

been under my care, two were seen by me once each in the 1990s and I have not had their charts since that time or at all and one further patient had died in 2006, after which I definitely returned his chart. A further set of notes was actually returned on the 3rd January 2017, and the final set of notes had been unavailable to me when the patient attended my clinic for review in September 2016. Even though it was claimed that this patient's hospital chart remained tracked to me, it was provided by Records in the usual fashion upon her elective admission for surgery in July 2017.

On the eve of an important meeting at which my exclusion was going to be considered, I was asked to explain the location of missing notes. If these notes were tracked out to me on PAS, in many cases it was for unexplained reasons, given that I had never had any interaction with them at all. This issue remained live throughout the investigation and the Case Investigator ultimately accepted my explanation for the location of the notes only at the conclusion of the Investigation in June 2018. I had not been advised at an earlier date.

2.5.3 Private Patients

The additional issue added related to private patients. In particular, an allegation had been made that I have given preferential treatment to nine patients who had consulted with me privately, in relation to waiting times for elective admission for prostatic resection as NHS patients.

I was informed of this at the meeting of the 24th January 2017. Mr Weir provided me with a document that included an update from the investigation (Tab 31). Mr Weir appeared to have become aware of the issue on the same date. He expressed the view that it was his experience that patients often consulted privately out of desperation, and as a consequence of their clinical condition.

The document itself stated:

“A review of TURP patients identified 9 patients who had been seen privately as outpatients, then had their procedure within the NHS. The waiting times for these patients are significantly less than for other patients. Further investigations are on-going”.

In Dr Wright's response to my questions on 30th March 2017 (Tab 27), he mentioned that it had been established that there were “at least 9 TURP patients who had been seen privately by you, who were routine in terms of clinical priority, but appeared to have had their NHS procedure done in non-chronological order”.

In response to this allegation, I completed an analysis of all of the TURP patients that I operated on in 2016. There were indeed 9 NHS patients who had been seen privately and another 37 patients who had not been seen privately. I provided a breakdown of the waiting times for all of these patients, including a mean waiting time (Tab 32). There was no significant difference. The mean waiting time for the patients who had been seen privately was 202 days and the mean time for the remaining patients was 219 days. The Trust would ultimately change the 9 patients that were of concern and I will address this issue at the conduct panel.

There is no reasonable explanation how a scoping exercise relating to the triaging of GP referrals or the dictation of NHS clinics could give rise to any concerns about my private practice. It is my belief that this allegation was and continues to be a vexatious and frankly malicious attempt to cause me professional reputational harm and significant distress. It had nothing to do with the investigation that was ongoing and nothing to do with the issues of concern.

2.5.4 Failure to Liaise with NCAS

In her letter of 29th December 2016, Dr Grainne Lynn noted that she had discussed with Dr Wright that NCAS would keep their file open. Dr Lynn also stated a review date of 27th January 2017. This review did not take place. In my phone call with Dr Lynn in October 2018, she confirmed to me that NCAS had tried to contact the Trust on occasions in early 2017 but received no response from the Trust and that given the lack of communication, NCAS then proceeded to close their file in May 2017.

I have requested the full file from NCAS under a freedom of information request and it has now been provided to me. It is clear that NCAS made attempts to contact the Trust of 27th January 2017, 30th March 2017 and 30th May 2017. However, the Trust did not cooperate with these requests for a review. This resulted in NCAS closing its file on 30th May 2017. I have attached these emails at Tab 33.

2.6 The Conduct of the Formal Investigation

On 1st October 2018, a decision was made to refer me to a Conduct Panel by the Case Manager. There are many issues that I take with the substantive matters raised during the investigation and the subsequent report and in the Case Manager's determination that I will present during that conduct hearing. However there are several issues or procedural impropriety that I believe are relevant to this grievance and these are addressed below.

2.6.1 Case Conference Determination 26th January 2017

On 26th January 2017, a Case Conference was held to consider my exclusion. I do not have minutes of this meeting. I received a formal notification on 6th February 2017 from Dr Khan setting out the decision of the Case Conference (Tab 34). The Case Conference did lift my exclusion from clinical duties.

The Case Conference also considered a report from the Case Investigator and determined that I had a "case to answer" in respect of all four concerns and that a formal investigation of the issues was required. A decision had already been made by the Oversight Committee to launch a formal investigation and that was ongoing. It is not at all clear what the purpose of this decision was intended to be. There is no part of the Trust Guidelines that mandate this decision.

More concerning, however, is the fact that the Case Manager was involved in the decision that I had a case to answer at an early stage of the investigation and before I had even provided a response as part of that investigation. This was materially prejudicial for clear reasons and makes it impossible for the Case Manager to have an open mind when making a determination at the conclusion of the formal investigation.

contrary to NCAS Guidelines as these advise that the practitioner should be the first to be interviewed. This interview could not cover all of the issues in the case because on the morning of the interview, Dr Chada had just been provided with an anonymised list of patients whom the Trust alleged had been electively admitted for surgery after a shorter period of time because they previously had had a private consultation (see Tab 39). Dr Chada explained that she herself had just received the list of patients. This resulted in a further delay to conclude my interview. This meeting was not scheduled until 6th November 2017.

This delay is unexplainable and unreasonable. The delay has compounded the stress and anxiety that I have contended with since 30th December 2016. It is a breach of contract and has caused personal injury and damage.

2.7 The Investigation into Patients seen privately

At Paragraph 2.5.3 above, I have detailed my grievance about how an issue regarding the scheduling of patient's that had been seen privately had been added to the areas of concern. For the avoidance of doubt, I wish to state clearly that I have never provided advantageous treatment to a Patient as a result of seeing them privately. I believe that if this issue is put before a conduct panel, I will be able to demonstrate that conclusively. Nonetheless, I am raising in this grievance my concern about how this issue of concern has been approached and investigated by the Trust.

As I have stated above, I was informed of the inclusion of this issue at the meeting of the 24th January 2017 when Mr Weir provided me with a document that included an update from the investigation (Tab 31). The document stated:

"A review of TURP patients identified 9 patients who had been seen privately as outpatients, then had their procedure within the NHS. The waiting times for these patients are significantly less than for other patients. Further investigations are on-going".

In Dr Wright's response to my questions on 30th March 2017 (Tab 27), he mentioned that it had been established that there were "at least 9 TURP patients who had been seen privately by you, who were routine in terms of clinical priority, but appeared to have had their NHS procedure done in non-chronological order".

There are further mentions of this investigation included in the witness statements. In Mr Carroll's statement (Tab 36) he says as follows:

"11. I met with Martina Corrigan, Head of Service to look at the letter from Mr Glackin. I needed to look into his concerns and so we broke the letter down into the separate issue i.e. triage, unreturned patient notes, clinic outcomes etc. Separately I received an e-mail from Mr Haynes. Mr Haynes was aware of a patient seen privately by Mr O'Brien who was treated un-chronologically. As a result of the e-mail, we looked to see if there was a trend for TURP patients to be seen out of sequence and there were a number identified."

I asked for a copy of this email but I have not yet received a copy. I made this request in an email to Dr Khan on 2nd November 2018 (Tab 37). Mr Haynes does mention sending two emails to Michael Young and Martina Corrigan in June and December 2015. It is not clear if either of these emails is the e-mail that Mr Carroll is referring to.

It is clear that there have been several references to a review of TURP patients and a consistent reference to 9 patients having been identified, and who were alleged to have had procedures conducted more quickly. As I have shown, the TURP patients seen privately and publically have broadly similar waiting times (Tab 32).

I was scheduled to meet Dr Chada on 3rd August 2017. I was becoming increasingly concerned about the procedural breaches that the Trust were continuing to commit and to the escalating unfairness of the process. I had not received full documentation in advance of the interview and I would have been expected to comment upon issues that I did not have knowledge of. I wrote to the Case Manager on 30th July 2017. This letter is attached at Tab 38. In this letter I detailed my concerns at that point and I included my concern about the handling of private patients. In reference to the meeting of 24th January 2017 with Mr Weir, I stated:

“It was at that meeting that it was claimed that a fourth issue of concern was identified during the initial scoping exercise and relating to nine patients who had private outpatient consultations, and who then had prostatic resections performed as NHS patients, after waiting times significantly less than for other patients. However, it was not possible for this fourth concern to be identified during scoping of triage of NHS referrals, NHS outpatient consultations and NHS charts retained at my home. I requested how this concern had been raised or who had raised it. I was advised that I would be advised of the source. Six months later, I have still not been advised. I requested the identity of the nine patients concerned. I still have not been advised of their identity. I asked whether patients who had had private consultations and who still awaited prostatic resection had been identified, or whether NHS patients who had prostatic resections performed after a similarly short waiting time would be included in a comparative manner in such an investigation. Indeed, in a further communication from the Medical Director, dated 30 March 2017, he advised that all nine patients were classified as routine. I do not know how he could have come to such a conclusion, or who did so, on his behalf. Now, six months later and four days before interview by the Case Investigator, I have still not been advised of any further developments in the investigation of the fourth concern.”

I never received a response to this letter from the Case Manager or from anyone. I met with Dr Neta Chada on 3rd August 2017. Dr Chada mentioned that she was aware of the correspondence and that some consideration was going to be given to the response. At this interview a list of 11 anonymized patients was provided to me (attached at Tab 39), of which 9 were said to have had their surgery performed unreasonably sooner than expected. It was clear at the meeting that Dr Chada had only recently been provided with the list and that she herself was not personally involved in that part of the investigation. Given that no detail had been provided about any of the patients, we could not discuss this issue at the meeting. I was given additional time and a second meeting was subsequently scheduled. Nonetheless, the provision of this list during the meeting was very distressing and impacted upon my ability to represent myself in the interview.

When I reviewed the patients, I discovered that of the 11 patients, only 3 were now prostatic resections (TURP). The other 8 patients were either day case surgery or had had investigative procedures. In all but one of these cases, the stated time periods that the patients had waited prior to the dates of their procedures, were wrong. I provided a corrected list together with a response in respect of each patient which is attached at Tab 40. The Case Investigator has

stated in her report that these cases were reviewed by Mr Michael Young and that it is Mr Young's assessment that was being relied upon.

Mr Young provided a witness statement, signed on 5th October 2017 (Tab 41). In response, to the issue of private patients, Mr Young stated:

"33. In respect of TOR 4, I am aware that Mr O'Brien does private consultations at home, he doesn't see private patients in the hospital at all to my knowledge. I know this through conversations with Mr O'Brien. As far as I am aware Mr O'Brien does not perform surgery privately, patients convert to the NHS for their treatment.

34. I can't comment on the placement of private patients in the NHS queue. I don't track Mr O'Brien's patients. Any concerns I heard about private patients were just hearsay. I had no idea when patients were seen by Mr O'Brien at his home. I would have thought patients go on to the NHS list as per clinical priority. I have subsequently heard that some private patients might have been given dates sooner on the list but I was not aware if this was down to clinical priority. While I have recently heard this, I personally had no evidence of it."

Mr Young's statement clearly contradicts any assertion that he was providing a clinical assessment of the priority given to patients or the appropriateness of their placement on the waiting list.

Dr Chada attached Mr Young's assessment to her report. The assessment is simply a post it note put on each of 11 letters that I had dictated to GP's for private patients. These are attached at Tab 42.

Dr Chada never conducted a comparative analysis of NHS patients. Without such an analysis, it is not possible to state that the private patients were given favourable treatment to NHS patients. I have been able to demonstrate that there was no favourable treatment given to TURP patients and I intend to review all of my elective patients to provide a similar comparison given the Trust's failure to do so. The sum total of the Trust's investigation was 11 post-it notes placed on 11 letters by a colleague who did not appear to know that he was providing an assessment of whether the waiting times were justified.

The investigation of patients seen privately by me has been handled in a vexatious manner. It is my belief that the approach taken has been to cause me the maximum distress and reputational damage. The Trust has not conducted a reasonable investigation into this matter. The Case Investigator was not the individual conducting the investigation. The investigation has not been transparent in providing the basis for which the patients were chosen from all of the procedures conducted in 2016 or the details of the individual/individual(s) who chose them. It is not clear who compiled the list at Tab 39.

As part of my grievance, I am relying on Appendix 2 of the Trust Guidelines where it is stated that the Case Manager must ensure the Case Investigator gives the Practitioner an opportunity to see all relevant correspondence. Accordingly, I am requesting the opportunity to see the following all correspondence that gave rise to the concern about private patients becoming part of this investigation and relating to the handling of the investigation. I believe that it is essential that the Trust be transparent about how these cases came to be assessed.

From: McCaul, Collette
Sent: 30 January 2019 12:33
To: Burke, Catherine; Cooke, Elaine; Cowan, Anne; Daly, Laura; Hall, Pamela; Kennedy, June; McCaffrey, Joe; Mulligan, Sharon; Nugent, Carol; Wortley, Heather; Wright, Brenda; Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; Loughran, Teresa; Neilly, Claire; Robinson, NicolaJ; Troughton, Elizabeth
Cc: Robinson, Katherine
Subject: Patients awaiting results
Importance: High

Hi all

I just need to clarify this process.

If a consultant states in letter " I am requesting CT/bloods etc etc and will review with the result. These patients ALL need to be DARO first pending the result not put on waiting list for an appointment at this stage. There is no way of ensuring that the result is seen by the consultant if we do not DARO, this is our fail safe so patients are not missed. Not always does a hard copy of the result reach us from Radiology etc so we cannot rely on a paper copy of the result to come to us.

Only once the Consultant has seen the result should the patient be then put on the waiting list for an appointment if required and at this stage the consultant can decide if they are red flag appointment, urgent or routine and they can be put on the waiting lists accordingly.

Can we make sure we are all following this process going forward

Collette McCaul

Acting Service Administrator (SEC) and EDT Project Officer

Ground Floor

Ramone Building

CAH

Ext

Personal
Information
Redacted by USI

From: O'Brien, Aidan
Sent: 06 February 2019 23:34
To: Elliott, Noleen
Subject: FW: Patients awaiting results

Importance: High

Noleen,

A copy of my email to Collette McCaul,

Aidan

From: O'Brien, Aidan
Sent: 06 February 2019 23:33
To: McCaul, Collette
Cc: Young, Michael; Glackin, Anthony; Haynes, Mark; ODonoghue, JohnP; [REDACTED]; Corrigan, Martina
Subject: FW: Patients awaiting results
Importance: High

Dear Ms. McCaul,

I have been greatly concerned, indeed alarmed, to have learned of this directive which has been shared with me, out of similar concern.

The purpose of, the reason for, the decision to review a patient is indeed to review the patient.

The patient may indeed have had an investigation requested, to be carried out in the interim, and to be available at the time of review of the patient.

The investigation may be of varied significance to the review of the patient, but it is still the clinician's decision to review the patient.

One would almost think from the content of the process that you have sought to clarify, that normality of the investigation would negate the need to review the patient, or the clinician's desire or need to do so.

One could also conclude that if no investigation is requested, then perhaps only those patients are to be placed on a waiting list for review as requested, or are those patients not to be reviewed at all?

Secondly, if all patients who have had an investigation requested are not to be placed on a waiting list for review, as requested, until the requesting clinician has viewed the results and reports of all of these investigations, when do you anticipate that they will have the time to do so?

Have you quantified the time required and ensured that measures have been taken to have it provided?

Thirdly, you relate that it is by ensuring that the results are 'seen' by the consultant that patients will not be missed. I would counter that it is by ensuring that the patient is provided with a review appointment at the time requested by the clinician that the patient will not be missed.

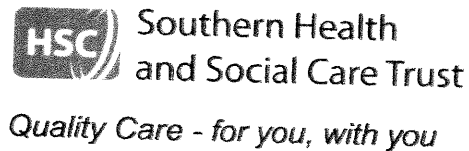
Perhaps, one example will suffice.

The last patient on whom I operated today is a 37 year old lady who has been known for some years to have partial duplication of both upper urinary tracts.

She has significantly reduced function provided by her left kidney.

She also has left ureteric reflux.

However, she also has had an enlarging stone located in a diverticulum arising by way of a narrow infundibulum from the upper moiety of her right kidney.



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

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

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

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

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

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

CONCERN 1

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

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

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

Red Flag referrals must be completed daily.

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

CONCERN 2

- That, 307 sets of patient notes were returned by Mr O'Brien from his home, 88 sets of notes located within Mr O'Brien's office, 13 sets of notes, tracked to Mr O'Brien, are still missing.

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

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

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

CONCERN 3

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

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

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

CONCERN 4

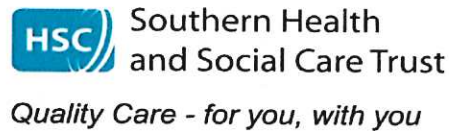
- A review of Mr O'Brien's TURP patients identified 9 patients who had been seen privately as outpatients, then had their procedure within the NHS. The waiting times for these patients are significantly less than for other patients.

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

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

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

**STRICTLY
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CONFIDENTIAL**



INVESTIGATION REPORT

Under the Maintaining High Professional Standards Framework

Mr Aidan O'Brien, Consultant Urologist

Case Investigator

Dr Neta Chada, Consultant Psychiatrist / Associate Medical Director

Assisted by

Mrs Siobhan Hynds, Head of Employee Relations

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REPORT OF FORMAL INVESTIGATION

1. Introduction

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

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

2. Context / Background

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

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

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

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

3. The initial concern

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

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

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

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

4. Timeline of the Investigation

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

March 2016

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

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

Four broad concerns were identified:

- Untriaged outpatient referral letters

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

- Current Review Backlog up to 29 February 2016

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

- Patient Centre letters and recorded outcomes from clinics

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

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

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

April to October 2016

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

November 2016

Mr O'Brien was off work on sick leave from 16 November 2016

Personal information redacted by the USI

and was

due to return to work on 2 January 2017.

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

December 2016

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

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

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

- from June 2015, 318 GP referrals had not been triaged in line with the agreed / known process for such referrals. Further tracking and review was required to ascertain the status of all referrals.
- there was a backlog of 60+ undictated clinics dating back over 18 months amounting to approximately 600 patients, who may not have had their clinic outcomes dictated. It was unclear what the clinical management plan was for these patients, and if the plan had been actioned
- some of the patients seen by Mr O'Brien may have had their clinical notes taken back to his home, and are therefore not available within the hospital. The clinical management plan for these patients was unclear, and may be delayed.

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

28 December 2016

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

30 December 2016

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

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

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

03 January 2017

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

20 January 2017

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

23 January 2017

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

24 January 2017

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

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

26 January 2017

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

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

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

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

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

6 February 2017

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

9 February 2017

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

20 February 2017

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

January and February 2017

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

16 March 2017

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

April, May and June 2017

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

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

(Appendix 11 to 23)**14 June 2017**

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

(Appendix 24)**19 June 2017**

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

05 July 2017

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

03 August 2017

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

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

16 October 2017

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

06 November 2017

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

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

15 February 2018

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

22 February 2018

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

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

16 March 2018

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

26 March 2018

No comments were received from Mr O'Brien.

29 March 2018

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

30 March 2018

No comments were received from Mr O'Brien.

2 April 2018

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

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

5. Terms of Reference for the Investigation (ToR)

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

Term Of Reference 1

- (a) To determine if there have been any patient referrals to Mr A O'Brien which were un-triaged in 2015 or 2016 as was required in line with established practice / process.
- (b) To determine if any un-triaged patient referrals in 2015 or 2016 had the potential for patients to have been harmed or resulted in unnecessary delay in treatment as a result.
- (c) To determine if any un-triaged referrals or triaging delays are outside acceptable practice in a similar clinical setting by similar consultants irrespective of harm or delays in treatment.
- (d) To determine if any un-triaged patient referrals or delayed tri-ages in 2015 or 2016 resulted in patients being harmed as a result.

Term Of Reference 2

(a) To determine if all patient notes for Mr O'Brien's patients are tracked and stored within the Trust.

(b) To determine if any patient notes have been stored at home by Mr O'Brien for an unacceptable period of time and whether this has affected the clinical management plans for these patients either within Urology or within other clinical specialties.

(c) To determine if any patient notes tracked to Mr O'Brien are missing.

Term Of Reference 3

(a) To determine if there are any undictated patient outcomes from patient contacts at outpatient clinics by Mr O'Brien in 2015 or 2016.

(b) To determine if there has been unreasonable delay or a delay outside of acceptable practice by Mr O'Brien in dictating outpatient clinics.

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

Term Of Reference 4

To determine if Mr O'Brien has seen private patients which were then scheduled with greater priority or sooner outside their own clinical priority in 2015 or 2016.

Term Of Reference 5

To determine to what extent any of the above matters were known to line managers within the Trust prior to December 2016 and if so, to determine what actions were taken to manage the concerns.

6. Data Gathered

ToR 1: Un-triaged Referrals

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

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

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

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

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

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

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

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

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

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

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

UROLOGY RED FLAG UPGRADES AND OUTCOMES

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

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

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

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

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

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

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

UROLOGY RED FLAG OUTCOMES AND DELAY

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

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

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

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

Hospital Number	Name	DOB
Personal Information redacted by the USI		

Received from Tughans OBO Mr Aidan O'Brien on 25/11/21. Annotated by the Urology Services Inquiry.

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

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

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

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

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

Examples of findings from the review of the patients are:

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

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

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

Private Patients

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

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

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

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

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

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

Casenote	Date on Waiting List	Date Operation	Days from Added to WL to Operation Date	Is there a clinical reason why the patient should have been treated within such a short time? M Young
Patient 114	22/02/2016	22/03/2016	29	No

Patient 115	25/04/2016	04/05/2016	9	Reasonable – Red Flag
Patient 116	11/04/2016	15/04/2016	4	No
Patient 117	01/04/2016	27/04/2016	26	No
Patient 118	08/07/2016	09/08/2016	32	No
Patient 119	29/07/2016	21/09/2016	54	No
Patient 120	04/12/2015	24/02/2016	82	Reasonable
Patient 121	11/07/2016	17/08/2016	37	No
Patient 122	08/10/16	02/11/16	25	No
Patient 123	31/10/16	04/11/16	5	No
Patient 124	16/02/2016	24/02/2016	8	No

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

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

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

Meeting with Mr O'Brien – 30 December 2016

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

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

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

The scale of the concerns at that time were

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

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

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

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

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

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

Meeting with Mr O'Brien – 24 January 2017

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

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

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

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

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

During the course of the meeting on 24 January 2017, Mr O'Brien referred to the issue of the triage referrals and advised that since the issue was raised with him in March 2016, he had been undertaking his own validation of referrals to him. He advised that prior to this the workload volume made it impossible to do so.

Mr O'Brien provided an explanation in respect of each of the 13 sets of missing notes. He stated that he had never lost a set of notes in his career.

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

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

Mr O'Brien advised he would make a full response to the concerns in due course but he wished it noted that significant workload pressures and additional operating sessions completed by him over the requirement within his job plan had impacted. Mr O'Brien noted that he had worked a high number of hours each week over and above his job plan, had undertaken Chair of the MDM meetings, had spent a significant number of hours reviewing cases in preparation for these meetings, sometimes into the early hours of the morning and had used his SPA time to undertake operations or reviews of patients in an attempt to keep on top of his workload.

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

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

Meeting with Mr O'Brien – 09 February 2017

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

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

Meeting with Mr O'Brien – 03 August 2017

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

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

Un-triaged referrals

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

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

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

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

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

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

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

Patient notes

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

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

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

Un-dictated clinics

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

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

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

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

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

Private patients

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

Management knowledge of the concerns

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

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

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

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

Meeting with Mr O'Brien – 06 November 2017

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

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

- At the outset of the investigation and at a number of subsequent meetings it had been advised to Mr O'Brien that the issue of concern related to his TURP private patients. Upon enquiry by Mr O'Brien and further investigation by the Case Investigator, it was established that a review had taken place of all Mr O'Brien's private patients. The 11 private patients highlighted as concerning were not solely TURP patients.
- The list of 11 patients provided to Mr O'Brien for comment highlighted the date upon which each patient had been entered onto the waiting list and also the date the procedure was performed. Mr O'Brien disputed the dates on which the case had been placed on to the waiting list in the majority of cases. He advised that, for example, in one case there was a difference between the date a patient was added to the waiting list versus the date of consultation when a decision to proceed to surgery was made.
- Concern that another clinician could have arrived at a judgement regarding the clinical justification for admission, after a period of time, on the basis of a letter alone.
- Concern that a comparative analysis of the periods of time awaited by those patients admitted for procedure having had a previous outpatient consultation and those who had not, had not been undertaken.

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

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

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

Casenote	Date on Waiting List	Date Operation	Days from Added to WL to Operation Date	Is there a clinical reason why the patient should have been treated within such a short time? M Young
Patient 114	22/02/2016 (20/02/2016)	22/03/2016	29 (31)	No
Patient 115	25/04/2016	04/05/2016	9 (46)	Reasonable – Red Flag
Patient 116	11/04/2016	15/04/2016	4 (349)	No
Patient 117	01/04/2016	27/04/2016	26 (25)	No
Patient 118	08/07/2016	09/08/2016	32	No
Patient 119	29/07/2016 (20/07/2015)	21/09/2016	54 (428)	No
Patient 120	04/12/2015 (21/11/2016)	24/02/2016	82 (94)	Reasonable
Patient 121	11/07/2016 (23/07/2016)	17/08/2016	37 (25)	No
Patient 122	08/10/16	02/11/16	25	No
Patient 123	31/10/16 (01/10/2016)	04/11/16	5 (34)	No
Patient 124	16/02/2016 (30/01/2016)	24/02/2016	8 (25)	No

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

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