

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

### **General comments**

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

## **8. Investigation Findings**

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

The following are the findings from the investigation into concerns:

### **Term Of Reference 1**

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

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

*(c) To determine if any un-triaged referrals or triaging delays are outside acceptable practice in a similar clinical setting by similar consultants irrespective of harm or delays in treatment.*

*(d) To determine if any un-triaged patient referrals or delayed tri-ages in 2015 or 2016 resulted in patients being harmed as a result.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Therefore, in response to the specific term of reference:

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

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

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

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

### **Term Of Reference 2**

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

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

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

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

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

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

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

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

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

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

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

### **Term Of Reference 3**

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

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

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

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

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

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

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

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

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

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

#### **Term Of Reference 4**

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

##### **1. Patient –**

Patient 114

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

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

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

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

**2. Patient –** Patient 116

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

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

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

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

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

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

**3. Patient –**

Patient 117

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

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

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

**4. Patient –**

Patient 118

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

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

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

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

**5. Patient –**

Patient 119

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

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

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

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

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

**6. Patient –**

Patient 121

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

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

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

**7. Patient –**

Patient 122

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

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

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

**8. Patient –**

Patient 123

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

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

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

## 9. Patient –

Patient 124

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

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

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

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

*Urology Waiting Times for 2015 and 2016 were:*

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

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

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

### **Term Of Reference 5**

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

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

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

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

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

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

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

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

## 9. Conclusions

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Having considered the information as outlined above I have concluded:

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

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

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

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

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

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

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

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

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

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

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

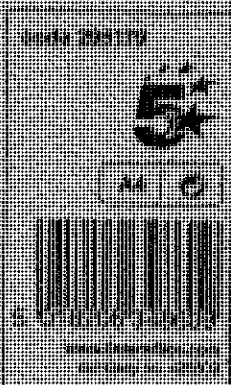
Lastly, during interviews and in correspondence, Mr O'Brien has displayed some lack of reflection and insight into the potential seriousness of the above issues. His reflection on the patients with delayed diagnoses was disappointing and is noted above. He did not seem to accept the importance of administration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

**Dr Neta Chada**

Consultant Psychiatrist / Associate Medical Director

Case Investigator

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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

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,

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**Eamon Mackle**  
**Associate Medical Director**

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**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  
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**Note of Meeting with Mr Aidan O'Brien, Consultant Urologist – 30<sup>th</sup> December 2016****Present:**

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

Dr Richard Wright, Medical Director

Ms Lynne Hainey, Employee Relations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

sessions. Mrs O'Brien stated that she and her children have sacrificed their family life for her husband's job and stated that she found it most hurtful that it should be reduced to this moment, and that it was grossly unfair.

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

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

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

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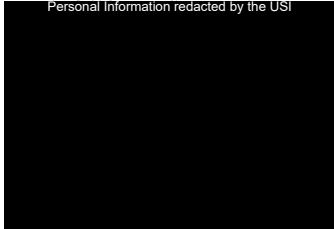


6<sup>th</sup> January 2016

**STRICTLY PRIVATE & CONFIDENTIAL**

Mr Aidan O'Brien

Personal Information redacted by the 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 30<sup>th</sup> 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 23<sup>rd</sup> 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 sick 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 30<sup>th</sup> 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]

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 3<sup>rd</sup> 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 5<sup>th</sup> 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 [REDACTED]

Personal Information  
redacted by the USI

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

Yours sincerely

Personal Information redacted by the USI

**Dr Richard Wright**  
**Medical Director**

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

Tel: [REDACTED]  
Personal Information redacted by the USI

Email: [REDACTED]  
Personal Information redacted by the USI

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*Quality Care - for you, with you*

20 January 2016

**STRICTLY PRIVATE & CONFIDENTIAL**

Mr Aidan O'Brien

Personal Information redacted by the 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 the 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

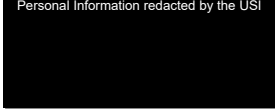
meet with myself and Mrs Hynds Tuesday 24 January 2017 at 2.30pm in Mrs Vivienne Toal's Office, 1<sup>st</sup> Floor, Trust Headquarters, Craigavon Area Hospital.

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

Personal Information redacted by the USI



**MR COLIN WEIR**  
**Case Investigator**

Copy to: Siobhan Hynds

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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, Michael O'Brien)

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 the USI] as her chart was not available to him and he stated he had returned [Personal Information redacted by the 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 Michael O'Brien 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. Michael 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. Michael O'Brien 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 Michael O'Brien 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.

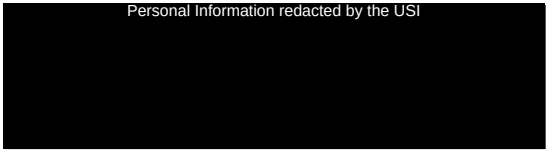
Page 3, Paragraph 3, in respect of the issues of concern, it states that Mr. O'Brien 'stated that he was surprised by the number of undictated clinics in SWAH, i.e., 272'. I do presume that the Note intended to refer to the number of patients attending clinics in SWAH whose consultations had not been 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 sick 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 the USI



Aidan O'Brien.  
27 March 2017.

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*Maintaining High Professional Standards Framework*



**Southern Health  
and Social Care Trust**

*Quality Care - for you, with you*

**STRICTLY PRIVATE AND CONFIDENTIAL**

**Preliminary Report from Case Investigator for  
consideration by Case Manager / Case  
Conference**

**Thursday 26 January 2017**

**Mr Aidan O'Brien**

## *Maintaining High Professional Standards Framework*

### **1.0 Introduction and Background**

Mr Aidan O'Brien is employed by the Southern Health and Social Care Trust as a Consultant Urologist based in Craigavon Area Hospital.

At a meeting on 30 December 2016, Mr O'Brien was advised of a decision by the Trust to place him on immediate exclusion. Mr O'Brien was advised that concern 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.

Concern in respect of Mr O'Brien's administrative practices had been previously addressed with him in an attempt to resolve the issues informally.

The SAI investigation identified a Urology patient under the care of Mr O'Brien who may have a poor clinical outcome because of delay in his triage of GP referrals. The SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason.

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.

At the meeting on 30 December 2016, Mr O'Brien was advised that the concerns would be managed in line with the Maintaining High Professional Standards Framework (MHPS).

Dr Ahmed Khan was appointed as Case Manager and Mr C

Colin Weir was appointed as Case Investigator assisted by Mrs Siobhan Hynds, Head of Employee Relations. Mr John Wilkinson was appointed as the identified Board member to oversee the process.

### **2.0 Initial Investigation**

### *Maintaining High Professional Standards Framework*

During the initial 4 week period following immediate exclusion of Mr O'Brien, investigations continued 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.

A meeting was held with Mr O'Brien, who was accompanied by his son, on Tuesday 24 January 2017 at which an update was provided in terms of the preliminary 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 was:

- 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'Briens 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.

Prior to the meeting with Mr O'Brien, a further update had been requested by the Case Investigator. This information was not available for discussion at the meeting with Mr O'Brien. On review of the update received following this request, early initial review of the un-triaged patients suggest that a number of patients required upgrading to red flag status, a number of others required upgrading from routine to urgent.

### **3.0 Statement of Case – Mr A O'Brien**

Mr O'Brien was provided with an opportunity at the meeting on 24 January to state his case to Case Investigator. Mr O'Brien advised that he will make a written submission as part of the investigation in due course.

### *Maintaining High Professional Standards Framework*

Mr O'Brien and his son raised concerns about process and time scale. We noted this. However he was made aware that because of the numbers of triages to review the process will take longer

During the course of the meeting Mr O'Brien offered some explanation in respect of the concerns including:

- Significant workload pressures
- Significant additional operating sessions completed by him over the requirement within his job plan.
- Inequity of workloads with some colleagues
- High number of hours worked each week
- Notification to a series of Trust managers regarding work pressures
- Notification to management that he did not have capacity to triage GP referrals.
- Use of SPA time to undertake operations or reviews of patients.

#### **4.0 Proposals for alternatives to exclusion – Mr A O'Brien**

Mr O'Brien was provided with an opportunity at the meeting on 24 January 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.

*Maintaining High Professional Standards Framework*

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.

**5.0 Summary**

There are 4 main issues of concern to be considered as outlined above. The initial 4 week preliminary investigation has scoped the likely scale of the concerns and the numbers of patients involved.

The investigation is at a very early stage. While initial indications suggest some patients have potentially been adversely affected/harmed as a result of failings in the practice of Mr O'Brien, the Case Investigator is reliant on completion of the review by 4 Consultants to determine the full implications.

Given the numbers involved, it is not possible to give any definite date for the conclusion of the investigation. It is envisaged that the investigation will take as a minimum, 12 weeks to complete.

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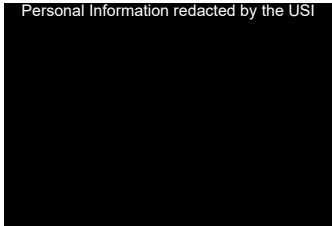
06 February 2017

**STRICTLY PRIVATE & CONFIDENTIAL**

**BY E-MAIL ONLY**

Mr Aidan O'Brien

Personal Information redacted by the USI

A large black rectangular box redacts the email address and any other contact information that might have been present.

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, following a case conference meeting to review your immediate exclusion from work which had been in place from 30 December 2016.

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 can 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 Wednesday 9 February at 4pm in \_\_\_\_\_, 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 the USI or via e-mail at Personal Information redacted by the USI to arrange an alternative date.

Yours sincerely

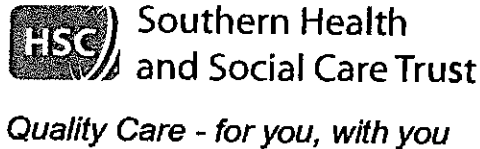
Personal Information redacted by the USI

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Dr Ahmed Khan  
Associate Medical Director &  
Case Manager

Copy to: Colin Weir, Siobhan Hynds

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

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

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

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

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

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

**CONCERN 1**

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

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

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

Red Flag referrals must be completed daily.

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

## **CONCERN 2**

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

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

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

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

## **CONCERN 3**

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

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

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

**CONCERN 4**

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

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

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

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

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|---------------------------------------------|
| <b>TERMS OF REFERENCE FOR INVESTIGATION</b> |
|---------------------------------------------|

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.

|                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|----------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Grade:</b>                          | Consultant, Urology                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Base Hospital:</b>                  | Southern Health & Social Care Trust<br>Craigavon Area Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>The matters to be investigated:</b> | <p><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></p> <p><b>Matters to be investigated:</b></p> <ol style="list-style-type: none"> <li>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.</li> <li style="margin-left: 40px;">(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.</li> <li style="margin-left: 40px;">(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.</li> <li style="margin-left: 40px;">(d) To determine if any un-triaged patient referrals or delayed triages in 2015 or 2016 resulted in patients being harmed as a result.</li> <li>2. (a) To determine if all patient notes for Mr O'Brien's patients are tracked and stored within the Trust.</li> <li style="margin-left: 40px;">(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.</li> <li style="margin-left: 40px;">(c) To determine if any patient notes tracked to Mr O'Brien are missing.</li> <li>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.</li> <li style="margin-left: 40px;">(b) To determine if there has been unreasonable delay or a delay outside of acceptable practice by Mr O'Brien in dictating outpatient</li> </ol> |

**TERMS OF REFERENCE FOR INVESTIGATION**

|                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                 | <p>clinics.</p> <p>(c) To determine if there have been delays in clinical management plans for these patients as a result.</p> <p>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.</p> <p>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.</p> |
| <b>Case Investigator:</b>       | <b>Dr Neta Chada, Associate Medical Director</b><br>supported Mrs Siobhan Hynds, Head of Employee Relations <div style="float: right; font-size: small;">Personal Information redacted by the USI</div>                                                                                                                                                                                                                                                                                                                 |
| <b>Case Manager: Designated</b> | <b>Dr Ahmed Khan, Associate Medical Director (Paediatrics), Daisy Hill Hospital</b><br><div style="font-size: x-small;">Personal Information redacted by the USI</div>                                                                                                                                                                                                                                                                                                                                                  |
| <b>Board Member</b>             | <b>Mr John Wilkinson, Non-Executive Director (contactable via the Chair's Office)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |

## Investigation under Maintaining High Professional Standards Framework

## Witness List

| NAME                     | DATE                    | TIME     | VENUE                                |
|--------------------------|-------------------------|----------|--------------------------------------|
| Ms Martina Corrigan      | Wednesday 15 March 2017 | 12 noon  | Admin Floor, Craigavon Area Hospital |
| Mr Michael Young         | Thursday 23 March 2017  | 11:00 AM | Admin Floor, Craigavon Area Hospital |
| Mrs Claire Graham        | Monday 3 April 2017     | 2.00 PM  | Admin Floor, Craigavon Area Hospital |
| Mr Ronan Carroll         | Thursday 6 April 2017   | 11.30 AM | Admin Floor, Craigavon Area Hospital |
| Mr Eamon Mackle          | Wednesday 3 May 2017    | 2pm      | Admin Floor, Craigavon Area Hospital |
| Mr Colin Weir            | Date to be confirmed    |          |                                      |
| Ms Heather Throuton      | Monday 24 April 2017    | 2pm      | Admin Floor, Craigavon Area Hospital |
| Mr Haynes                | Date to be confirmed    |          |                                      |
| Mr Glackin               | Date to be confirmed    |          |                                      |
| Mr Weir                  | Date to be confirmed    |          |                                      |
| Mrs Anita Carroll        | Date to be confirmed    |          |                                      |
| Ms Helen Forde           | Date to be confirmed    |          |                                      |
| Ms Catherine Robinson    | Date to be confirmed    |          |                                      |
| Mr O'Brien Secretary     | Date to be confirmed    |          |                                      |
| Secretarial line manager | Date to be confirmed    |          |                                      |

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### Comments concerning Witness Statements

In commenting upon the statements of witnesses, I have endeavoured to restrict them to those which I have considered pertinent to the substantive issues of concern, while avoiding repetition unless relevant to do so. Lack of comment on all said does not infer acceptance.

#### **Comments concerning the Witness Statement of Ms. Katherine Robinson**

- Paragraph 5 relates that Mr. O'Brien's triage was raised every Tuesday morning at Dr. Rankin's meeting, as she would have tabled the issue, and that triage was always discussed every Tuesday morning. I find it remarkable that management would have discussed an issue every week during the tenure of Dr. Rankin, and failed to have discussed that issue with me as frequently as it was discussed about and without me.
- In Paragraph 8, Ms. Robinson relates that copies of referrals to Mr. O'Brien were kept in case they were not triaged, and so that they could go to other consultants. This is a new revelation for me. I have not been aware of this having been done. I would have thought that I would have been advised of such by my colleagues if it had been the case, or have read reference to it in their Witness Statements.

#### **Comments concerning the Witness Statement of Mrs. Heather Trouton**

- I am alarmed to read in Paragraph 5 that Mrs. Trouton asserted that she was aware that I did not agree with triage, and that I made it clear that I did not agree with the three categories of referral, that red flags were important but that the others were not. This is of course completely untrue. I have never disagreed with triage. On the contrary, I believe that triage is most important, and so important that it requires time to do properly. Ironically, the triaging of red flag referrals is less important and less time consuming by the very nature of their clinical urgency which will dictate that they will be assessed in an appropriately, timely manner. It is the remaining majority of referrals that are even more important and time consuming, particularly in the context of an urgent referral having to wait over 80 weeks for an outpatient consultation, and a routine referral having to wait over 100 weeks for a similar consultation. It requires time to request investigations, give advice, initiate treatment and review reports, so that such patients may have some progress made in their investigation and management during those periods of time.
- On the contrary. I do believe that Mrs. Trouton was absolutely correct when she asserted that I did not agree with the system in place, and for all of the reasons which I have alluded to above and previously.
- I am pleased to note in Paragraph 9 that Mrs. Trouton related that I had possibly said that I was not doing triage. At least one person has been able to equate my reporting that I had found it impossible to do, with not doing so. In relating that it was never agreed that he could not do it, I assume that she may have meant to say that it was never agreed that I was permitted not to do so. It is indeed true that I did not receive a permission not to do

so, but I was advised of the implementation of the default process of reverting to the category of referral stated in the letter of referral, for that very reason.

- Mrs. Trouton is mistaken in paragraph 11 in asserting that most referrals are red flag referrals, which have always and still do comprise a minority of the total of referrals
- I was surprised to learn in Paragraph 13 that a meeting had been held with Dr. Wright on 11 January 2016 regarding the issues raised in the letter given to me on 23 March 2016. I was surprised particularly as I had had a meeting with Dr. Wright on Friday 01 April 2016 concerning unrelated matters. I would have considered that concerns of such import would have been raised with me at that time.
- Mrs. Trouton is mistaken in relating in Paragraph 14 that a complaint had been received from me, accusing Mr. Mackle of bullying. I did not submit any complaint of bullying on the part of Mr. Mackle. Instead, I had submitted on 30 January 2012 a formal written grievance concerning deductions that Mr. Mackle had unilaterally made to payments owed to me for extra-contractual work undertaken by me. The grievance was upheld. Personal Information redacted by the USI Personal Information redacted by the USI at that time, I suspended further proceedings, reserving the right to resume doing so, if the need arose.
- In Paragraph 20, Mrs. Trouton asserted that nothing was recorded in patients' charts concerning consultations. This I would entirely dispute. I have never in my career not entered a legible, hand-written note in a patient's chart concerning their consultation, in sharp contrast to many who have written nothing.

#### **Comments concerning the Witness Statement of Mr. Colin Weir**

- I have found it remarkable, if not alarming, to read in Paragraphs 6 -9 that discussions were being regularly held between so many people regarding the issues contained in the letter of 23 March 2016, and over a period of months thereafter, and including Dr. Mc Allister, Mr. Weir, Mr. Haynes, Mr Young, Mrs. Corrigan and Mr. Carroll, and that during all of that time, no one had managed to discuss the issues with me, with a view to arriving at a supported plan to assist in addressing and resolving the issues.
- I certainly have found it alarming to read in Paragraph 10 that Mr. Weir was told at a point not to meet with me concerning the issues. As I have previously asserted, there has been a complete failure of management to provide support to me after 23 March 2016 to address and resolve the issues. To learn that the Clinical Director was directed not to do so, is a more serious matter altogether.
- In paragraph 15, Mr. Weir related that Dr. Mc Allister felt that the correspondence of 23 March 2016 had not addressed the problem. I agree.

### Comments concerning the Witness Statement of Mr. Eamon Mackle

- In Paragraph 10, Mr. Mackle relates that he had to deal with the appropriateness of Mr. O'Brien's use of antibiotics. In fact, this issue related to the practice of both Mr. Young and I electively readmitting patients, who regularly suffered from recurring urosepsis, for intravenous hydration and antibiotic therapy, in order to minimise the frequency and severity of infection. This practice was disapproved by the Trust. However, our experience was subsequently published, having proven to be successful in its purpose, and without emerging antibiotic resistance.
- In Paragraph 10, Mr. Mackle relates that they had been alerted by nursing staff that Mr. O'Brien had removed notes from a patient's chart and dumped them in a bin in the ward. In fact, I had removed fluid balance charts of years previously from the chart of [REDACTED] as there was not enough space in her chart to file continuation sheets on which I had written clinical notes while the patient was an inpatient. I had formed the judgement that the fluid balance charts of years previously were not likely ever to be required, while the current clinical notes were pertinent. I did place them in the confidential waste bin in the ward. My doing so was reported by a ward clerk, not by nursing staff. Personal information redacted by the USI
- It is worthy of note that, in Paragraphs 11 and 12, Mr. Mackle relates that I had complained that he was bullying / harassing him, while omitting to report that the single complaint that I had formally submitted related to the deduction of payments and the resulting breach of contract referred to above.
- In paragraph 14, Mr. Mackle relates that I had stopped seeing new patients to clear a backlog and that 18 months previously, I had asked for another month free to similarly do so. Again, this is untrue.
- Most importantly of all, Mr. Mackle certainly did not set out to me the actions I needed to take when he gave me the letter of 23 March 2016, and as he claims to have done in Paragraph 21. He has been correct in his statement that no supports to address the issues were discussed.

### Comments concerning the Witness statement of Mrs. Martina Corrigan

- Mrs. Corrigan relates in Paragraph 12 that the issues of concern had been verbally addressed with me by Dr. Patrick Loughran and by Dr. John Simpson. I only had one meeting with Dr. Loughran during his tenure as Medical Director, and that was in the company of Mr. Young and in relation to the elective readmission of patients for intravenous hydration and antibiotic therapy. The only occasions when in the company of Dr. John Simpson was on interview panels. I have never had a meeting with Dr. Simpson. Neither spoke to me at any time regarding these issues. Even though I had had a meeting

with Dr. Wright on Friday 01 April 2016, these issues were not raised by him. The first time he raised these issues with me was on 30 December 2016.

- In Paragraph 14, Mrs. Corrigan relates that I was offered help. Mr. Young did indeed carry out triage for me from February 2014 to June 2014, and which I very much appreciated at that time as I had to spend so much time on preparing the Trust for Peer review of Urological Cancer Services. I gain the impression that other help was offered. None was.
- In Paragraph 14, Mrs. Corrigan asserts that I would always have said that I was determined to give a Rolls Royce service to his patients. This assertion is just patently untrue. I have never used the metaphor and have never considered that the service which I have provided, has been to some unnecessary standard of luxury or perfection. This is a good example of a perception of me being attributed to me.
- Mrs. Corrigan incorrectly states in Paragraph 15 that I needed 30 minutes consultation with each patient. The only patient cohort for which I claimed to need 30 minutes of consultation time was cancer patients, whether new or review. The BAUS guidelines 2016 state that 20 minutes be provided for the new, generic patient and 10 – 15 minutes for the review generic patient. For new patients attending a specialist clinic, the BAUS guidelines recommended 30 – 45 minutes per patient and 15 – 45 minutes for the review patient.
- In Paragraph 15, Mrs. Corrigan states that I 'see' on average 10 patients where others will have 14 – 16 patients booked to their clinics. However, it is my understanding that 9 new patients attend each New Clinic per consultant, and that 12 patients attend each general review clinic per consultant. At oncology review clinics, I review 7 or 8 patients in addition to 2 or 3 patients for urodynamic studies, with or without flexible cystoscopy. I believe that this is in accordance with BAUS guidelines. If I have been 'seeing' less patients than my colleagues, then perhaps it is my colleagues who may not be practising in accordance with BAUS guidelines.
- In Paragraph 16, Mrs. Corrigan asserts that it was preference to operate rather than do outpatient clinics, and that I would sometimes agree and do a 9 am to 8 pm list (always my choice). Indeed, I always agreed to do a 9 am to 8 pm operating session if available, and without remuneration, foregoing annual leave on those days, only due to having 280 patients awaiting surgery for up to four years.
- In Paragraph 17, Mrs. Corrigan states that I have been allocated additional administration sessions because of my attention to detail. As stated previously, I have been unaware of having additional time allocated to administration.
- In Paragraph 17, Mrs. Corrigan relates that I spent large amounts of time preparing for the chairing of Urology MDM and that others considered was unnecessary. I believe that it was necessary, and I have never been advised by others that it was unnecessary.
- In Paragraph 19, Mrs. Corrigan refers to 365 charts returned to my office from my home in January 2017. For the sake of accuracy, 288 were returned from my home, the remainder having been on shelves in my office.

- In Paragraph 22, Mrs. Corrigan relates that 668 patients did not have letters dictated. I do not recognise this figure, and I have not been provided with documentary evidence in support of it.
- In Paragraph 25, Mrs. Corrigan repeats the assertion that there were 66 clinics not dictated. As I have submitted in detail, there were only 189 patients for whom letters had not been dictated from 41 clinics

#### Comments concerning the Witness Statement of Mr. Ronan Carroll

- In Paragraph 6, Mr. Carroll states that at one time, in 2007, I told him that I did not agree with the cancer standards, and that I would continue to practise as I had always done. For the sake of clarification, I only reservation I had in relation to cancer standards was the complete lack of any standards relating to the rest of urological pathology. If I had not agreed with the cancer standards per se, I would not have dedicated so much of my time over a period of four years being Lead Clinician and Chair of the NICaU Urology Clinical Reference Group, and Lead Clinician of the Southern Trust urology MDT and Chair of its MDM.
- In Paragraphs 7 and 8, Mr. Carroll states that either Mr. Haynes or Mr. Glackin felt that the patient, <sup>Patient</sup> 10 should have been upgraded to red flag based on the symptoms. As detailed in my response to the SAI relating to this patient, the symptom of pain could not have been considered a reason to upgrade to red flag status a patient reported to have a simple renal cyst.
- In Paragraph 18, Mr. Carroll states that Mr. O'Brien never said that he was not doing triage. I find Mr. Carroll's omniscience remarkable.
- In Paragraph 26, Mr. Carroll states that my colleagues follow the two categories of urgency allocated to patients on waiting lists. I certainly hope that they are not doing so!

#### Comments concerning the Witness Statement of Mr. Mark Haynes

- I do agree with Mr. Haynes' assertion in Paragraph 10 that triage should by definition be conducted and categorised by the referrer, rather than by the secondary care clinician to ensure that the referrer has done so properly. However, I do not anticipate that allocating the proper category of referral to the referrer will gain much traction. Nevertheless, I do believe that it should be possible to raise the threshold for referral, as much more investigation and management could, and should, be carried out in primary care, particularly in the light of long waiting times for a first outpatient consultation.
- Also in Paragraph 10, Mr. Haynes correctly asserts that triage takes up an inordinate amount of consultant time. We receive approximately 176 referrals per week. If five minutes were spent on each referral, that would require almost 15 hours, almost two working days. Though I have referred to this matter previously, undertaking triage while

being Urologist of the week, has resulted in triage being conducted instead of patient management. Patients have been acutely admitted and discharged without ever having been seen by the Consultant, have had unsupervised surgery performed by the registrar with suboptimal outcomes, have been discharged without surgery which could have been done. It has appeared to me that triage has assumed a primacy whilst being urologist of the week, because of its associated standards, whilst the management of inpatients has lost that primacy, because it does not have standards related to it.

#### **Comments concerning the Witness Statement of Mr. Anthony Glackin**

- In Paragraph 17, Mr. Glackin refers to the referral which gave rise to the SAI. I believe that this Paragraph is of central importance to the issue of triage. I do agree that it had been entirely reasonable for the GP to have referred this patient routinely. I do still contend that it can only be logical that the referral would have been triaged as routine, if triage is confined to the information contained in the referral. I then find it most interesting that Mr. Glackin asserts that we had agreed as a team to arrange investigations before attendance at clinics, and if this had been done, it would have been appreciated that there were other aspects to the case which would have resulted in upgrading to red flag status. I have already submitted documentary evidence that I had been unable to obtain a commitment from my colleagues to do so for red flag referrals which constitute a minority of referrals. In Paragraph 14 of her Witness Statement, Mrs. Corrigan stated that I had wanted to conduct advanced triage, but that advanced triage had not been agreed. This lack of agreement to a standard of triage in every case, and the complete failure of Trust management to address this issue, persists. I do believe that the waiting times relating to urgent and routine referrals should mandate that proper, complete, advanced triage be conducted on each case. I believe that the time required to do so, whilst Urologist of the week, has been and remains untenable and unsafe. It was for that reason that I advised that I had found it impossible to do.
- In Paragraph 18, Mr. Glackin relates that my written response to the SAI was very lengthy and written in an adversarial and legal manner. I agree that it was very lengthy indeed, and was so because it was forensic, and being so led to conclusions which I reached, and which have been highlighted once again in the Comment above.
- In Paragraph 35, Mr. Glackin relates that I had requested administration time on the Tuesday morning which followed the monthly Monday clinic at SWAH, and that this caused dissent among other members of the team. I have not appreciated that doing so could have caused dissent. I still do not understand how it is that not undertaking either of the twice monthly, day case surgical operating list on the morning after the SWAH clinic could have done so.
- In Paragraph 36, Mr. Glackin asserts that productivity at the SWAH clinic has been poor. It has been my understanding that it was agreed that Mr. Young and I would have 16 patients attend our clinics in SWAH. I have had no appreciation that the numbers attending my SWAH clinic has been lower than those attending Mr. Young's clinic, and have been provided with evidence to that effect.

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## Witness Statement

|                                 |                                                                    |
|---------------------------------|--------------------------------------------------------------------|
| <b>NAME OF WITNESS</b>          | Mrs Martina Corrigan                                               |
| <b>OCCUPATION</b>               | Head of ENT, Urology, Ophthalmology and Outpatients                |
| <b>DEPARTMENT / DIRECTORATE</b> | Directorate of Acute Services, Craigavon Area Hospital             |
| <b>STATEMENT TAKEN BY</b>       | Dr Neta Chada, Associate Medical Director / Case Investigator      |
| <b>DATE OF STATEMENT</b>        | Wednesday 15 March 2017                                            |
| <b>PRESENT AT INTERVIEW</b>     | Mrs Siobhan Hynds, Head of Employee Relations                      |
| <b>NOTES</b>                    | The terms of reference were shared prior to the date of statement. |

1. My name is Martina Corrigan. I am employed by the Southern Health and Social Care Trust as Head of ENT, Urology, Ophthalmology and Outpatients. I have been in this position for 8 plus years and have worked with Mr O'Brien since I came into my position. Prior to working for the Southern HSC Trust, I worked for the Western HSC Trust.
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. By way of background, I advised that during my time in post there have been many service changes. The biggest radical change was in 2014 when the Urology service moved from an old way of working to moving to a Consultant of the Week model which changed the way that Urology Outpatients were delivered. . Mr O'Brien was central to the changes that occurred. Mr O'Brien was Chair of the NICAN group at this time and the focus of that group was to look at the work on cancer. So by moving to the consultant of the week model and the one-stop clinics it was felt that there would be more time to focus on the Cancer Targets and the inpatient emergency care.

5. The Trust had not been performing particularly well in terms of cancer patients and Mr O'Brien's work on the NICAN group helped change the focus on this. For all Specialties including Urology we are required to work to either a 31 or 62 day pathway for all cancer patients and because this was not happening it was necessary to change the way that the Urology department worked. Mr O'Brien Chaired the NICAN group until September 2016.
6. Since my time in post I have always found difficulties with Mr O'Brien completing triage. This was an issue that was known by many people within the Trust including previous Director's. Mr O'Brien always liked to do things his own way. I am aware that in the past Dr Gillian Rankin, former Director of Acute Services would have addressed the problem with Dr John Simpson in his role as Medical Director and then Debbie Burns, Acting Director would have addressed this issue. I am aware of this through various attendances at meetings when the matter was discussed. I know Mr Eamon Mackle who was the Associate Medical Director tried to deal with the matter on a number of occasions. I would also have escalated the issue to my Assistant Director, Heather Trouton. however I was unaware there was a drawer full of referral letters not triaged.
7. I recall at one point Mr O'Brien being told he could not attend the BAUS conference unless his triage was done and up to date. He did do it all but I know he didn't get to attend the conference because of an ash cloud.
8. Prior to 2014 and the move to the Urologist of the Week model, referrals would have come in through a variety of routes, e.g. through the Referral and Booking Centre, from GP's, or through the Cancer Team. Some GP's would have addressed referrals directly to Mr O'Brien or Mr Young as they were both long standing consultants and so were well known and then the rest would have been addressed to 'General Urologist'. Pre 2014 albeit there was a Consultant of the Week, the consultant would have continued with his clinical duties and would have had to fit in all the triage during the working week, however when we moved to Urologist of the Week the Consultant on Call receives all the referrals (including named to other consultants) – which all come in via the Referral Booking Centre or Cancer Team (apart from those directly addressed to the consultant from another source as they come via the secretary)
9. When a referral comes in from a GP they will have put a classification on it which will be Routine, Urgent or Red Flag. A Red Flag referral is one where there is a suspicion of cancer. When the referral is received it is the role of the Urologist to triage each referral to determine if there should be any change to the category given by the GP. The Urologist is the specialist in this field and will pick up concerns a GP may not have within their assessment of the patient.
10. The red flag referrals that go through the red flag team are assigned to the Urologist of the Week. All other referrals go through the Referral and Booking Centre and are again given to the Urologist of the Week for triage. I have had been made aware on numerous occasions by the red flag team and the referral and booking centre that Mr O'Brien has not returned his triage. I would have chased Mr O'Brien for these to be returned. . This has been a problem for the past 8 years since I have been in post. On occasions when the red flag being returned from triage has been

delayed I have raised the concern with Mr Young who is the clinical lead and he was happy for me to proceed on authorising the Red Flag Team to appoint these patients without Mr O'Brien's triage. I can't afford to wait with red flag referrals.

11. Mr O'Brien's practice is very different to that of all the other Urologists. On occasion I may have to chase up 1 or 2 outstanding referrals from the other Consultants. I have in the past run lists from PAS for Mr O'Brien's referrals and there may have been 20, 30 or 40 outstanding letters. Sometimes after escalating to him, Mr O'Brien would have a burst of returning them and I would get responses from him, but in the main I didn't get a response.
12. I escalated these concerns to Eamon Mackle and Heather Trouton over the years. I know the issue would have been addressed with Mr O'Brien verbally but I suspect it was never in writing to him. I know it was verbally addressed by Eamon Mackle, Paddy Loughran, John Simpson and more recently Dr Wright. I am aware that on one occasion after Mr Mackle addressed the concerns with Mr O'Brien that Mr O'Brien made an allegation and complaint of bullying by Mr Mackle. As a result of this from Mr O'Brien, Mr Mackle was told to back off. After that Mr Mackle didn't try to address the concerns again.
13. After continuously not getting a response from Mr O'Brien I agreed that the patients should be added to the outpatients waiting list according to the category that the GP had assessed the patient as being. I had met with Anita Carroll and Katherine Robinson and agreed this and Heather Trouton as my AD had confirmed that she was happy with this. At that time the waiting lists had shorter waiting times and were more manageable however, this has changed and the waiting times have become much longer. At one point there was a plan to use available monies to get patients seen out of hours. When all routine and urgent referrals started to be added to the waiting list as per GP category I was no longer able to run a report which showed what patients had not been triaged. It was agreed by Debbie Burns, Heather, Anita, Katherine and I that the attempts to get the triage done didn't work so we needed a way of ensuring that patients were at least on a list so that they were not disadvantaged chronologically. Because by being on this list then we were assured that they were then always allocated an appointment when it was their turn. By adding these patients to the waiting list it looked as if they had been triaged so it wasn't being escalated to me anymore.
14. Mr O'Brien complained he didn't have time to do triage because of his patient care or admin commitments. He was offered help and I know at one point Mr Young took his triage for about 8 months. Mr O'Brien would always have said he was determined to give 'a roils royce service' to his patients and my view along with others was; 'but what about all the patient's you don't see?' I know he felt this wasn't his responsibility. He wanted to do advanced triage but that wasn't what was agreed and there wasn't time for that, so he didn't get much of the triage done at all.
15. Mr O'Brien said he needed 30 mins consultation with each patient. BAUS guidelines set out that appropriate time for review patients is 10 minutes and 20 minutes for new patients. To accommodate Mr O'Brien, clinics were set up with less patients for him on each of the clinics he

did. For example Mr O'Brien sees on average 10 patients in a clinic where others will have between 14-16 patients booked on their clinics. Other consultants were seeing 11 new patients in the time Mr O'Brien was seeing 7. The patient sitting in front of Mr O'Brien would have received an excellent service and would have been given plenty of time but this just backlogged the rest of the patients. Mr O'Brien was seeing many less patients than his Urology colleagues in the same clinic timeslots.

16. Mr O'Brien's job plan was never agreed but there were some requests that he asked for once a month Mr O'Brien had a SWAH outpatient clinic which was from 10am to 4pm on a Monday, it was agreed there would be 8 review patients and 8 new patients. Mr O'Brien always requested an admin session on a Tuesday morning to complete his admin from the clinic. This was mostly facilitated. Mr O'Brien's preference was to operate rather than do outpatient clinics and he would sometimes agree and do a 9am to 8pm list (always his choice). From changes in the Urology service in December 2014, there is protected urology time for discussions between 12 – 1.30 on Thursdays. Mr O'Brien would not be a frequent attendee at these departmental meetings.

17. Mr O'Brien's attention to detail is immense. His letters could be pages long. Other colleagues would have said to him that he only needed to do a paragraph of the salient points but his practice didn't change. Mr O'Brien also undertook tasks that should have been passed on to his secretary, for example, he schedules his own patients and phones them personally to arrange for them to come in for a procedure. This is something his secretary should be doing. I am aware of conversations with patients where Mr O'Brien would discuss the care of animals while the patient was in hospital. He has a different prioritisation system so he has different categories so it looks as if he is picking patients out of order. At a point Mr O'Brien was on 15 PA's but was reduced to 13 PA's. He had additional admin sessions because of his attention to detail. When he Chaired MDT he spent large amounts of preparation time that others felt was unnecessary.

18. Mr O'Brien does his private patient work on Saturday's so there is no need to have it scheduled in his job plan. When a Consultant is seeing a patient privately, they should let the referral and booking centre know so the patient comes off PAS. Mr O'Brien's secretary doesn't manage his private work. Leanne Hanvey does some typing for Mr O'Brien's private patients. If a patient is seen privately and then comes back onto the NHS, a form is supposed to be completed and they should be put back on the NHS waiting list according to clinical priority and given no advantage to anyone else on the list. Letters in relation to private patients did appear to be dictated and in the notes. At times it appeared private patients were being operated on out of order.

19. The terms of reference for the investigation have been shared with me. In respect of TOR 1, I am aware that some patients have been adversely affected because triage was not done by Mr O'Brien. The notes for this patient could also not be found and were in Mr O'Brien's house. One patient <sup>Patient 10</sup> was a patient who was deemed to be routine by the GP and was then added onto the routine waiting list and when she was seen in clinic, it would appear that her referral should have been a red flag. This concern was screened and I am aware has been investigated as a Serious



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Adverse Incident (SAI). It was this matter that has led to the current investigation process. At the outset of the investigation, Mr O'Brien was met by the oversight committee and he was advised that he was required to return all the patients notes to me. He did this over the New Year Holiday weekend and left them in his office and let me know that they were there. He then contacted me and requested me to meet with him in the carpark (I totally understood the reason why as it would have been very difficult for him to come into the hospital and I was sympathetic to this). I At this meeting he gave me folders with the outcomes for all of the 365 charts that he had returned and he also advised me that there was letters in the third drawer of his filing cabinet in his office. After the meeting with him I went to his office and found 783 untriaged referral letters dating back to June 2015 I was really shocked and taken aback at the number of referrals in his office as I never realised that this was the extent of the problem.

20. The look back exercise that has taken place was done by the other Consultant Urologists and in total there are 24 cases which another consultant would have upgraded to red flag via the triage process but was not done. Of these cases 4 patients have a confirmed cancer diagnosis, the fifth case being that of the original patient <sup>Patient 10</sup>. All patients have been booked for clinics to be seen. One patient <sup>Patient 13</sup> is a 50 year old man with aggressive cancer. He waited 193 days before being seen. All 4 of Mr O'Brien's colleagues agree that this referral should have been upgraded to red flag. I understand this patient's prognosis is not good. If this patient had been triaged by Mr O'Brien within 24 hours he would have been on the 62 day pathway and would have commenced treatment much sooner. The other 4 are still awaiting results. They are prostatic cancer and that's usually more confined apparently so hopefully the prognosis has not been affected.
21. In respect of TOR 2, on review of the notes handed back to me by Mr O'Brien, they date back to November 2014. Many of the notes relate to Enniskillen patients. There is no Trust transport between CAH and SWAH and so I took the notes to the clinic for Mr O'Brien and Mr Young, as it is near to where I live. I was aware that Mr O'Brien did not return the notes back to the hospital as he was supposed to. Mr Young always did.
22. Again, many people were aware there was a problem with Mr O'Brien keeping patient notes at home. On many occasions, patient notes were not available for clinics when they were required. A request would be made through Mr O'Brien's secretary for the notes and generally he would have brought the notes back in. There is no system within the Trust that will alert to a large number of notes being missing or off site. Mr O'Brien's secretary did not escalate that she wasn't getting notes back. When I asked her line manager why she hadn't escalated this and I have been informed that she replied that she thought everyone knew Mr O'Brien didn't dictate clinics. 365 sets of notes relate to undictated clinics. In total 668 patients were not dictated on.
23. At one point, some staff within Medical records started to fill in Datix because notes were missing. Mr O'Brien advised me that he had planned to deal with the admin on the files and then bring them back to the Trust. I didn't know the scale of the problem until the notes were returned.



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24. On review of the notes, there are 13 sets of notes missing which are signed out to Mr O'Brien. A thorough search has been conducted for the notes but there are times when notes will remain missing. I have seen Mr O'Brien's response to the missing notes and he remembers a lot of detail about each case. I would doubt Mr O'Brien has these notes. In March 2016 Mr O'Brien was spoken to by Mr Mackle regarding the charts and he brought about 30 back at that stage. He was asked to put in an action plan about the other issues at that time but never responded to the letter Mr Mackle gave him.
25. The 365 charts waiting to be dictated and actioned are all routine patients. On one chart there is no dictation for 5 previous attendances at clinic by one patient going back to 2012. Part of the governance arrangements that are in place requires a dictated outcome for every patient on every occasion even if the patient doesn't attend. In total there are 66 clinics not dictated.
26. There are also clinic outcome sheets which should be completed by the Consultant at a clinic and returned to the secretary for action onto waiting lists. Mr O'Brien's secretary should have been aware that she was not getting these returned.
27. Most Consultants will try to ensure they dictate after each clinic. This has become standard with digital dictation and then the outcome can be typed within 3 days. Pre digital dictation, they would probably have aimed to get everything done within a week of the clinic. Mr O'Brien was given time the morning after the SWAH clinic for his admin of the clinic.
28. The lack of dictation by Mr O'Brien results in additional work for the service as we will likely get a second referral in because there has been no outcome. The GP's would not have been aware what was happening with their patients.
29. The lesson I have learned through all of this is that I didn't keep enough notes of the problems and escalations. It became 'oh that's just Mr O'Brien' rather than actually dealing with the problems. The whole team are very surprised by the extent/volume of the problems. I would have tried to help Mr O'Brien if he had made it known to me the extent of the problem. He never asked me for help. I knew Mr O'Brien complained about his workload to others and that Mr Young had tried to help him but no-one was aware that Mr O'Brien was just not doing triage or dictation. At times he was advised to stop phoning patients himself and doing other things that his secretary could have been doing for him. No-one knew just how long Mr Young helped him out with the triage. The rest of the consultants get it done.
30. I know Mr O'Brien agrees triage is the right thing to do and is important so I don't know why he didn't ask for help. The work Mr O'Brien completed was always done very well and sometimes there was just too much detail.

*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.*



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*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 | <div data-bbox="525 566 1011 669" data-label="Text"><p>Personal Information redacted by the USI</p></div> |
| DATE      | 25/9/17.                                                                                                  |

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## Witness Statement

|                                 |                                                                    |
|---------------------------------|--------------------------------------------------------------------|
| <b>NAME OF WITNESS</b>          | Mr Michael Young                                                   |
| <b>OCCUPATION</b>               | Consultant Urologist                                               |
| <b>DEPARTMENT / DIRECTORATE</b> | Directorate of Acute Services, Craigavon Area Hospital             |
| <b>STATEMENT TAKEN BY</b>       | Dr Neta Chada, Associate Medical Director / Case Investigator      |
| <b>DATE OF STATEMENT</b>        | Thursday 23 March 2017                                             |
| <b>PRESENT AT INTERVIEW</b>     | Mrs Siobhan Hynds, Head of Employee Relations                      |
| <b>NOTES</b>                    | 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. 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.
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 though 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.*

|                  |                              |
|------------------|------------------------------|
| <b>SIGNATURE</b> | M. Young                     |
| <b>DATE</b>      | 5 <sup>th</sup> October 2017 |

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## Witness Statement

|                                 |                                                                                                                                                                                                        |
|---------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>NAME OF WITNESS</b>          | Mrs Claire Graham                                                                                                                                                                                      |
| <b>OCCUPATION</b>               | Head of Information Governance                                                                                                                                                                         |
| <b>DEPARTMENT / DIRECTORATE</b> | Directorate of Performance and Reform                                                                                                                                                                  |
| <b>STATEMENT TAKEN BY</b>       | Dr Neta Chada, Associate Medical Director / Case Investigator                                                                                                                                          |
| <b>DATE OF STATEMENT</b>        | Monday 3 April 2017                                                                                                                                                                                    |
| <b>PRESENT AT INTERVIEW</b>     | Mrs Siobhan Hynds, Head of Employee Relations                                                                                                                                                          |
| <b>NOTES</b>                    | The terms of reference were not shared prior to the date of statement. I was advised that the investigation was dealing with concerns in respect of the transportation and storage of patient records. |

1. My name is Mrs Claire Graham. I am employed by the Southern Health and Social Care Trust as the Head of Information Governance. I have been employed in this role since 2004. My role is to ensure Trust compliance with the Data Protection legislation, Freedom of Information legislation and in respect of matters of confidentiality.
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 explained that responsibility for operational records management lies with Ms Helen Forde who is responsible for the storage and management of health records. I explained that my role is an oversight and advisory role and to interpret the legislation.
4. I was asked to explain the regulation within the Trust in respect of the storage of patient files. I advised that there is Departmental approved guidance in place 'Good Management, Good Records, DHSSNI'
5. I was asked to outline how I would monitor missing charts. I explained that I wouldn't know this. I would not pick up information in respect of patterns of missing records.

6. I was asked to explain what the Guidance details in terms of taking patients home. I explained that it shouldn't happen unless business needs require this. I outlined that all records should be taken back to the Trust immediately after any off site clinic. I referred to Section 3.1 of the Guidance.
7. I was asked to explain if large numbers of missing charts would be picked up. I outlined that if it is regularly found that charts are missing this should flag in the KPI's. I advised, I was not made aware of any bundle of charts not available within the Trust.
8. I outlined that that in my view, the greater the number of charts missing, the more serious the matter is for the Trust. I advised that there is no acceptable period of time to have charts off the Trust site but if it is necessary, it should be for the minimum period necessary for the purpose of treating a patient.
9. Following my initial meeting on 3 April 2017, I researched sources in relation to
  - a. 'taking records outside the Trust' and
  - b. 'record keeping responsibilities in relation to the need to update records in a timely manner'.

I provided this information to the case investigator via e-mail dated 21 April 2017.

10. I outlined that issue 'b' is encompassed in guidance on good record keeping including
  - GMC 2013 (referenced in guidance by MDU titled 'Good record keeping, staying patient focused' states 'records should be made straight away or as soon as possible after patient care'. Also 'all records need to be kept secure and confidential at all times'.
  - GMC 2013 'Good Medical practice. Working with doctors, working for patients. The duties of a doctor registered with GMC'. 25.03.2013

#### Trust Policy

- Records Management Policy section 5.1.10 page 6 covers responsibilities of individual member of staff including the need to ensure that
  - o The record can be accessed
  - o The record is accessible and meaningful, in the right format to those who need to use it
- Records Management Procedure
  - o Recordkeeping 2.7 record kept correctly and legibly recorded, kept up to date and easily accessible when needed
  - o Health Care records 2.7.2
  - o Records in transit 4.0 'accurate recording of all record movements is essential...one of the main reasons why records are misplaced is because record movements are not recorded'

- Tracking/Tracing Records 4.2 'managers must ensure that effective systems are in place for tracking the location of files containing confidential information'
- Policy for the Safeguarding, Movement and transportation of Patient/Client/Staff/Trust Records, Files and Other Media between facilities (attached) is the most relevant regarding removing of records off site, tracking and confidentiality.
  - Section 1,3; 2.1; 2,4 and 3.1;
  - Section 5.1; 5.2 and 5.3
  - Section 7.1 and 8.0

#### Trust Training

- 'You're the key to data security' – Data Security update for Medical Staff dated 2009
- Memo (April 2017) from SIRO on missing case notes and implications sent to SMT with revised template (attached)
- Induction checklists for training of staff (attached) has link to guidance on Information Governance including the Policy for Safeguarding and Transportation of records as referenced above and guidance 'IG and what you need to know' mentions tracking of records.
- Information Governance training session was held in CAH in January 2017 targeted at senior personnel and over 100 staff attended

#### National case of interest (Wales Health Board)

- Medical records lost on bike ride home (UK)
- 'Is it a HIPPA violation for physicians to take patient charts home or on vacation to complete dictation'? (USA)

In summary, the policy for the safeguarding, movement and transportation of patient/staff/client Trust records is the most relevant guidance. It has been in place since Jan 2008.

*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 | Personal Information redacted by the USI |  |
| DATE      | 31 May 2017                              |  |