Patients:	482 patients

Additional patients = 133

Additionality

Each additional session is 4 hours of operating:	71.16 hours
Each additional session required one hour to arrange:	17.79 hours
Each additional session preceded by 0.5 hours to consent:	08.90 hours

Total additional time allocated to elective day case operating 2012 – 16:

= 97.85 hours

Mean additional time allocated to elective day case operating per week:

= 0.52 hours

Elective Day Case Surgery 2012

Tuesday	24 January	x 5 patients
Tuesday	31 January	x 5 patients
Tuesday	14 February	x 5 patients
Tuesday	21 February	x 5 patients
Tuesday	13 March	x 5 patients
Tuesday	27 March	x 4 patients
Tuesday	03 April	x 5 patients
Tuesday	24 April	x 4 patients
Tuesday	01 May	x 4 patients
Tuesday	08 May	x 4 patients
Tuesday	29 May	x 5 patients
Tuesday	19 June	x 5 patients
Tuesday	26 June	x 5 patients
Tuesday	24 July	x 3 patients
Tuesday	07 August	x 4 patients
Tuesday	14 August	x 5 patients
Tuesday	29 August	x 3 patients
Tuesday	04 September	x 5 patients
Tuesday	11 September	x 5 patients
Tuesday	02 October	x 5 patients
Tuesday	09 October	x 5 patients
Tuesday	30 October	x 4 patients
Tuesday	06 November	x 5 patients
Tuesday	13 November	x 5 patients
Tuesday	04 December	x 5 patients

Total sessions = 25

Total patients = 115

Elective Day Case Surgery 2013

Tuesday	22 January	x 4 patients
Tuesday	05 February	x 5 patients
Tuesday	12 February	x 5 patients
Tuesday	12 March	x 5 patients
Tuesday	09 April	x 5 patients
Tuesday	16 April	x 5 patients
Tuesday	14 May	x 4 patients
Tuesday	04 June	x 5 patients
Tuesday	11 June	x 5 patients
Tuesday	02 July	x 4 patients
Tuesday	09 July	x 5 patients
Tuesday	27 August	x 5 patients
Tuesday	03 September	x 5 patients
Tuesday	10 September	x 5 patients
Tuesday	15 October	x 5 patients
Tuesday	22 October	x 5 patients
Tuesday	12 November	x 4 patients
Tuesday	26 November	x 5 patients
Tuesday	03 December	x 5 patients
Tuesday	10 December	x 5 patients

Total sessions = 20

Total patients = 96

Elective Day Case Surgery 2014

Tuesday	14 January	x 5 patients
Tuesday	28 January	x 5 patients
Tuesday	11 February	x 4 patients
Tuesday	25 February	x 3 patients
Tuesday	18 March	x 5 patients
Tuesday	25 March	x 4 patients
Tuesday	08 April	x 5 patients
Tuesday	15 April	x 5 patients
Tuesday	06 May	x 4 patients
Tuesday	27 May	x 6 patients
Tuesday	03 June	x 6 patients
Tuesday	08 July	x 5 patients
Tuesday	22 July	x 5 patients
Tuesday	29 July	x 5 patients
Tuesday	05 August	x 5 patients
Tuesday	26 August	x 5 patients
Tuesday	02 September	x 5 patients
Tuesday	16 September	x 5 patients
Tuesday	07 October	x 5 patients
Tuesday	21 October	x 5 patients
Tuesday	18 November	x 5 patients
Tuesday	16 December	x 4 patients
Tuesday	30 December	x 4 patients

Total sessions = 23

Total patients = 110

Elective Day Case Surgery 2015

Tuesday	06 January	x 4 patients
Tuesday	27 January	x 5 patients
Tuesday	10 February	x 4 patients
Tuesday	17 February	x 4 patients
Tuesday	10 March	x 4 patients
Tuesday	24 March	x 4 patients
Tuesday	28 April	x 4 patients
Tuesday	12 May	x 4 patients
Tuesday	26 May	x 4 patients
Tuesday	09 June	x 3 patients
Tuesday	23 June	x 5 patients
Tuesday	28 July	x 4 patients
Tuesday	25 August	x 4 patients
Tuesday	08 September	x 4 patients
Tuesday	22 September	x 4 patients
Tuesday	13 October	x 4 patients
Tuesday	03 November	x 5 patients
Tuesday	24 November	x 5 patients
Tuesday	08 December	x 4 patients
Tuesday	22 December	x 5 patients

Total sessions = 20

Total patients = 84 patients

Elective Day Case Surgery 2016

Tuesday	19 January	x 5 patients
Tuesday	02 February	x 4 patients
Tuesday	23 February	x 4 patients
Tuesday	15 March	x 4 patients
Tuesday	22 March	x 5 patients
Tuesday	05 April	x 5 patients
Tuesday	19 April	x 4 patients
Tuesday	03 May	x 5 patients
Tuesday	31 May	x 5 patients
Tuesday	28 June	x 5 patients
Tuesday	19 July	x 5 patients
Tuesday	26 July	x 5 patients
Tuesday	09 August	x 4 patients
Tuesday	06 September	x 4 patients
Tuesday	20 September	x 4 patients
Tuesday	11 October	x 4 patients
Tuesday	01 November	x 5 patients

Total sessions = 17 sessions Total patients = 77

Lead Clinician of MDT & Chair of MDM

I was appointed Lead Clinician of Urology MDT and Chair of Urology MDM on 01 April 2012.

I held the post of Lead Clinician of Urology MDT until 31 December 2016.

I chaired every MDM from April 2012 until the introduction of a three person rotation for chairing MDM in September 2014.

The numbers of cases discussed at each MDM was limited to 40.

Chairing MDM requires the Chairperson to preview all cases for discussion.

This task was made all the more taxing due to failure of clinicians to provide clinical summaries of all cases, as is required.

Previewing each MDM required 3 to 4 hours of time depending upon the numbers discussed.

MDM was followed by proof reading outcomes prior to them being sent to GPs.

**Additional Time spent previewing and proof reading MDMs chaired:
(allocating a mean total of 4 hours per MDM)**

2012: 31.5 weeks:	MDM x 25 = 100 hours = 3.17 hours per week
2013: 42 weeks:	MDM x 44 = 176 hours = 4.19 hours per week
2014: 39.5 weeks:	MDM x 35 = 140 hours = 3.54 hours per week
2015: 35 weeks	MDM x 17 = 68 hours = 1.94 hours per week
2016: 30.5 weeks	MDM x 16 = 64 hours = 2.09 hours per week

In addition as Lead Clinician, I brought the SHSCT Urology MDT from one which did not meet any National Cancer Plan target in 2012 to one that did not have a single case outside target timelines in 2015 when Peer Reviewed.

During the years as Lead Clinician, I established and secured agreement for all urological cancer referral and clinical management pathways.

I wrote and secured agreement for the MDT Operational Policy by having Business Meetings on alternate months.

I lead the SHSCT Urology MDT through National Peer Review in June 2015 and through the Peer Review update in September 2016.

All of these duties of Lead Clinicianship required a minimum of 1 additional hour of time allocated every week from April 2012 to September 2016.

The mean additional time allocated to MDT and MDM from 2012 to 2016 per week = 3.9 hours.

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Maintaining High Professional Standards Formal Investigation

Case Manager Determination

Dr A [REDACTED] K [REDACTED], Case Manager

1.0 Case Manager Determination following Formal Investigation under the Maintaining High Professional Standards Framework in respect of Mr A O'B, Consultant Urologist

Following conclusion of the formal investigation, the Case Investigator's report has been shared with Mr O'B for comment on the factual accuracy of the report. I am in receipt of Mr O'B's comments and therefore the full and final documentation in respect of the investigation.

2.0 Responsibility of the Case Manager

In line with Section 1 Paragraph 38 of the MHPS Framework, as Case Manager I am responsible for making a decision on whether:

1. No further action is needed
2. Restrictions on practice or exclusion from work should be considered
3. There is a case of misconduct that should be put to a conduct panel
4. There are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer
5. There are concerns about the practitioner's clinical performance which require further formal consideration by NCAS (re-named as Practitioner Performance Advice)
6. There are serious concerns that fall into the criteria for referral to the GMC or GDC
7. There are intractable problems and the matter should be put before a clinical performance panel.

3.0 Formal Investigation Terms of Reference

The terms of reference for the formal investigation were:

1. (a) To determine if there have been any patient referrals to Mr A O'B which were un-triaged in 2015 or 2016 as was required in line with established practice / process.

(b) To determine if any un-triaged patient referrals in 2015 or 2016 had the potential for patients to have been harmed or resulted in unnecessary delay in treatment as a result.

- (c) To determine if any un-triaged referrals or triaging delays are outside acceptable practice in a similar clinical setting by similar consultants irrespective of harm or delays in treatment.
- (d) To determine if any un-triaged patient referrals or delayed tri-ages in 2015 or 2016 resulted in patients being harmed as a result.
- 2. (a) To determine if all patient notes for Mr O'B█'s patients are tracked and stored within the Trust.
- (b) To determine if any patient notes have been stored at home by Mr O'B█ for an unacceptable period of time and whether this has affected the clinical management plans for these patients either within Urology or within other clinical specialties.
- (c) To determine if any patient notes tracked to Mr O'B█ are missing.
- 3. (a) To determine if there are any undictated patient outcomes from patient contacts at outpatient clinics by Mr O'B█ in 2015 or 2016.
- (b) To determine if there has been unreasonable delay or a delay outside of acceptable practice by Mr O'B█ in dictating outpatient clinics.
- (c) To determine if there have been delays in clinical management plans for these patients as a result.
- 4. To determine if Mr O'B█ has seen private patients which were then scheduled with greater priority or sooner outside their own clinical priority in 2015 or 2016.
- 5. To determine 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.

4.0 Investigation Findings

In answering each of the terms of reference of the investigation, the Case Investigator concluded:

- 1. (a) It was found that Mr O'B█ did not undertake non-red flag referral triage during 2015 and 2016 in line with the known and agreed process that was in place. In January 2017, it was found that 783 referrals were un-triaged by Mr O'B█. Mr O'B█ accepts this fact.

- (b) It was found that there was the potential for 783 patients to have been added to the incorrect waiting list. A look back exercise of all referrals by other Consultant Urologists determined that of the 783 un-triaged referrals, 24 would have been upgraded to red-flag status, meaning the timescales for assessment and implementation of their treatment plans was delayed. All un-triaged referrals were added to Trust waiting lists based on the GP referral assessment.
- (c) It was found that all other Consultant Urologists undertook triage of all referrals in line with established practice.
- (d) It was found that of the 24 upgraded patient referrals, 5 patients have a confirmed cancer diagnosis. All 5 patients have been significantly delayed commencing appropriate treatment plans.
2. (a) It was found that in January 2017 Mr O'B [REDACTED] returned 307 sets of patient notes which had been stored at his home. Mr O'B [REDACTED] accepts that there were in excess of 260 patient notes returned from his home in January 2017.
- (b) The notes dated as far back as November 2014. It was found that Mr O'B [REDACTED] returned patient notes as requested and he asserts therefore there was no impact on patient care.
- (c) It was found that there are 13 sets of patient notes missing. The Case Investigator was satisfied these notes were not lost by Mr O'B [REDACTED].
3. (a) It was found that there were 66 undictated clinics by Mr O'B [REDACTED] during the period 2015 and 2016. Mr O'B [REDACTED] accepts this.
- (b) It was accepted by Mr O'B [REDACTED] that he did not dictate at the end of every care contact but rather dictated at the end of the full care episode. This is not the practice of any other Consultant Urologist. The requirements of the GMC are that all notes / dictation are contemporaneous.
- (c) There are significant waiting list times for routine Urology patients. It is therefore unclear as to the impact of delay in dictation as the patients would have had a significant wait for treatment. The delay however meant that the actual waiting lists were not accurate and the look back exercise to ensure all patients had a clear management plan in place was done at significant additional cost and time to the Trust.
6. It has been found that Mr O'B [REDACTED] scheduled 9 of his private patient's sooner and outside of clinical priority in 2015 and 2016.

7. Concerns about Mr O'B█'s practice were known to senior managers within the Trust in March 2016 when a letter was issued to Mr O'B█ regarding these concerns. The extent of the concerns was not known. No action plan was put in place to address the concerns. It was found that a range of managers, senior managers and Directors within the Acute Service Directorate were aware of concerns regarding Mr O'B█'s practice dating back a number of years. There was no evidence available of actions taken to address the concerns.

Other findings / context

Other important factors in coming to a decision in respect of the findings are:

Triage

1. Mr O'B█ provided a detailed context to the history of the Urology service and the workload pressures he faced. Mr O'B█ noted that he agreed to the triage process but very quickly found that he was unable to complete all triage. Mr O'B█ noted that he had raised this fact with his colleagues on numerous occasions to no avail. Mr O'B█ accepts that he did not explicitly advise anyone within the Trust that he was not undertaking routine or urgent referral triage. Mr O'B█ did undertake red-flag triage.
2. It was known to a range of staff within the Directorate that they were not receiving triage back from Mr O'B█. A default process was put in place to compensate for this whereby all patients were added to the waiting lists according to the GP categorisation. This would have been known to Mr O'B█.
3. Mr Y█ is the most appropriate comparator for Mr O'B█ as both have historical long review lists which the newer Consultants do not have. Mr Y█ managed triage alongside his other commitments. Mr Y█ undertook Mr O'B█'s triage for a period of time to ease pressures on him while he was involved in regional commitments.

Notes

1. There was no proper Trust transport and collection system for patient notes to the SWAH clinic in place.
2. There was no review of notes tracked out by individual to pick up a problem.
3. Notes were returned as requested by Mr O'B█ from his home.