



**Southern Health  
and Social Care Trust**

**UROLOGY DEPARTMENT  
OUTPATIENTS LETTER**

Consultant Urologist: Mr John O'Donoghue  
Secretary: Mrs Nicola Robinson  
Telephone: Personal Information redacted by the USI  
Office hours: 9:00am to 1:00pm

DR J. BURNETT  
THE HEALTH CENTRE  
TAVANAGH AVENUE  
PORTADOWN  
CO ARMAGH  
BT62 3BU

Dear DR BURNETT

**Re: Patient Name:** Patient 15  
**D.O.B.:** Personal Information redacted by the USI  
**Address:** Personal Information redacted by the USI  
**Hospital No:** Personal Information redacted by the USI **H&C No:** Personal Information redacted by the USI

|                                      |                   |
|--------------------------------------|-------------------|
| <b>Date/Time of Clinic:</b> 08/02/16 | <b>Follow Up:</b> |
|--------------------------------------|-------------------|

Thank you for referring this 74 year old chap who has had a rising PSA since 2013. I note in December 2013 it was 7.75, in April 2015 it was 11.34 and in February 2016 it went up to 16.32. He is on Dutasteride and so his real PSA is double this. I note his EGFR is >60 and he has co-morbidities including fracture right femur in 1970, hypertension, osteoarthritis and he has had endovascular repair of abdominal aortic aneurysm in 2014.

I note his list of medications includes Aspirin, Co-codamol, Coracten, Dutasteride, Irbesartan, Metronidazole and Pravastatin. He has no drug allergies.

He tells me that his urinary stream is very slow and he double voids. He passes urine every couple of hours during the day and every hour at night time. He has intermittent urgency and hesitancy.

On examination he is somewhat immobile and on abdominal examination there is nothing to find. His genitalia are normal. On digital rectal examination he has a 40-50 gram prostate that is malignant feeling that is at least a T2 cancer.

He had a prostate biopsy today. His prostate measures 45cc. After a stat dose of Ciprofloxacin 750mg he had prostate biopsies, 6 from the left and 6 from the right and these were sent for histology. There were no immediate complications.

He also did a flow rate for us which showed a very poor flow with Q-max of about 8mls per second for a voided volume of 200mls. The flow time was prolonged at 54 seconds. I await the results of the histology but I suspect he will probably

My father was understandably upset when told that he had a raised PSA count and was being referred to Urology and the longer the silence lasted after the referral the more worried he became. Having been told that you need specialist attention for what could become a potentially life-threatening problem was stressful for my father and my mother. As a result of Urology ignoring the referral for 6 months, our family saw a very pronounced change for the worse in my father's personality and demeanour; he was much quieter and more withdrawn than we ever knew him to be. We only attribute this to him worrying about his condition.

When prostate cancer was eventually confirmed my father was acutely aware that the length of time which had passed could only have made things worse and he feared that he would not survive. He spoke to me about preparing for the worst possible outcome and he genuinely believed that he was not going to survive.

This was an immensely stressful time for my father as he dealt with these fears and it was also an extremely anxious time for my mother.

Treatment for the prostate cancer was ultimately successful in June of 2017, almost two years after being referred but we question why the process took so long and if the cancer and treatment would have been as severe if my father's case had been reviewed sooner. When he did eventually get the all clear, he was a changed man. He returned to being the happy man we knew before this all started. We believe there were an additional six months of unnecessary stress due to Urology's inaction.

My father passed away in Personal information redacted by the USI. On the 19th of May 2021 my mother received a call (which I witnessed) from Mr Mark Haines on behalf of the Trust to advise that an article would be running in the Irish News about Mr Aiden O'Brien and that my mother should basically disregard anything in the article. He framed the piece as a witch hunt and there was nothing relevant to my father's case and despite the delay in diagnosis this that would not have affected his treatment. As a family we were unaware that Mr O'Brien was involved in any stage of my father's treatment or diagnosis and so accepted this at face value but noted with Mr Haines that the additional months of unnecessary stress took its toll on both my father and my family. This call is to date the singular contact from the Trust. We read the Irish News article with interest along with the media reports which followed. There were reportedly five cases which were undiagnosed which turned out to be positive for cancer and therefore assume that my father was one of those five. We also assume that Mr Haines did not call round hundreds of people to put the Trusts 'spin' on the Irish News article.

In hindsight, this phone call appears to have been an appalling attempt to obscure the truth of what was going on and the patronising manner which was used with my mother was unacceptable. His attitude came across as treatment was successful therefore you can ignore what has happened.

With the information available to us we believe that not only was Mr O'Brien negligent in failing to review my father's case but the Trust were also negligent as it appears they have been aware for years of the concerns around Mr O'Brien's practices yet took no action to address his performance. Furthermore, Mr Haines attempt to deflect attention casts a shadow over the Trust's moral and ethical standards. We also note that this inquiry did not contact my mother until the second round of contacts which suggests that information was withheld by the Trust.

Additional sheets, if needed, can be attached

obtaining diagnosis and a recommendation of treatment for a prostate cancer.

**Causal Factors**

1. Referral letters did not have their clinical priority accurately assigned by the GP. Referral letters were not triaged following receipt by the Hospital.

**HSCB****Recommendation 1**

HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.

**Recommendation 2**

HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices.

**Recommendation 3**

HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients.

**HSCB, Trust and GPs****Recommendation 4**

GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields.

**TRUST****Recommendation 5**

Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

**Recommendation 6**

The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW.

**Recommendation 7**

The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely

**APPENDIX 6**

Revised November 2016 (Version 1.1)

**Root Cause Analysis report on the  
review of a Serious Adverse Incident  
including  
Service User/Family/Carer Engagement  
Checklist**

Organisation's Unique Case Identifier:

Personal Information  
redacted by USI

Date of Incident/Event: January 2016 – September 2016

HSCB Unique Case Identifier:

Personal Information  
redacted by USI

Service User Details: *(complete where relevant)*

Responsible Lead Officer: Dr J R Johnston

Designation: Consultant Medical Advisor

Report Author: The Review Team

Date report signed off: 22 May 2020



## 1.0 EXECUTIVE SUMMARY

During an internal review in 2016, following an Index Case, the Trust identified a number of GP Urology referrals who were not triaged by one particular Consultant Urologist; 30 patients should have been red-flag referrals and of these 4 had cancer. A fifth patient <sup>Patient 15</sup> discovered during an outpatient clinic, was included as he was also not triaged and subsequently had a cancer confirmed.

<sup>Patient 15</sup> – a 68-year-old male was referred to Urology Outpatients on 30 August 2015 for assessment and advice for an elevated Prostate specific antigen (PSA) (The blood level of PSA is often elevated in men with prostate cancer). The referral was marked Routine by the GP. The referral was not triaged on receipt. However, a second GP referral was received on 29 January 2016 marked Suspected Cancer Red Flag and had received a red flag appointment. Following this referral, he was seen in clinic on 8 February 2016 (D153). On day 166 <sup>Patient 15</sup> was diagnosed with a confirmed cancer; a resultant 6-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

<sup>Patient 14</sup> – a 63-year-old male was referred to Urology Outpatients on 3 June 2016 for assessment and advice for an elevated PSA. The referral was marked Urgent by the GP. The referral was not triaged on receipt. As part of the internal review, the referral was upgraded to Red Flag and was seen in clinic on day 246. On day 304, the patient had a confirmed cancer diagnosis. There has been a resultant 10-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

<sup>Patient 11</sup> – a 68-year-old male was referred to Urology Outpatients on 28 July 2016 for assessment and advice for an elevated PSA. The referral was marked Urgent by the GP. The referral was not triaged on receipt. As part of an internal review the referral was upgraded to Red Flag and seen in clinic on day 217. On day 258 <sup>Patient 11</sup> was diagnosed with a confirmed cancer; a resultant 9-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

<sup>Patient 13</sup> – a 51-year-old male referred to Urology following an episode of haematuria on 28 July 2016. The referral was marked Routine by the GP. The letter was not triaged and <sup>Patient 13</sup> was placed on a routine waiting list on 30 September 2016. As part of an internal review this patient's referral letter was upgraded to a Red Flag referral <sup>Patient 13</sup> was reviewed at OPD on 31 January 2017. Subsequent investigations diagnosed with bladder and prostate cancer <sup>Patient 13</sup> has locally advanced bladder cancer. There has been a resultant 6-month significant delay in obtaining a diagnosis and a recommendation of treatment for his bladder cancer.

<sup>Patient 12</sup> – a 73-year-old male was referred to Urology Outpatients on 8 Sept 2016 for assessment and advice on lower tract symptoms and elevated PSA. The referral was marked Urgent by the GP. The referral was not triaged on receipt. As part of the internal review the referral was upgraded to Red Flag and was seen in clinic on day 152. On day 215 <sup>Patient 12</sup> had a confirmed cancer diagnosis T3a with no nodal metastases. There has been a resultant 8-month delay in

obtaining diagnosis and a recommendation of treatment for a prostate cancer.

#### **Causal Factors**

1. Referral letters did not have their clinical priority accurately assigned by the GP. Referral letters were not triaged following receipt by the Hospital.

#### **HSCB**

##### **Recommendation 1**

HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.

##### **Recommendation 2**

HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices.

##### **Recommendation 3**

HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients.

#### **HSCB, Trust and GPs**

##### **Recommendation 4**

GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields.

#### **TRUST**

##### **Recommendation 5**

Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

##### **Recommendation 6**

The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW.

##### **Recommendation 7**

The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely

manner.

### **Recommendation 8**

The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list.

### **Recommendation 9**

Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10.

### **Recommendation 10**

The Trust must set in place a robust system within its medical management hierarchy for highlighting and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence.

## **CONSULTANT 1**

### **Recommendation 11**

Consultant 1 needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner.

### **Recommendation 12**

Consultant 1 needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation 6.

## **2.0 THE REVIEW TEAM**

Dr J R Johnston - Consultant Medical Adviser - Chair

Mr M Haynes - Consultant Urologist

Mrs K Robinson - Booking & Contact Centre Manager

Mrs T Reid - Acute Clinical & Social Care Governance Coordinator

## **3.0 SAI REVIEW TERMS OF REFERENCE**

1. To undertake an initial investigation/review of the care and treatment of patients Personal Information redacted by the USI in the period after referral to the SHSCT Urology service using Personal Information redacted by the USI

### 3.0 SAI REVIEW TERMS OF REFERENCE

National Patient Safety Agency root cause analysis methodology.

2. To determine whether there were any factors in the health & social care services interventions delivered or omitted to [REDACTED] that resulted in an unnecessary delay in treatment and care.
3. The investigation / Review Team will provide a draft report for the Director of Acute Services. This report will include the outcome of the Team's investigation/review, identifying any lessons learned and setting out their agreed recommendations and actions to be considered by the Trust and others.
4. The Trust will share or disseminate the outcomes of the investigation/review with all relevant parties internally and externally including the service user and relevant family member(s) (where appropriate).

### 4.0 REVIEW METHODOLOGY

The Review Team will undertake an analysis of the information gathered using RCA tools and may make recommendations in order that sustainable solutions can minimise any recurrence of this type of incident. The Review Team will request, collate, analyse and make recommendations on such information as is relevant under its Terms of Reference in respect of the incident outlined above.

#### Gather and review all relevant information

- Inpatient notes Craigavon Hospital.
- Information from the Northern Ireland Emergency Care Record (NIECR) and Patient Administration System.
- Information from laboratory systems.
- Information obtained from relevant medical, nursing and management staff.
- Review of Relevant Reports, Procedures, Guidelines.

#### Information mapping

- Timeline analysis
- Change analysis for problem identification and prioritisation of care delivery problems and service delivery problems as well as identifying contributory factors.

### 5.0 DESCRIPTION OF INCIDENT/CASE

#### 5.1 Triage of GP referrals - background

The general public expect that, when they engage with their GP complaining of symptoms that are potentially due to a cancer, they will be referred to the appropriate secondary care services promptly and that they will respond, also promptly, to confirm or exclude the diagnosis of cancer.

## 5.0 DESCRIPTION OF INCIDENT/CASE

The DHSSPSNI Service Framework for cancer prevention, treatment and care (Standard 13) of 2011 indicates, *"All people with signs and symptoms that might suggest cancer should be appropriately assessed by their GP and referred promptly on to hospital for further tests if needed"*.

Cancer specialists, working in networks, have formulated lists of symptom and sign triggers which can signify the development of a cancer. Using these lists, primary care doctors can refer patients into secondary care; triaging a large number of patients by assigning them to different degrees of urgency (Routine, Urgent and Red-flag). If these are used as designed, this can provide an efficient referral system.

NICE have been instrumental in ensuring uniformity and the validity of these cancer recognition and referral lists of symptoms and signs. They have also formulated guidance regarding how safety nets should be setup to ensure patients are not missed. Local programmes, using this type of guidance, have been established, under the auspices of NICaN and the HSCB, to set up these triage pathways and safety nets.

### 5.2 Triage of GP referrals – Northern Ireland

#### NI Referral Guidance for Suspected Cancer (2012)

The Northern Ireland Referral Guidance for Suspected Cancer 2012 is based on the NICE clinical guideline, CG 27 - *Referral guidelines for suspected cancer*, published in June 2005. This has a section on Urological Cancer. It was introduced to GPs by HSCB correspondence (30/12/2012), revealing the new red-flag process and indicating in appendix A that, *"triaging will take place in a timely manner, within 72 hours of receipt of referral or the referral should continue with the GP Prioritisation"*.

This is still the only set of referral guidance for suspected urological cancer available online on the NICaN website (last accessed 18/11/2018).

However, the 2005 CG27 guidance has been replaced by NICE Guideline NG12 *Suspected cancer: recognition and referral* published in June 2015. This was endorsed by the Department of Health (NI) with HSC (SQSD) (NICE NG12) 29/15 on the 19<sup>th</sup> August 2015 which instructed the HSCB / PHA to send out the guidance to the appropriate Family Practitioners. This particular kind of guidance requires the HSCB to circulate regionally endorsed NICE guidelines to Trusts and GPs for implementation. Trusts are expected to review guidance against a base line assessment and provide HSCB with an assurance that the guidance has been implemented. If a Trust is unable to fully implement the guidance within the one-year period without regional co-ordination and/or additional resources, they should provide a formal assurance to HSCB, and this is to be managed as part of the risk management process. This assurance process does not however apply to primary care and GP's.

## 5.0 DESCRIPTION OF INCIDENT/CASE

### NICaN Urology Cancer Clinical Guideline (2016)

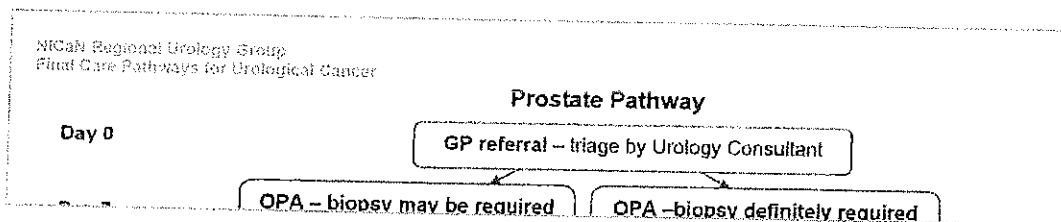
The NICaN Urology Cancer Clinical Guideline document, (version 1.3, March 2016), was produced regionally to support the diagnosis, treatment and management of urological cancer. This version included amendments, to replace the previous red flag guidelines, with those from NICE NG12; the document was signed off on behalf of the NICaN by Consultant Urologist, Cons1.

The Review Team's evaluation of the advantages of NICE NG12 (2015) over the CG27 (2005) guidelines reveals fewer cases would be red-flagged for Urology, as a result of,

- a reduction in number of non-visible haematuria patients; and
- increases in age criteria of 45 years and over.

However, rollout of NG12 by the HSCB does not appear to have happened. The Review Team understands that the reason NG12 has not been implemented lies with ongoing discussions between the HSCB and GPs.

Appendix 2 of the NICaN Urology Cancer Clinical Guideline guidelines highlights the Urology Care pathways. Cons1 was present at the workshop discussing those on 02/10/2008. It clearly indicates that, for the Prostate pathway, the GP referral would be triaged by the Urology Consultant.



### 5.3 Triage of GP referrals – SHSCT

The process of Urology triage in CAH is based upon the NI Referral Guidance for Suspected Cancer of 2012 as described above i.e. it is based on the 2005 NICE CG27 guidelines and not the more up to date 2012 NG12. In CAH, triage of referrals is performed by the Consultant Urologist of the week.

The SHSCT Urological Cancer multi-disciplinary team (MDT) was led at the time by Consultant 1 (Cons1), who was also a joint chair.

Over a period of decades, within the SHSCT and Craigavon AH, there were occasions when triage was not performed; and this varied between consultants and specialities. Acute Services had a particular problem with this issue. Preliminary discussions by the Review Team revealed that triaging within Acute Services was a, "very haphazard process going back for approximately 25 years. There were many Consultants who would not triage but Consultant 1 was the most persistent and there were multiple attempts to tackle this issue".

## 5.0 DESCRIPTION OF INCIDENT/CASE

### Interview with Associate Medical Director (AMD1)

AMD1 first became aware of waiting list problems with Cons1 in 1996–8 when AMD1 was the lead clinician in outpatients. Cons1's OPD letters were being kept in a ring binder and were not on any waiting list. Once challenged, Cons1 would stop this practice and improve but would then slip back. There were further non-triage meetings with Cons1 when AMD1 was the Clinical Director of Surgery.

### Interview with Director of Acute Services (DAS2)

In 2007, DAS2 (while in previous post in CAH) found a waiting list which was 10 years long. They worked on this with the Consultant, Cons1, and cleaned it up; they found no serious patient related issues.

### Interview with Director of Acute Services (DAS1)

DAS1 indicated that the Urology Services were under various kinds of pressure during her time as Director. There was a regional transformation project in place for Regional Urology Services under Mr M. Fordham; this generated an element of pressure to modernise and change. Along with this and other issues, including the triage problem, Consultant 1 struggled to adapt to these changes and to comply with the other issues and triaging. DAS1 paints a picture of many issues with Cons1, triaging being only one of many issues but, in her opinion, not the most important issue.

Nevertheless, in April 2010, Consultant 1 (Cons1) was put under pressure to complete his triage list. The surgical Associate Medical Director (AMD1) brought concerns to DAS1. The other Urologists had been 'covering' triaging for Cons1; the Head of Service Surgery had informed AMD1 of this. They met Cons1 the next day. The European Association of Urology meeting was in Spain the following day and Cons1 wished to attend. DAS1 and AMD1 informed Cons1 he would not be attending the meeting unless he triaged all his referrals immediately. Cons1 duly addressed the triage backlog, completing them that evening. From that time on, AMD1 and the Head of Service (HoS1) monitored that Cons1 was triaging the GP referral letters. However, DAS1 commented that the HoS1 had a difficult job managing Cons1.

### Following interview with Head of Service (HoS1)

The Head of Service for Urology (HoS1) indicated that she inherited the problem upon appointment although she was aware that it was a long running issue, going back perhaps 25 years. She highlighted this was an ongoing issue with Cons1. He had the longest backlog and took longest to triage. There were issues with other Consultants who, on occasion, did not triage but Cons1 was the only one, when asked to triage, didn't do it. This came to head in 2010 (referred to above) and again in 2014.

### Informal Default Triage (IDT) process

In May 2014, after escalation to HoS1, an Informal Default Triage (IDT) process was put in place by the Trust's booking centre. This process allowed the booking office to allocate



## 5.0 DESCRIPTION OF INCIDENT/CASE

patients, who had not been triaged in time, to be allocated to a 'waiting list' using the GP triage category. Therefore, this IDT process of putting patients on the waiting list without triage meant that they did not get missed. However, some patients, who should have been triaged as a red flag, waited on the waiting list with their 'incorrect' GP triage category. After much discussion, this detailed process was formally circulated to all specialties on the 6<sup>th</sup> November 2015 by the Assistant Director of Support Services (ADSS1).

When questioned about this IDT process, the DAS2 was not aware of it even though it started during her time in post i.e. May '14. When asked about its potential problem of leaving incorrectly triaged (by their GP) patients on a waiting list she stated, *"Completely ridiculous, because would allow a cancer patient who should have been red flagged by their GP to go unchallenged by a Consultant triage process i.e. could have to wait for 11 months"*.

### 5.4 Index case

In 2016, the SHSC Trust investigated (RCA ID [Personal Information redacted by USI]) in what subsequently became an 'Index case' for the cases in this RCA, the treatment and care of [Patient 10] [Patient 10] was a patient who had had Ca Colon (2010), breast carcinoma (2013) and then developed renal carcinoma. During review for her Breast Ca in June 2014, a CT Scan revealed that, previously noted, renal cysts had increased in size. Further investigation by a MRI scan was reported in a limited and incomplete fashion; resulting in a 'routine' referral GP letter on 29/10/2014.

During the investigation, the Review Team identified that [Patient 10] GP referral letter had not been triaged; the Consultant Urologist with responsibility that week for triage duties was Cons1. This referral therefore waited as a 'new routine' referral till January 2016 to be seen by a Consultant Urologist.

The index case Review Panel agreed 3 main contributing factors led directly to [Patient 10] delay in diagnosis. Firstly, the content of the MRI report; secondly a letter following a CT scan did not mention important information and thirdly, the opportunity to upgrade the referral to red flag was lost by the omission of triage; this resulted in a 64-week delay to diagnosis of a suspicious renal mass.

The index case Review Panel concluded in March 2017 that, *".... a significant number of letters within Urology are not being triaged by the minority of the Team. It is clear that the default triage management process (vide infra) continues to be initiated secondary to the omission of Triage by individual members of the urology team and not the entire Urology Team"*.

Of the 2 lessons learnt, one indicated that,

*"Triage of GP referral letters remains a key element in validating appropriate utilisation of specialist services and ensuring patient safety. Triage also serves as an opportunity for early intervention for patients at risk of malignant disease or clinical deterioration."*

## 5.0 DESCRIPTION OF INCIDENT/CASE

This led to a recommendation that,

*"This SAI has demonstrated that patients will be at an increased risk of harm when the opportunity for early intervention at Triage is omitted. The Review Panel recommend that the Trust reviews the process which enables the clinical triaging and escalation of triage non-compliance in accordance with the Integrated Elective Access Protocol (IEAP).*

*In particular the fundamental issue of triaging GP referral letters remains a challenge within Urology. The Urology operational and medical management teams immediately need to address the issue of un-triaged referrals not being processed in accordance with IEAP."*

The findings of this investigation, chaired by Consultant Urologist 2 (Cons2), were made available in December 2016 and formally signed off on the 15<sup>th</sup> March 2017. A letter highlighting a number of concerns was sent to the (then) lead for Acute Governance for Acute Services (AGAS1), on the 15<sup>th</sup> December 2016.

The letter pointed out that the IDT process implied that triage non-compliance was to be expected but that this process did not have a clear escalation plan to include the individual Consultant and, indeed, had not been effective in addressing triage non-compliance. Furthermore, the letter pointed out that, from July 2015 till October 2016, there were 318 non-triaged letters which the Trust could not provide assurance that patients were not being exposed to harm by waiting as a routine or urgent appointment i.e. when they should have been red-flagged.

It is not absolutely clear who wrote this letter as it has no signature, but it appears to have been written by, or on behalf of, Cons2. On the 10<sup>th</sup> January 2017, Cons2 was requested by the Medical Director (MD3) to share the report with the 2 key Consultants involved in the SAI. One of these was Cons1. Cons2 refused, stating that he was Cons1's colleague and not his manager.

This letter was escalated to the Director of Acute Services (DAS3) and the Assistant Director of Anaesthetics & Surgery. This was further escalated to the Chief Executive of the SHSCT.

Cons1 was written to by AMD1 on the 23<sup>rd</sup> March 2016, acknowledging his hard work as a Consultant Urologist but pointing out that there were governance and patient safety concerns with regard to untriaged letters dating back over 2 years, and other important issues. Cons1 was asked to respond with a commitment and immediate plan to address these issues.

The Review Panel also determined that there were 7 other patients who were not triaged that week along with Patient ID. They subsequently performed a 'look-back' exercise (number 1) of these referrals. Of the seven referrals, six charts were available and each patient had an appropriate

**5.0 DESCRIPTION OF INCIDENT/CASE**

management plan. One set of notes were missing and efforts were made to find them.

Cons1 provided his personal review, dated 25/01/2017, of the Index Case to the Chairman of this Review Team. It provides an argued retrospective rationale that a timely triage by himself would not have altered the referral grading. However, it does not provide a sound reason for his actual lack of triage. His report is consistent in arguing his view that he does not have time to perform both Consultant of the Week (CoW) duties and triaging of non-red flag referrals.

**5.5 Look back exercise #2**

Upon realisation that the 'look-back' exercise #1 had resulted from non-triage over the week beginning the 30/10/2014, further efforts were made to investigate the size of this non-triage issue and to find missing referral letters. Cons1 was contacted and the Head of Service for Urology (HoS1) obtained permission to look for missing GP referral letters in his filing cabinet. Cons1 stated that there were referral letters in a filing cabinet in his office. During interview, he stated that he kept the referrals to ensure they would not be missed or overlooked. The Head of Service for Urology retrieved these referral letters, which numbered over 700 along with the triage lists from the booking centre.

These referrals were then reviewed by the Urology Consultant Team revealing 30 patient referrals should have been red-flagged and four of these patients, following review, were diagnosed with cancer, becoming the subject of this review.

This (RCS ) Review Team reviewed the clinical notes from these 4 patients and following discussion, under the Urological guidance of AMD1, detailed the clinical course and made the following conclusions.

 Patient 14 03/06/2016 - 63-year-old male referred to Urology Outpatients by GP for assessment and advice with a raised PSA.

The referral was marked Urgent by the GP.

The referral was not triaged on receipt.

09/08/2016 - added to W/L Urgent.

27/01/2017, as part of the internal review #2, the referral was upgraded to R/F and was seen in clinic on day 246. Therefore, this was an incorrect GP referral.

05/04/2017 (D304), following U/S guided biopsy, the patient obtained a confirmed cancer diagnosis and there was a recommendation for treatment of a prostate cancer by surveillance protocol.

**Conclusions**

Resultant 10-month delay in obtaining diagnosis.

Following Review Team consideration, deemed not to be a clinically significant delay.

 Patient 11 28/07/2016 - 68-year-old male referred to Urology Outpatients by GP for assessment and advice, concerning elevated PSA.

The referral was marked Urgent by the GP.

**5.0 DESCRIPTION OF INCIDENT/CASE**

The referral was not triaged on receipt.

30/09/2016 - added to W/L Urgent.

18/01/2017 - as part of an internal review #2, upgraded to R/F. Therefore, this was an incorrect GP referral.

20/02/2017 (D207) seen at R/F appointment. Sent for MRI and prostate biopsy.

11/04/2017 (D258) - diagnosed with a confirmed low risk prostate cancer and there was a recommendation for treatment of a prostate cancer by surveillance protocol.

**Conclusions**

Resultant 9-month delay in obtaining diagnosis.

Following Review Team consideration, deemed not to be a clinically significant delay.

Patient 13

28/07/2016 - 51-year-old male referred to Urology by GP following an episode of haematuria.

The referral was marked Routine by the GP.

The letter was not triaged.

30/09/2016 - [redacted] was placed on a Routine waiting list.

19/01/2017 - As part of an internal review #2, upgraded to a R/F referral. Therefore, this was an incorrect GP referral.

31/01/2017 (188d) - reviewed at OPD and flexible cystoscopy.

22/02/2017 TURBT/TURP - diagnosed with bladder (locally advanced) and prostate cancer and there was a recommendation of treatment for his bladder cancer.

**Conclusions**

Resultant 6-month delay in obtaining diagnosis.

Following Review Team consideration, it is probable that the delay is clinically significant; time will tell\*.

\* The Review Team referred to an expert for advice.

*Delay in definitive surgical treatment beyond 12 weeks conferred an increased risk of disease-specific and all-cause mortality among subjects with stage II bladder cancer. He remains disease free as of September 2018.*

1. John L. Gore, Julie Lai, Claude M. Setodji, Mark S. Litwin, Christopher S. Saigal, and the Urologic Diseases in America Project. Mortality increases when radical cystectomy is delayed more than 12 weeks. Results from a surveillance, epidemiology, and end results--Medicare analysis. *Cancer* March 1, 2009.
2. Nader M. Fahmy, Salaheddin Mahmud, Armen G. Aprikian. Delay in the surgical treatment of bladder cancer and survival: Systematic Review of the Literature. *European Urology* 50 (2006) 1176-1182.

Patient 12

08/09/2016 - 73-year-old male was referred to Urology Outpatients on for assessment and advice on lower tract symptoms and elevated PSA.

The referral was marked Urgent by the GP.

The referral was not triaged on receipt.

27/01/2017 - further GP letter - please upgrade to R/F.

30/01/2017 - as part of the internal review #2, upgraded to R/F.



## 5.0 DESCRIPTION OF INCIDENT/CASE

06/02/2017 - seen in clinic on day 152.

11/04/2017 (D215) - confirmed cancer diagnosis T3a with no nodal metastases – high risk and there was a recommendation of treatment for a locally advanced non-metastatic prostate cancer.

### Conclusions

Resultant 8-month delay in obtaining diagnosis.

Following Review Team consideration, it is probable that the delay is not clinically significant.

At a later date, towards the end of 2018, another patient came to the attention of the Review Team – Patient 15. This patient could also have been one of those found in Cons1 filing cabinet but appeared at an outpatient clinic before the outworking of the look back exercise #2. A Consultant Urologist realised in the clinic that this was also a Cons1 non-triaged patient who was incorrectly referred by their GP.

Patient 15 30/08/2015 - 63-year-old male referred to Urology Outpatients by GP for assessment and advice with a raised PSA.

The referral was marked Routine by the GP.

The referral was not triaged on receipt.

29/01/2016 2<sup>nd</sup> GP referral marked as Suspected Cancer – Red flag; Patient 15 was added to W/L R/F following this referral.

As part of the internal look back #2, the referral was noted.

Patient 15 had already received an appointment and was seen in clinic on day 153. Therefore, 1<sup>st</sup> GP referral was incorrect; the 2<sup>nd</sup> was a correct GP referral.

11/02/2016 (D166), following a prostate biopsy, the patient obtained a confirmed cancer diagnosis T3a and there was a recommendation for treatment of a prostate cancer.

### Conclusions

Resultant 6-month delay in obtaining diagnosis.

Following Review Team consideration, it is felt that the delay is unlikely to be clinically significant.

## 7.0 CONCLUSIONS

The Review Team interviewed a number of Trust staff including Directors (past and present), an Assistant Director, Head of Service and an Associate Medical Director as part of the review process. These interviews, along with clinical documents and health records systems, have helped inform the conclusions by providing the evidence and also corroboration where there appeared to be differences of opinion.

The Review Team and everybody interviewed, including Cons1, provided affirmation that a timely, efficient triage system which checked the initial GP referral was very important to patients. Comments made when interviewees were asked about the importance of triage and where the process of triaging a potential cancer patient ranked alongside other issues such as probity, patient experience and performance, were consistent,

*"Very significant". Very high up the list in terms of importance".*

*"It is fundamental people are seen in the appropriate time".*

*"Very important" ... "Important for the patient".*

*"Vital" ... "Very significant .. patients are often anxious and depend on the system to work".*

Cons1 replied,

*"It is a serious issue, very important"..... "Number one ranking in overall scheme of things"*

The Review Team established that there were factors in HSC service delivery to the 5 patients under examination that resulted in an unnecessary delay in treatment and care. In 4 patients the delay was thought not to be clinically significant but in 1 Patient 13 there probably was a significant delay.

Consideration of the causative factors to the patients' delays reveal,

- Referral letters did not have the clinical priority accurately assigned by the GP; and
- Referral letters were not triaged following receipt by the Hospital.

### 7.1 Referral letters did not have the clinical priority accurately assigned by the GP.

#### Contributory factors

##### *Task Factors (policy and guidelines)*

The Review Team reviewed the GP referrals regarding the five patients listed above. They concluded, as judged from the Northern Ireland Cancer Network (NICaN) Referral Guidance for Suspected Cancer (December 2012), that all five patients should have been referred to Urology by the GP's as red flag referrals (suspected cancer) i.e. incorrect triage.

##### *Task Factors (decision aids)*

The current decision aid for GPs is the NI Referral Guidance for Suspected Cancer 2012 based on NICE CG 27 *Referral guidelines for suspected cancer* published in June 2005. It is clear that Secondary care, in the form of Consultant Urologists, should triage these GP referrals; by doing so, 11% of GP referrals are changed (from Review Team member). It is also clear that Cons1 would have been in no doubt as to his responsibilities; he was intimately

Involved in setting this standard and signed off the NICE clinical guidelines.

However, it is clear this very important and critical triage safety net, work can be considered onerous and other electronic methods which GPs can use might be more efficient and help to reduce that load.

According to the HoS1, most patient referrals by GPs to Trusts for outpatient appointments are now made through the electronic Clinical Communication Gateway (CCG). However, some paper referrals are still received. CCG is a digital referral system for Primary care which can contain referral criteria that meet NICE and NICE clinical guidelines. This would enable appropriate clinical triaging of referrals to be performed as part of the selection of referral reasons and/or symptom description.

Using the electronic CCG pathway, some clinical specialties, such as gynaecology, have worked closely with the Public Health Authority to develop a better GP referral tool e.g. using 'banner guidance' (a specialty specific banner, listing symptoms and signs) which complies with NICE/NICE clinical guidelines. This 'banner guidance' helps by directing clinicians to use the NICE/NICE clinical guidelines referral criteria which allow for timely and appropriate triage of patients to clinically appropriate appointment types. It is possible when red flag symptoms are chosen that an immediate alert could go to the Red Flag booking team, to allow the appointment booking process to begin immediately. However, currently, the referral criteria fields are optional i.e. not mandatory, so opening up the possibility that fields are not completed, leading to error and delay.

#### **NICE NG12**

The reference CG27 guidance has been replaced by NICE Guideline NG12 *Suspected cancer: recognition and referral* but, despite being endorsed by the DHSSPSNI and accepted by the Regional Urologists, it has yet to be implemented. Its use as a triage standard should result in fewer red-flagged cases which should ease some of the pressure on waiting lists. Its adoption would take place in primary care and should form the basis of the electronic CCG referral tool.

There was a consistent medical staff view from the Review Team, the AMD1, and indeed Cons1, that GP's have a crucial and important responsibility in getting the referral criteria/urgency category correct. If the GP does not provide enough, or the correct information, the NI Electronic Care Record (NIECR) needs to be checked and that slows the whole triage process down. It was clear that the triage system works best when the initial GP referral is usually correct and the Secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

### **7.2 Referral letters were not triaged following receipt by the hospital.**

#### Contributory factor

#### *Task Factors (policy and guidelines)*

The Integrated Elective Access Protocol (IEAP) (DHSSPS, April 2008) defines the roles and responsibilities of staff (in both primary and secondary care) when patients enter an elective care pathway. It states,

*'...an Executive Director will take lead responsibility for ensuring all aspects of this Protocol are adhered to.... Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first'.*

The Principles for booking Cancer Pathway patients states,

*"Clinical teams must ensure triage is undertaken daily, irrespective of leave, in order to initiate booking patients".*

and,

*"Referrals will be received, registered within one working day and forwarded to Consultants for prioritisation".*

However, the IEAP states,

*"...if clinical priority is not received from Consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the GP's classification of urgency".*

Following on from the IEAP of 2008, national and regional policies and guidelines, already referred to above, have been introduced which have outlined the detailed role of the Urology Consultant in triaging referrals that have come in from Primary care e.g.,

- Service Framework for cancer prevention, treatment and care (Standard 13) 2011;
- NI Referral Guidance for Suspected Cancer 2012; and
- NICA N Urology Cancer Clinical Guideline document, (version 1.3, March 2016).

These have provided agreed lists of the critical symptomatology of Urological cancers and the roles and responsibilities of Primary and Secondary care staff in ensuring patients receive prompt recognition and treatment of their cancer.

#### *Review of Adult Urology Services in Northern Ireland*

In March 2009, a *Review of Adult Urology Services in Northern Ireland - A modernisation and investment plan* was published. Its External Advisor was Mr Mark Fordham. SHSCT Consultant Urologists were represented on the committee.

Recommendation 4 states, *"Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system".*

Consultants indicated that they would routinely upgrade a significant number of routine and urgent referrals (GP) to urgent or red flag. It was noted that the development of agreed referral guidelines/criteria for suspected Urological cancers was a priority piece of work for the recently formed NICA N Group. That work was led by Cons1; see page 6.

Section 3.31 of the report indicates that, *"Consultant Urologists unanimously consider that referral triage should be led by Consultants. With over 40% of referrals being cancer related*



*(and with many not red flagged or marked urgent) they believe that they are best placed and skilled to undertake the triage process. They also believe that despite the volume of referrals, this is not a particularly time consuming process."*

#### Contributory factor

##### *Staff factor*

It is obvious from reading the documents referred to above that Cons1 has been aware of developments in this field and, indeed has been party to the discussions and signed some of them off. Cons1 was chair of NICA<sup>N</sup> (Urology) and was involved in drafting the NICA<sup>N</sup> regional Urology guidance, and therefore was very familiar with the requirement to triage GP referrals.

Despite all of this, and even though Cons1 agreed that this triaging role was, "very important", .... it was, "a very serious matter not to be minimised, very serious" he stated he would not triage non-red flag referrals.

When asked, "Does triage still need done?" Cons1 answered, "a procedure is needed to highlight when it needs done and who does it". When further asked, "Who was involved in SHSCT Urology service in setting up triage"? Cons1 answered for urological cancer, "I was the Lead".

He felt triage of referral letters was too time consuming and the amount of time spent on triage, in his opinion, rendered inpatient care unsafe. He highlighted that he had previously escalated his concerns about work load to management teams and medical directors.

In relation to triage, Cons1 stated, 'I would love if we had a Trust Urology agreement on the type of triage to be conducted'. When it was pointed out that, "Consultant colleagues did triage for you. How did they do it?" He stated, "It depends on how you do it" ..... "Not all do advanced / enhanced triage, they compromise. It is a spectrum"... "They have not done it in the detail I felt it needed for routine/urgent non-red flag case".

When questioned further, regarding his way of organising his own work load, Cons1 stated, '....yes I did it my way – I wasn't cognisant of being unbending, I am very particular'.

Cons1 highlighted to the Review Team that he currently takes annual leave each Friday and spends the weekend triaging. He stated that it is impossible to be Urologist of the Week and triage referrals appropriately. He stated he still can't do triage and everything else. He stated, 'I do triage entirely in my own time to allow me to do it properly'.

When asked about using the NIECR - Electronic Referral using the Clinical Communication Gateway (CCG) method, Cons1 stated found the new CCG triage system, "Very, very good, I wish all information was available on ECR. It is less time consuming. ECR makes it easier to check information".

The Review Team concluded that there was a serious inconsistency between the guideline

standard that a Consultant should triage GP referrals (which Cons1 helped to construct) along with his stated view of the crucial importance of triage and Cons1's actual practice.

Cons1's chosen method of triage was beyond what is required. His triage is the equivalent of a virtual clinic where he reviews NIECR and books investigations for patients. While the Review Team recognised this was a detailed triage process, they concluded that his prioritisation of work and attention to detail meant that some patients got a higher standard of triage/care, while, crucially, others were not triaged, leading to a potentially critical delay in assessment and treatment for those patients. Cons1 is aware of this.

The Review Team concluded that Cons1's prioritisation of work and attention to detail led to some patients receiving a high standard of care, while others ran the real risk of having a cancer diagnosis delayed till it was dangerously late.

#### Contributory factor

##### *Work load/scheduling*

In 2008, when the IEAP was published, there was a maximum waiting time of 9 weeks for a first Outpatient appointment. On 30<sup>th</sup> September 2016, there were 2012 patients on the routine Urology outpatient waiting list, with 597 patients showing as waiting 52 weeks and over. The longest waiting time was 554 days (80 weeks). Therefore, if patient referrals are incorrectly referred, or not triaged and continue to use the GP's classification of urgency, there will be a significant wait. Cons1 is aware of this reality.

The Review Team considered the Consultant of the Week (CoW) work load, including ward rounds, clinics, emergency theatre sessions as a contributory factor. Cons1 has consistently argued that he cannot triage non-red flag referrals and carry out the duties of the CoW. He has not indicated who else should carry out the triage duties. However, the Review Team note that the other Consultant Urologists were able to manage this work load and triage referral letters in a timely fashion, with other members of the consultant team also ordering investigations, providing treatment recommendations and adding patients directly to waiting lists, similar to outcomes achieved from Cons1's 'advanced triage'.

#### Contributory factor

##### *Organisational*

The Review Team concluded that the non-triage of Urology referrals by Cons1 has been an ongoing problem in the Trust for many years, possibly decades. While there were pockets of non-compliance by other Consultants, when escalated, compliance improved. However, the Review Team note that Cons1 consistently did not return triage information on referrals thus not allowing the appropriate prioritisation of appointments by clinical need.

Interviews with 2 previous and the current Director of Acute Services, AMD1 and the Head of Surgery Service have highlighted that on many occasions, over a prolonged period, attempts had been made by the Trust's officers to address Cons1's non-compliance with triage. These

attempts encompassed both direct face to face conversations which were often heated, correspondence and, as in 2010, study leave refusal until there was compliance. These interventions all resulted in a familiar pattern of response; temporary improvement in compliance with triage, followed by a return to non-compliance.

In 2014, due to continuing non-compliance, the Trust implemented an 'Informal' Default Triage Process to manage the referrals which were not being triaged and returned to the Booking Centre. The Review Team considered the intention of this process was to prevent any delay in patients being added to the waiting list. However, this meant the 'non-return of triage' was not individually addressed with the non-compliant clinicians. Furthermore, and most importantly, it allowed patients, who should have been red-flagged, to remain on a waiting list until review.

In 2014, the Director of Acute Service 2 (DAS2) discussed non-compliance with Cons1 and agreed that Cons1 would no longer triage referral letters. Cons1 was heavily involved with formulating the NICA Urology guidelines at the time and was grateful to the extent that he thanked DAS2. This task was delegated to other Urology Consultants for a time. However, Cons1 does not recollect having to formally stop triage. At interview, DAS2 was not aware that he had resumed those duties; she remembered that their Cancer performance figures improved when Cons1 was not triaging.

#### *Escalation within Organisation*

At every interview, questions were asked whether Cons1's consistent and prolonged non-compliance with triaging was referred upwards to executive level i.e. the Medical Director and Chief Executive.

Director DAS1 considered that the problem was being managed at Service level, although as it was only one of a series of issues and considered to be a 'minor' one, it did not predominate at higher level meetings with the Medical Director (MD1); to the extent that he may not have been aware of it.

Director DAS2 considered that the problem was dealt with by agreeing with Cons1 to stop triaging. There were other issues that were flagged up to MD2, but she was not able to remember whether MD2 was made aware of the triage problem.

During DAS3's current tenure Executive members certainly knew; at CAH Oversight meeting level and at the time of the look back exercise #2 which ultimately led onto this SAI and RCA process. The Medical Director (MD3) was directly involved in the RCA process and the CEO was aware. At Trust Board level, it is thought that a non-Executive member was asked to examine the situation which would indicate that it had also reached that level.

Overall, the Review Team in considering whether there was a satisfactory escalation of this 'non-triage' issue have concluded that there was no evidence of consistent and proactive escalation of 'non-return of triage' either to the Medical Director or the Chief Executive until the look back exercise #2 basically forced the seriousness of the issue out into the open. Indeed,

they do not appear to have appreciated the importance of triage, certainly from the patient's perspective. The Trust's officers made efforts to address Cons1's non-triage over time but were consistently thwarted by Cons1's refusal to comply. The Trust failed to put systems, processes and fail safes in place to ensure Cons1's consistently triaged patient referrals until 2017.

Systems and processes have now been put in place so that the Head of Service for Urology reviews Cons1's compliance with triage. HoS1 will check all Urology triage on an adhoc basis but, with Cons1, she will check daily when he is the Consultant of the Week. Any non-compliance with returning referrals without triage is addressed immediately. However, this process is heavily dependent on HoS1 who, when she is on leave, often has to recover non-triaged cases upon her return.

## 8.0 LESSONS LEARNED

1. The clinical urgency category allocated by GPs to 30 patients referred to Urology were incorrect. The referrals using NICE guidance should have been referred as a Red Flag. Four (plus 1) of these patients were subsequently shown to have cancer.
2. The process of triaging Urology cancer referrals from Primary Care to Secondary Care, under the direction of the HSCB, appears to be less efficient than it could be, bearing in mind that NICE NG12 guidance has not been adopted and electronic referral using CCG is not being used as efficiently as it could.
3. GP's are not mandated to provide HSCB with an assurance that they comply with the most up to date NICE or other guidelines. Therefore, HSCB are unaware of any risks consequent upon the non-compliance with NICE and other guidance within GP practices.
4. GP's are not mandated to refer patients using CCG clinical criteria banners; this can lead to error and delay.
5. There is no Regional or Trust guidance or policy on what is expected of clinicians when triaging referral letters. Triage of patient referrals is obviously viewed as extremely important but does not seem to be at an equivalent level of importance when ranked alongside other clinical governance issues. Despite being an evident problem for decades and requiring considerable time and effort to find a solution, it only really surfaced within the Trust after an Index case forced the situation out into the open.
6. Despite it being absolutely clear to Consultant 1 (based upon his close proximity to the development and signing off of regional guidance) of the consequences of non-triage, he did not routinely triage referral letters. The Review Team consider that Cons1's refusal to triage to a level similar to other clinicians, led to patients not being triaged,

and this resulted in delays in assessment and treatment. This may have harmed one patient.

7. Cons1 confirmed that despite the Trust reminding him of the requirement to triage, he did not consistently triage referrals. He argued that, due to time pressures, he felt he was unable to perform the duties of the Consultant of the Week and his triaging duties. He has highlighted those views to Trust operational and management teams over a number of years.
8. The Trust made efforts to address Cons1's non-triage over time. However, the Trust failed to put systems, processes and fail safes in place to ensure Cons1 consistently triaged patient referrals until 2017. However, this safeguarding process is heavily dependent on the Head of Service checking triage is completed when Cons1 is Consultant of the Week.
9. The Informal Default Triage process allows patients who should be red flagged to remain on a waiting list of routine or urgent cases.
10. From examining the triaging issue over the length of time it has existed, it is obvious that there is an unwillingness or inability within the medical hierarchy to tackle its 'difficult colleague' problem. The reasons behind this probably include not taking ownership of its own problems and poor support from senior medical management perhaps resulting in issues not being referred upwards.

## 9.0 RECOMMENDATIONS AND ACTION PLANNING

### HSCB

#### **Recommendation 1**

HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.

#### **Recommendation 2**

HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices.

#### **Recommendation 3**

HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients.

### HSCB, Trust and GPs

#### **Recommendation 4**

GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields.

### TRUST

#### **Recommendation 5**

Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

#### **Recommendation 6**

The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW.

#### **Recommendation 7**

The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely manner.

#### **Recommendation 8**

The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list.

## 9.0 RECOMMENDATIONS AND ACTION PLANNING

### Recommendation 9

Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10.

### Recommendation 10

The Trust must set in place a robust system within its medical management hierarchy for highlighting and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence.

## CONSULTANT 1

### Recommendation 11

Consultant 1 needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner.

### Recommendation 12

Consultant 1 needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation 6.

## 10.0 DISTRIBUTION LIST

In addition to the Review Team, the following.

Mr S Devlin, Chief Executive SHSCT.

Dr Maria O'Kane, Medical Director, SHSCT.

Mrs Melanie McClements Interim Director of Acute Services.

Health & Social Care Board (HSCB).

Chairs of Morbidity & Mortality Groups SHSCT.

**Checklist for Engagement / Communication  
with Service User<sup>1</sup> / Family / Carer following a Serious Adverse Incident**

|                                                         |                                                         |                         |                                                         |
|---------------------------------------------------------|---------------------------------------------------------|-------------------------|---------------------------------------------------------|
| <b>Reporting Organisation</b><br><b>SAI Ref Number:</b> | <small>Personal Information redacted by the USI</small> | <b>HSCB Ref Number:</b> | <small>Personal Information redacted by the USI</small> |
|---------------------------------------------------------|---------------------------------------------------------|-------------------------|---------------------------------------------------------|

| <b>SECTION 1</b>                                                                                                                                                |                            |                                        |                                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------------------|-------------------------------------|
| <b>INFORMING THE SERVICE USER<sup>1</sup> / FAMILY / CARER</b>                                                                                                  |                            |                                        |                                     |
| 1) Please indicate if the SAI relates to a single service user, or a number of service users.<br><br><small>Please select as appropriate (✓)</small>            | <b>Single Service User</b> | <b>Multiple Service Users*</b>         | <input checked="" type="checkbox"/> |
| <b>Comment: 5</b><br><i>*If multiple service users are involved please indicate the number involved</i>                                                         |                            |                                        |                                     |
| 2) Was the Service User <sup>1</sup> / Family / Carer informed the incident was being reviewed as a SAI?<br><br><small>Please select as appropriate (✓)</small> | <b>YES</b>                 | <input checked="" type="checkbox"/>    | <b>NO</b>                           |
| If YES, insert date informed: 19.2.18                                                                                                                           |                            |                                        |                                     |
| If NO, please select <u>only one</u> rationale from below, for NOT INFORMING the Service User / Family / Carer that the incident was being reviewed as a SAI    |                            |                                        |                                     |
| a) No contact or Next of Kin details or Unable to contact                                                                                                       |                            |                                        |                                     |
| b) Not applicable as this SAI is not 'patient/service user' related                                                                                             |                            |                                        |                                     |
| c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user                                            |                            |                                        |                                     |
| d) Case involved suspected or actual abuse by family                                                                                                            |                            |                                        |                                     |
| e) Case identified as a result of review exercise                                                                                                               |                            |                                        |                                     |
| f) Case is environmental or infrastructure related with no harm to patient/service user                                                                         |                            |                                        |                                     |
| g) Other rationale                                                                                                                                              |                            |                                        |                                     |
| If you selected c), d), e), f) or g) above please provide further details:                                                                                      |                            |                                        |                                     |
| 3) Was this SAI also a Never Event?<br><small>Please select as appropriate (✓)</small>                                                                          | <b>YES</b>                 |                                        | <b>NO</b>                           |
| 4) If YES, was the Service User <sup>1</sup> / Family / Carer informed this was a Never Event?<br><br><small>Please select as appropriate (✓)</small>           | <b>YES</b>                 | If YES, insert date informed: DD/MM.YY |                                     |
|                                                                                                                                                                 | <b>NO</b>                  | If NO, provide details:                |                                     |
| <b>For completion by HSCB/PHA Personnel Only (Please select as appropriate (✓))</b>                                                                             |                            |                                        |                                     |
| Content with rationale?                                                                                                                                         | <b>YES</b>                 |                                        | <b>NO</b>                           |

| <b>SHARING THE REVIEW REPORT WITH THE SERVICE USER<sup>1</sup> / FAMILY / CARER</b><br><small>(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)</small> |            |           |                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-----------|-------------------------------------|
| 5) Has the Final Review report been shared with the Service User <sup>1</sup> / Family / Carer?<br><br><small>Please select as appropriate (✓)</small>                                                                           | <b>YES</b> | <b>NO</b> | <input checked="" type="checkbox"/> |
| If YES, insert date informed:                                                                                                                                                                                                    |            |           |                                     |
| If NO, please select <u>only one</u> rationale from below, for NOT SHARING the SAI Review Report with Service User / Family / Carer:                                                                                             |            |           |                                     |
| a) Draft review report has been shared and further engagement planned to share final report                                                                                                                                      |            |           |                                     |
| b) Plan to share final review report at a later date and further engagement planned                                                                                                                                              |            |           | <input checked="" type="checkbox"/> |



**SHARING THE REVIEW REPORT WITH THE SERVICE USER<sup>1</sup> / FAMILY / CARER**
*(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*

|                                                                                     |                                                                                                                                                 |    |
|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|----|
|                                                                                     | c) Report not shared but contents discussed<br>(if you select this option please also complete 'I' below)                                       |    |
|                                                                                     | d) No contact or Next of Kin or Unable to contact                                                                                               |    |
|                                                                                     | e) No response to correspondence                                                                                                                |    |
|                                                                                     | f) Withdrew fully from the SAI process                                                                                                          |    |
|                                                                                     | g) Participated in SAI process but declined review report                                                                                       |    |
|                                                                                     | (if you select any of the options below please also complete 'I' below)                                                                         |    |
|                                                                                     | h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user <sup>1</sup> family/ carer |    |
|                                                                                     | i) case involved suspected or actual abuse by family                                                                                            |    |
|                                                                                     | j) identified as a result of review exercise                                                                                                    |    |
|                                                                                     | k) other rationale                                                                                                                              |    |
| l) If you have selected c), h), i), j), or k) above please provide further details: |                                                                                                                                                 |    |
| <b>For completion by HSCB/PHA Personnel Only (Please select as appropriate (✓))</b> |                                                                                                                                                 |    |
| Content with rationale?                                                             | YES                                                                                                                                             | NO |

**SECTION 2**
**INFORMING THE CORONERS OFFICE**
**(under section 7 of the Coroners Act (Northern Ireland) 1959)**
*(complete this section for all death related SAs)*

|                                                                                                                                      |                                    |  |    |  |     |  |           |  |
|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|--|----|--|-----|--|-----------|--|
| 1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death?<br>Please select as appropriate (✓)           | YES                                |  | NO |  |     |  |           |  |
|                                                                                                                                      | If YES, insert date informed:      |  |    |  |     |  |           |  |
|                                                                                                                                      | If NO, please provide details:     |  |    |  |     |  |           |  |
| 2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner?<br>Please select as appropriate (✓) | YES                                |  | NO |  |     |  |           |  |
|                                                                                                                                      | If YES, insert date report shared: |  |    |  |     |  |           |  |
|                                                                                                                                      | If NO, please provide details:     |  |    |  |     |  |           |  |
| 3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed?<br>Please select as appropriate (✓)              | YES                                |  | NO |  | N/A |  | Not Known |  |
|                                                                                                                                      | If YES, insert date informed:      |  |    |  |     |  |           |  |
|                                                                                                                                      | If NO, please provide details:     |  |    |  |     |  |           |  |

|                                 |                  |
|---------------------------------|------------------|
| <b>DATE CHECKLIST COMPLETED</b> | <b>22.5.2020</b> |
|---------------------------------|------------------|

<sup>1</sup> Service User or their nominated representative

Report of Mr C Dawson BSc FRCS MS LLDip / GMC 3124839  
Consultant Urological Surgeon  
On behalf of Claimant – Patient 13

### Medical Records

- 15 Jan 96 – Letter from Dr Patterson. "...continues to complain of intermittent bladder symptoms....I think we should now try and get him off the steroids but leave him on cyclophosphamide..."
- 14 Jun 1996 – Discharge letter. Admitted 29 May 96 with haematuria and dysuria. Flexible cystoscopy – patchy degree of cystitis with granulomatous lesion. MSU positive for infection
- 18 Jun 96 – Letter from Dr Watt, Consultant Neurologist. Current treatment with Prednisolone 60mg and Cyclophosphamide 150mg per day
- 8 Jul 1996 – Letter from Dr Patterson, Consultant Neurologist

RE: Patient 13 Personal information redacted by USI

I saw him today at last and I am delighted about his muscle disease because he is now normally strong and you have found his CK to be perfectly normal and so it seems that his dermatomyositis is well controlled.

I think he should reduce his Prednisolone now to 30 mgs and in 1 months time if his CK is still normal to 20 mgs.

I will see him here in 6 weeks time.

We discussed the Cyclophosphamide. The situation as far as I am concerned is quite clear, Patient 13 had bladder symptoms before he started Cyclophosphamide. His urine at that time did not contain any red blood cells and ultrasound of his bladder appeared to be normal. He was apparently told when he was being investigated by Mr Brien that the Cyclophosphamide might be causing the bladder symptoms which were found in Craigavon. He was put on Cyclophosphamide because it was a last resort treatment for a potentially life threatening disease. I think he would need to have a lot of red cells in his urine persistently for me to think that Cyclophosphamide was involved in his bladder disease and I certainly would be very adverse to him stopping it.

The long term aim is to keep Patient 13 on some control for 2-3 years and then try and wean him off the drugs. I have explained all this in words of 1 syllable to Patient 13 and his Mother today.

Yours sincerely

- 2 Oct 1996 – Letter from Dr S Woolsey, SHO to Mr O'Brien

Report of Mr C Dawson BSc FRCS MS LLDip / GMC 3124839  
Consultant Urological Surgeon  
On behalf of Claimant – Patient 13

Dear Dr Hackett

This thirty year old gentleman was admitted to Ward 2 South on 1.10.96. As you know, he has had a history of frequency, nocturia and dysuria, associated with haematuria for some time now. Previous flexible cystoscopy showed a lesion in the bladder. This was a booked admission for transurethral resection of this bladder lesion. However, at cystoscopy, the bladder was entirely normal. Multiple biopsies were taken. As you know, he has a history of dermatomyositis and has been on Cyclophosphamide. Histology showed some atypia with granulomatous inflammation. It was unsure whether this was related to the Cyclophosphamide therapy or not. He was discharged home on 3.10.96 to be reviewed at the out-patient clinic on 19.11.96. We will keep you informed on his progress.

Yours sincerely

- 12 May 97 – Letter from Mr O'Brien. "Further to previous correspondence pertaining to this gentleman, I write belatedly to confirm that I reviewed him on 19 November of last year, finding him to remain very well indeed. I have arranged to review him again in 6 months' time"
- 14 Aug 97 – Letter from Dr J Hamill, SHO to Mr O'Brien

I reviewed this gentleman at Mr O'Brien's clinic today. He has been remaining quite well until approximately 2 weeks ago when he developed symptoms of frequency, haematuria and dysuria. He also tells me that he noted his urine to be cloudy. He was commenced on Trimethoprim by your goodself which appears to have had some effect. He has no other symptoms, but I do note he is on Cyclophosphamide. Today I will be checking a routine FBP, U&E and his MSU. I have told him if his symptoms do not settle within the next few days to return to your good self. We will review him in 2 weeks.

- 16 Oct 97 – Letter from Urology Registrar

The above named gentleman who suffers from dermatomyositis and is on regular doses of Cyclophosphamide was reviewed in the urology outpatients today. He still continues to have nocturia and terminal haematuria with a burning sensation. On his last visit in July 1997 he was commenced on Trimethoprim 200mgs and Cimetidine 400 mg tablets, twice daily. Unfortunately this treatment has not helped him. He also has been on long term treatment with Cyclophosphamide. Suspect he might have ongoing symptoms due to urothelial toxicity caused by Cyclophosphamide. After discussing this with Mr O'Brien I am putting him on Mesna 400mgs once daily orally for a period of 3 months and we have checked his MSSU today and his name has been transferred from flexible cystoscopy list to the rigid cystoscopy list. We will keep you informed.

Yours sincerely

- 26 Nov 97 – Letter from Dr Patterson. "he still complains of the bladder symptoms"
- 3 Feb 98 – Letter from Urology Registrar. "Patient 13's recent urine culture indicates a urinary tract infection with coliforms"

Report of Mr C Dawson BSc FRCS MS LLDip / GMC 3124839  
 Consultant Urological Surgeon  
 On behalf of Claimant – Patient 13

- 17 May 99 – Letter from Mr O'Brien

Further to Mr Thompson's letter of 3 February 1998, I write to advise you that Patient 13 was subsequently reviewed in May of last year, and again in June of last year. As you will recall, we believe that Patient 13 has had a Cyclophosphamide induced cystitis. Generally speaking, his lower urinary tract symptoms have improved since discontinuing the Cyclophosphamide and since being managed with MESNA. At review in May of last year, Patient 13 had by then discontinued the MENSEA as well as the Cyclophosphamide. Whilst he no longer had any nocturia, and had decreasing diurnal urinary frequency, he still did have occasional frank haematuria, this was confirmed by urinary microscopy in May of last year, when it was also noted that he had minimal pyuria and bactiuria. However, urinary culture was negative. When I reviewed him on 16 June of last year, I advised him that we should have him readmitted for cystoscopy under general anaesthesia at some time in the future. I have not been able to arrange his admission to date but I will arrange to do so in due course.

- 26 Jan 01 – Letter from Mr Wilson, Consultant Urologist

Patient 13 is on the waiting list for cystoscopy and bladder biopsies. He gives a history of Dermatomyositis and was on Cyclophosphamide in April 1996. The then had frank haematuria associated with dysuria. Patient 13 tells me he had a cystoscopy and his bladder appeared normal but biopsies showed atypia. He stopped taking Cyclophosphamide and he has been well since then with no further blood. Urinalysis today was clear.

I do not think Patient 13 requires a cystoscopy at this stage and I have discharged him back to your care.

- 28 Jul 16 – GP referral to Urology. Marked as Routine

Reason for Referral/ History of Presenting Complaint

Description:

Comment:

Episode of single haematuria 4 wks ago, no associated flank pain, nil since.  
 No other urinary symptoms.  
 Normal cystoscopy in 1996 for haematuria in context of dermatomyositis.  
 o/e abdo snt, prostate enlarged, nodule right lobe

- 23 Jan 17 – Letter from Southern Care and Social Care Trust informing Claimant of Haematuria Clinic Appointment on 31<sup>st</sup> January 2017
- 31 Jan 17 – Letter from Urology

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**From:** Glackin, Anthony [Personal Information redacted by the USI]  
**Sent:** 13 September 2018 17:15  
**To:** Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael  
**Subject:** 24th September 2018

Dear All,

Further to discussion today we will meet as a group of Consultants from 9am -1pm with a break for coffee.

We will meet with the nurses and Martina (if she is able to attend) from 2-4pm.

Please forward topics for discussion to me.

It is envisaged that we will need to meet again with the whole group including trust management in November.

Kind regards

Tony

Anthony J Glackin MD FRCSI(Urol)  
Consultant Urologist  
SHSCT

Secretary: Elizabeth Troughton [Personal Information redacted by the USI]

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**From:** Glackin, Anthony [Personal Information redacted by the USI]  
**Sent:** 27 November 2018 16:11  
**To:** Corrigan, Martina; Caddell, Caroline; O'Neill, Kate; McMahon, Jenny; McCourt, Leanne; Young, Jason; Haynes, Mark; Hennessey, Derek; Jacob, Thomas; O'Brien, Aidan; O'Donoghue, JohnP; Young, Michael  
**Subject:** Away day draft minutes  
**Attachments:** Away day draft minutes.docx

Please forward any corrections to me.

Thanks  
Tony

## Minutes of Urology Service Development Day

### Consultants Meeting

**In attendance:** Mr Young,  
Mr O'Brien,  
Mr Haynes,  
Mr Glackin,  
(Mr O'Donoghue joined later).

#### **1.1 Urologist of the week working model.**

This topic was discussed extensively with each consultant able to contribute to the discussion. The consensus was that the inpatient ward round was of prime importance requiring consultant presence. The structure for referral and advice provided needs to be improved. Where possible definitive care should be delivered during the current inpatient stay.

#### **1.2 Triage of new referrals.**

The Trust needs to provide a plan detailing what exactly it expects the consultants to do in terms of triage. This must include recognition of the time constraints and time commitment required to complete triage including time spent speaking to patients, booking scans, reviewing results and mitigating risk for patients on the current long outpatient waiting list. Consideration was given to decoupling the triage activity from that of the Urologist of the week.

#### **1.3 Annual leave.**

The team is to define the number of consultants and other members of middle grade staff who can be away at any one time. Discussion of Christmas and Summer holidays should be well in advance of holiday time to permit good planning. A process for agreeing leave should be developed and adhered to.

#### **Other business:**

Mr O'Brien tabled a written document setting out his issues of concern for discussion at the meeting. Similarly Mr Young provided an email listing topics for discussion. It was suggested that those items not discussed should be given time at the weekly departmental meetings.

- First Out Patient Consultation Waiting Times
- Development of care pathways (bladder cancer, LUTS/BOO)
- Outreach clinics
- Specialty Doctor Clinics
- Consultant Job Planning

- Care of Benign Urology Patient
- Cancer MDT
- Theatre allocation and usage
- Waiting List Management
- Winter pressure planning
- Technology & Equipment

## Meeting of consultants and senior nursing staff

### **In attendance:**

Sr Caddell,  
Sr McElvanna,  
Sr Magill,  
Sr Lockhart,  
Sr Magee,  
Sr O'Neill  
Sr McMahon,

Sr McCourt,  
Charge Nurse Young,  
Mr Young,  
Mr O'Brien,  
Mr Haynes,  
Mr Glackin,  
Mr O'Donoghue

### **2.1 Ward issues:**

1. Outlying of urology patients to facilitate medical inpatients.
2. Staff retention and vacancies.
3. Staff education program for Urology inpatient care.
4. Lack of medical support for medical inpatients on ward 3 South due to locum staff and a lack of continuity.
5. Interruptions to ward rounds.

### **2.2 Thorndale issues:**

1. Too few cystoscopes.
2. Clinics overrunning.
3. Requests for inpatient flexible cystoscopy.
4. Introduction of endoscopy check list.
5. New patient clinic running problems due to time keeping and case mix.
6. Provision of intravesical chemotherapy service.

Sr Leanne McCourt tabled a prostate cancer option grid to be piloted within the Department.

Sr Jenny McMahon tabled the Southern Health and Social Care Trust endoscopy safety checklist.



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**From:** Corrigan, Martina <Martina [redacted] Personal Information redacted by the USI>  
**Sent:** 30 November 2018 14:50  
**To:** [redacted] Aidan O'Brien's email address; [redacted] Michael Young's email address; Glackin, Anthony; Haynes, Mark; Mark [redacted] Mark Haynes's email address; Young, Michael; O'Brien, Aidan; ODonoghue, JohnP; [redacted] John P O'Donoghue's email address; Tony Glackin [redacted] Anthony Glackin's email address  
**Subject:** Monday 3 December

Dear all,

Apologies as I had meant to send this email earlier.

It has been agreed that the away day on Monday is cancelled but that the consultants and I would get together at 10am for a couple of hours to discuss some of the issues that had been raised on 24<sup>th</sup> September.

I have reinstated the PM activity.

Regards

Martina

Martina Corrigan  
Head of ENT, Urology, Ophthalmology and Outpatients  
Craigavon Area Hospital

**INTERNAL: EXT** [redacted] Personal Information redacted by the USI  
**EXTERNAL :** [redacted] Personal Information redacted by the USI  
**Mobile:** [redacted] Personal Information redacted by the USI



**Business Services  
Organisation**

**Directorate of Legal Services**

Practitioners in Law to the  
Health & Social Care Sector

2 Franklin Street, Belfast, BT2 8DQ

FAO: Andrew Anthony  
Tughans  
Marlborough House  
30 Victoria Street  
Belfast  
BT1 3GG

Date: 25<sup>th</sup> October 2020

Our Ref: ERLS104/03

Your Ref: AFA/AK/9MP28112

Dear Sir,

**RE: Your Client – Mr A O'Brien  
Our Client – Southern HSC Trust**

Thank you for taking my telephone call on Friday afternoon. As advised, the matter of my Client's ongoing review of your client's patient case load is now subject to media interest. As I explained, it is not known to my Client how the media has become aware of the concerns relating to your Client. The media interest was drawn to the attention of the Trust on Friday afternoon directly by The Irish News. The media outlet appeared to be aware of the relevant specialty, but your client was not mentioned by name. I explained that I was contacting you to advise you of this development as per your Client's request conveyed in your email of 16<sup>th</sup> July 2020 that the Trust should not correspond directly with your Client. However, my Client has made it clear that, given the very difficult circumstances which will undoubtedly result for your Client, including the potential for intense media interest, the Medical Director, Dr Maria O'Kane, would wish to speak directly with your Client. I trust that you will discuss this offer with your Client.

I also advised you yesterday of the increasing scale of concerns which continue to come to light as a result of the review exercise currently ongoing within the Trust regarding your client's practice.

A more detailed look back of your client's patient cases is still ongoing for the period 1<sup>st</sup> January 2019 to 30<sup>th</sup> June 2020. Mr Haynes' letter to your client dated 11<sup>th</sup> July 2020 included a summary of concerns following initial review of patient records for this period. I can confirm that the 2 potential Serious Adverse Incidents (SAI) identified in that summary, relating to

Patient 1

and Patient 9 have since been screened, and having met the threshold, these are now being addressed as SAI reviews.

As a result of the detailed ongoing review, additional serious concerns relating to your client's practice have been identified, and these are summarised as follows:

**Elective care** – the review has identified that your Client had operated on 334 patients, and out of these 120 patients were found to have undergone delays in dictation of their discharge with a further 36 patients having no record of their discharge on the Trust's electronic care record (NIECR). **Of the 36 patients, there have been 2 incidents identified that meet the threshold for SAI reviews.**

**Management of Pathology and Cytology Results** – the review has identified 50 out of 168 patients that require review as a result of un-actioned Pathology or Cytology results. **Of the 50 patients requiring review there have been 3 incidents identified that meet the threshold for SAI reviews with a further 5 requiring a review follow-up to determine if these patients have come to harm.**

**Management of Radiology Results** – the review has identified 1536 radiology results which require review to ascertain if appropriate action was taken. A review of the 1536 cases is ongoing.

**Actions required as a result of Multidisciplinary Team Meetings** – there were 271 patients under your client's care whose cases were discussed at Multidisciplinary Team Meetings. A review of these patient records is being undertaken. To date there are currently **3 confirmed SAI's and a further 1 needing a review follow-up** to determine if these patients have come to harm. This exercise is ongoing.

**Oncology Review Backlog** – 236 review oncology outpatients will be seen face to face by a Urologist in the independent sector for review. To date there has been **one SAI confirmed** from this backlog as the patient presented to Emergency Department and he has been followed up as a result of this attendance.

**Patients on Drug “Bicalutamide”** - There are concerns regarding your Client's prescribing of androgen deprivation therapy outside of established NICE guidance regarding the diagnosis and management of prostate cancer<sup>1</sup>.

*Bicalutamide is an Anti-androgen that has a number of recognised short term uses in the management of prostate cancer. In men with metastatic prostate cancer NICE Guidance states;*

*‘1.5.9 For people with metastatic prostate cancer who are willing to accept the adverse impact on overall survival and gynaecomastia with the aim of retaining sexual function, offer anti-androgen monotherapy with bicalutamide<sup>[6]</sup> (150 mg). [2008]*

*1.5.10 Begin androgen deprivation therapy and stop bicalutamide treatment in people with metastatic prostate cancer who are taking bicalutamide monotherapy and who do not maintain satisfactory sexual function. [2008]’*

All patients currently receiving this treatment are being identified by a number of parallel processes utilising Trust and HSC / Primary Care systems in order to facilitate a review to ascertain if the ongoing treatment with this agent is indicated or if an alternative treatment / management plan should be offered.

**In the interests of immediate patient safety, the Trust is requesting details of your Client's prescribing practices regarding anti-androgen therapy and specifically with regard to Bicalutamide. This can be undertaken in the form of a video discussion, telephone call or written format. Given the severity of this concern and the potential implications for affected patients, my Client asks that this is provided as a matter of urgency.**

#### **Summary table of Serious Adverse Incidents (SAI) confirmed to date**

The following table contains the summary details of the SAI reviews required to date. The SAI process will be led by an external independent Chair, commissioned by the Trust and the Public Health Agency.

| <b>Element of Concern</b>                                                                                                                                                                                                                                                                                                                                                                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Elective Exercise</b><br>** had a follow up CT scan of chest abdomen and pelvis performed on 17 December 2019 which was reported on 11 January 2020. The indicate for this was restaging of current renal cell carcinoma. ** had a right radical nephrectomy March 2019. The report noted possible sclerotic metastasis in L1 vertebral body. Result was not actioned. Patient contacted with result on 28 July 2020 and further |

<sup>1</sup> Prostate cancer: diagnosis and management. National Institute for Health and Care Excellence. NICE guideline 131. May 2019.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| assessment required                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Elective Exercise</b><br>Patient underwent TURP on 29/1/20. Pathology reported incidental prostate cancer. No follow-up or action from pathology result until picked up from elective exercise                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Pathology</b><br>Patient diagnosed with prostate cancer Gleason 7. MDM 08/08/19- Significant Lower urinary tract symptoms but declined investigations. On maximum androgen blockade - No onward oncology referral was made.                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Pathology</b><br>Diagnosed with penile cancer, recommended by cancer MDM for CT scan of Chest, Pelvis and Abdomen to complete staging. Same delayed by 3 months.                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Pathology</b><br>Patient diagnosed with a slow growing testicular cancer (Seminoma) had delayed referral to oncology and therefore delay in commencing chemotherapy.                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>MDM</b><br>CT renal report of 13/11/2019 unsigned on NIECR. No record of action taken recorded in NIECR. Case identified at urology MDM of 3/9/2020 following review of backlog                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>MDM *deceased</b><br>(Previously notified in Mr Haynes' letter (11.7.20) as potential SAI – Patient 1)<br>** was diagnosed with locally advanced prostate cancer in August 2019. An MDT discussion on 31 October 2019 recommended androgen deprivation therapy (ADT) and external beam radiation therapy (EBRT). ** was not referred for EBRT and his hormone treatment was not as per guidance. In March 2020 ** PSA was rising and when restaged in June 2020 ** had developed metastatic disease                                                                                                             |
| <b>MDM/ Bicalutamide *deceased</b><br>MDM outcome not followed and inadequate treatment given. MDM outcome = commence LHRHa. Started on low dose of bicalutamide (unlicensed and sub-therapeutic dosage), subsequently re-presented with local progression January 2020 and appropriate treatment (Degarelix) was given along with TUR and stent / nephrostomy. The evidence for LHRHa in context of metastatic disease is that it reduces the risk of local progression (renal failure and spinal cord compression). This man had inadequate treatment and experienced a complication likely as a result of this. |
| <b>Review Op Backlog</b><br>(Previously notified in Mr Haynes' letter (11.7.20) as potential SAI – Patient 9)<br>In May 2019 ** had an assessment which indicated he had a malignant prostate. ** was commenced on androgen deprivation therapy (ADT). Reviewed in July 2019 in outpatients and planned for repeat PSA and further review. Patient lost to review and attended Emergency Department in May 2020. Rectal mass investigated and diagnosed as locally advanced prostate cancer                                                                                                                        |

I would reiterate that given the number of patient cases from this review period (January 2019 to June 2020), this review exercise continues to be ongoing, and the above information is the current position at this point in the review. I would advise that it is very likely that my Client will be required to undertake an incremental approach to the review of patients and further time periods prior to January 2019 will undoubtedly have to be considered in a similar way.

As a result of the concerns being identified, my Client issued an Early Alert to the Department of Health and has continued to update Departmental Officials on the extent of the emerging concerns. As you will appreciate, the matter is of significant concern to the Department and my Client has been advised of the Department's intention to have external oversight of various work streams arising from the ongoing review exercise being undertaken by my Client. It is expected that the Minister for Health will make a statement to the NI Assembly in the coming days in relation to the concerns and ongoing review by my Client. The Trust anticipates that the Department of Health/the Minister will need to consider whether your client should be referred to in the course of this statement.

In light of the concerns, the Chief Medical Officer has deemed that it is appropriate to issue a Professional Alert as per guidance found in DHSSPS Circular HSS (TC8) 6/98 (copy attached).

The General Medical Council has also been updated regarding the emerging position.

I will of course contact you as quickly as possible if or when my Client is made aware of any planned timescale for Assembly and / or media activity.

Yours faithfully,

Personal Information redacted by the USI

June Turkington  
Assistant Chief Legal Adviser

Phone:

Personal Information redacted by the USI

Email:

Personal Information redacted by the USI

Att: Circular HSS (TC8) 6/98

**Aimee Crilly**

---

**From:** Andrew Anthony  
**Sent:** 16 July 2020 14:35  
**To:** 'Vivienne.Toal' Personal information redacted by the USI

Dear Ms Toal

**MR AIDAN O'BRIEN**

You have previously been corresponding with my colleague, Patricia Rooney, in respect of my client Mr Aidan O'Brien. I would be grateful if you would note that I am dealing with the case from this point onwards. My instructions are from the MPS.

Can you please note that all further correspondence should be forwarded to me. No further correspondence should be sent directly to Mr O'Brien.

I am writing to you to provide observations in relation to correspondence, from Mr Haynes of 11 July 2020, and received by Mr. O'Brien on 12 July 2020. I am not replying directly to Mr Haynes as he appears to be the individual who has raised concerns and has either investigated, or caused an investigation to be undertaken. As such he forms part of the factual matrix and thus it would be inappropriate for him to make further decisions in relation to what, if any, further action is appropriate.

I reserve my client's position in relation to whether it is appropriate for you to undertake any decision making role. I do however need a point of contact at the Trust to respond to.

Mr O'Brien's comments have been invited on concerns outlined in a document attached to Mr Haynes' correspondence entitled "Summary of Concerns".

Under the MHPS framework, which is quoted as being the basis of Mr Haynes' investigation, it is necessary "*to ascertain quickly what has happened and to establish the facts*", There is an obligation here to clarify what has happened and the nature of the problem or concern. To do so than requires input from the clinician concerned.

Mr O'Brien cannot comment on the broad ranging allegations contained in the document entitled "Summary of Concerns" without the underlying data upon which that document is based. It is inappropriate and unfair to ask him to do so, given the numerous patients that are referred to, yet not a single piece of supporting documentation has been provided. In any event having received correspondence on a Sunday, prior to bank holidays, allows him less than three working days to obtain advice. Such advice cannot meaningfully be obtained in the absence of underlying documentation and in the absence of the underlying documentation relied upon and in such an unreasonable timescale.

Mr O'Brien notes the restrictions which have been imposed as outlined in Mr Haynes' letter. It is however concerning that such restrictions were imposed on Mr O'Brien in the absence of any opportunity for him to comment on the allegations that have been raised.

Mr O'Brien has not seen private patients since the early days of the pandemic, due to the obvious risk of importing the Corona virus to his home. As a consequence, he had already decided not to resume private practice. Therefore, he has no difficulty in undertaking to refrain from seeing any private patients at his home or any other setting.

My colleague Patricia Rooney has been in touch with you in relation to the two NHS patient records which Mr O'Brien had in his possession. Mr. O'Brien has confirmed that these have been collected from his home. He has no further records.

Yours sincerely,

**ANDREW ANTHONY**

Partner

Personal Information redacted by the USI

T: +44 (0)

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M: +44 (0)

D: +44 (0)

Tughans / Marlborough House, 30 Victoria Street, Belfast BT1 3GG

In order to protect our staff, their families and our clients, our staff are now working remotely.

We are all still available by telephone and email and will ensure that you will continue to receive a prompt response.

A complete list of contacts is available on our [website](#).

Thank you in anticipation of your understanding and cooperation.

**Tughans**

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Northern Ireland

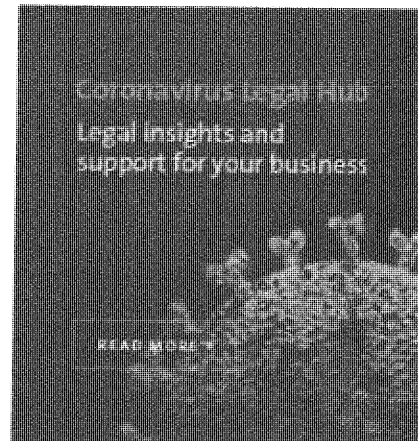
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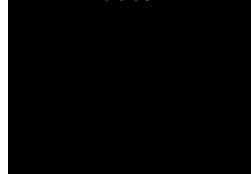


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Personal Information redacted by  
the USI



31 July 2020.

Mr. Chris Brammall,  
Investigation Officer,  
General Medical Council,  
3 Hardman Street,  
Manchester,  
M3 3AW

Dear Mr. Brammall,

GMC Registration: 1394911

Thank you for your email of 29 July 2020.

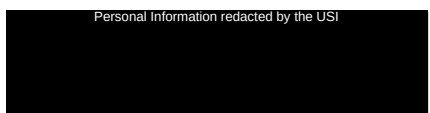
As you have noted, my employment with the Southern Health & Social Care Trust has terminated, my last day in its employment being Friday 17 July 2020.

As requested, I write to confirm that I am not in employment elsewhere, and I have no intention of applying for employment elsewhere, including any employment as a locum, or with any locum agency.

As you have indicated, I have undertaken not to resume private practice which ceased in early 2020 due to Covid 19 and which I had not intended to resume in any case due to the ongoing risks associated with Covid 19. Therefore, I confirm that I do not intend any resumption of private practice, now that my NHS practice has terminated. I will advise patients of my retirement from private practice, and their GPs if indicated, to ensure continuity of care.

Yours sincerely,

Personal Information redacted by the USI



Aidan O'Brien

Tughans

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**STRICTLY PRIVATE AND CONFIDENTIAL  
TO BE OPENED BY ADDRESSEE ONLY**

Dr Michael McBride  
Chief Medical Officer  
Castle Buildings  
Stormont Estate  
Belfast  
BT4 3SQ

Our Ref: AFA/AK/00003911.100  
9MP28112

Your Ref:

Date: 10 November 2020

**BY EMAIL**

Personal information redacted by the USI

Dear Dr McBride

**RE MR AIDAN O'BRIEN**

GMC Registration No: 1394911

Please note that I have been instructed by the Medical Protection Society on behalf of Mr Aidan O'Brien, Consultant Urologist.

I was notified on 25 October 2020 by the Department of Legal Services on behalf of its client, Southern Health and Social Care Trust (hereinafter "the Trust"), that:-

*"..... the Chief Medical Officer has deemed that it is appropriate to issue a professional alert as per the guidance found in DHSSPS Circular HSS(TC8) 6/98 (copy attached)".*

It is unclear whether such an alert letter has in fact been issued. If it has been issued, it is unclear to whom it has been sent.

Issuing such a letter is significantly damaging to Mr O'Brien's reputation.

The Trust raised a number of matters in correspondence with Mr O'Brien of 11 July 2020 (and which it reported to the GMC at that time). On that occasion, Mr Haynes, on behalf of the Trust, requested Mr O'Brien to give an undertaking "To refrain from seeing any private patients at your home or in any other setting." I responded on behalf of Mr O'Brien, on 16 July 2020 including the following comments:-

*"Mr O'Brien has not seen private patients since the early days of the pandemic, due to the obvious risk of importing the coronavirus to his home. As a consequence, he had already decided not to resume private practice. Therefore, he has no difficulty in undertaking to refrain from seeing any*

|                    |    |                      |
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| Belfast BT1 3GG    | E  | law@tughans.com      |

A full list of our partners is available for inspection at the above office | Partners qualified to practice in the Republic of Ireland: Andrew Anthony, Neil Smyth, Timothy Kinney & Alistair Wilson.  
Service address in the Republic of Ireland: Hamilton House, 28 Fitzwilliam Place, Dublin 2.

**00003911/100.6568374.1**

private patients at his home or any other setting."

This approach demonstrates that Mr O'Brien was quite prepared to liaise with the Trust in relation to clinical commitments be they within, or outside, the Trust. The Trust did not request Mr. O'Brien to give an undertaking not to seek employment elsewhere. Had the Trust requested such confirmation from Mr. O'Brien, it would have been provided. No such confirmation has been sought by the Trust at any time

On 31 July 2020 Mr O'Brien wrote to the GMC, at its invitation, confirming that he was not in employment and had no intention of applying for employment elsewhere. He also confirmed he had ceased private practice and had no intention of resuming it. Please see copy letter attached.

I understand that you have considered matters pursuant to DHSSPS Circular HSS(TC8) 6/98 (copy attached). That guidance is from a different era and is not in compliance with ECHR. It will be apparent to you the GMC has actively used its powers over the last 20 years to intervene, when necessary, to restrict a practitioners registration on an interim basis. Before an interim order is made the practitioner is put on notice and has the opportunity of making representations on the basis of available evidence before any decision is reached. Mr O'Brien was not been provided with such opportunity before any decision was made under (TC8) 6/89.

The criteria to be applied (TC8) 6/89 include:-

1. Consideration as to whether the "employee" (which Mr O'Brien no longer is) is a potential danger to the safety of patients (my paraphrasing); and
2. "The HSS Board or Trust have reason to believe that he/she would seek work elsewhere (either in a permanent position or as a locum)". (my emphasis)

Moreover, "The Processes for Issuing an Alert Letter", as detailed in Annex C, necessitate, "in all cases, it is considered that the doctor or dentist will seek employment elsewhere, either *permanently or as a locum*" before an alert letter is issued.

With regard to the first criterion, you should note that it is not accepted that Mr. O'Brien has been a danger to the safety of patients, and there are certainly no sufficient, reasonable grounds to support the view that he could be a potential danger to the safety of patients as, apart from any other consideration, Mr. O'Brien has retired from all practice with no intention to resume any form of work for which registration is required.

The purpose of this letter is to question how, in particular, the second criterion has been applied.

It is clear the second criterion has not been met. In the circumstances we have set out there is no reason to believe that Mr O'Brien has, or will, seek to work elsewhere. There is no possible basis for the Trust to have considered Mr O'Brien "will seek employment elsewhere".

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It is unclear whether you have been made aware Mr O'Brien has retired and provided an assurance to the GMC that he does not intend to work again. Prior to his retirement he was co-operative with the Trust in confirming that he was not treating private patients and had no intention of so doing. It is unclear to us when the Trust approached you in relation to issuing an alert letter.

The Trust did not approach Mr O'Brien to seek his views on either of the criteria outlined above. Had the simple question been asked whether he would seek work elsewhere, the Trust would have been advised of his position, as advised to the GMC. We do not know if the GMC has communicated the content of Mr O'Brien's letter to the Trust.

In the above circumstances there is no possible "reason" to believe Mr O'Brien would seek work elsewhere, and therefore no basis to make a decision under that limb of the criteria.

In light of the above either:

1. Confirm that no alert letter has been issued and will not be issued on the basis of the reassurances provided herein; or
2. If an alert letter has been issued, provide a copy of the letter and a list of recipients, in addition to confirming that you will take immediate steps to ensure the recall of the alert letter.

Please provide me with a response within 7 days.

Yours sincerely,

Personal information redacted by the USI

ANDREW ANTHONY

Personal information redacted by the USI

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|                    |    |                      |
|--------------------|----|----------------------|
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00003911/100.6568374.1

**GENERAL HEALTHCARE POLICY  
DIRECTORATE**

Mr Andrew Anthony  
Tughans Solicitors  
Marlborough House  
30 Victoria Street  
Belfast

General Healthcare Policy  
Directorate  
Room D2.9  
Castle Buildings  
Stormont Estate  
BELFAST  
BT4 3SQ

Date: 24 November 2020

Dear Mr Anthony,

**RE: YOUR CLIENT: MR AIDAN O'BRIEN**

Thank you for your correspondence dated 10 November 2020 relating to the issuing of a Professional Alert letter concerning your client.

I can confirm that under Departmental guidance circular HSS(TC8) 6/98, an alert letter was issued on 16 October 2020 to the Chief Executives of the following organisations: HSC Board, HSC Trusts, the Public Health Agency, Business Services Organisation, NHS Resolution, Practitioner Performance Advice (formerly NCAS) and the Chief Medical Officers in Scotland and Wales.

The alert letter provided the consultant's name and General Medical Council number and advised organisations to contact the Southern Trust's Medical Director if an application for permanent or temporary employment is made. A copy of the letter and its attachment are attached here for your information.

I can advise that Department was not in receipt of your client's letter to Mr Brammall of the GMC dated 31 July 2020 at the time the alert letter was issued. I can further advise that, in response to assurances having now been received from your client that he has no intentions to seek employment elsewhere, the Department is in the process of withdrawing the alert letter. I expect this to happen imminently.

Yours sincerely

Personal Information redacted by the USI

Michael O'Neill  
**Director of General Healthcare Policy**

cc: Dr Michael McBride

**Working for a Healthier People**

**FROM:** Ryan Wilson  
Director of Secondary Care

**DATE:** 6 August 2020

**TO:** Robin Swann MLA, Minister

**EARLY ALERT (182/20) - CONSULTANT UROLOGIST RESTRICTED FROM CLINICAL PRACTICE**

|                                 |                                                                                                                                                                                                                                                            |
|---------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>ISSUE:</b>                   | The Southern HSC Trust has submitted an Early Alert (EA 182/20) about a retired Consultant Urologist, who was restricted from clinical practice pending further investigation regarding approximately 230 patients who may have received sub-optimal care. |
| <b>TIMING:</b>                  | Immediate.                                                                                                                                                                                                                                                 |
| <b>PRESENTATIONAL ISSUES</b>    | Potential to attract media attention in the event it enters the public domain. DoH Press Office will liaise with colleagues in SHSCT to agree lines. Cleared by Press Office 6/8/20 (TS).                                                                  |
| <b>FOI IMPLICATIONS</b>         | Consideration should be given to Section 30 – investigations and proceedings conducted by public authorities.                                                                                                                                              |
| <b>FINANCIAL IMPLICATIONS</b>   | None                                                                                                                                                                                                                                                       |
| <b>LEGISLATION IMPLICATIONS</b> | None                                                                                                                                                                                                                                                       |
| <b>SPECIAL ADVISOR</b>          |                                                                                                                                                                                                                                                            |
| <b>COMMENTS:</b>                |                                                                                                                                                                                                                                                            |
| <b>RECOMMENDATION:</b>          | It is recommended that you note the details in this submission and the following: <ul style="list-style-type: none"><li>• <b>Annex A</b> – Early Alert notification from Southern HSC Trust; and</li><li>• <b>Annex B</b> – lines to take.</li></ul>       |

**Background**

1. An Early Alert was received on 31 July 2020 from the Southern Health and Social Care (HSC) Trust regarding concerns about a Consultant Urologist. A copy of the Early Alert is attached at **Annex A**.

2. The Trust also notified the Health and Social Care Board (HSCB) on 31 July 2020, as per the Early Alert protocol.

**Issue**

3. On 7 June 2020, potential concerns were raised with the Southern HSC Trust about the treatment of surgical patients under the care of a Trust employed Consultant Urologist, who has since retired from Trust employment at the end of June.
4. Given the potential patient safety concerns, the Trust conducted a review of the Consultant's work over a 17 month period to ascertain any wider service impacts. During this process, concerns were identified in: 46 of 147 surgical cases for the insertion of stents; 120 of 334 elective in-patients where delays of between 2-41 weeks were identified in the dictation of clinical notes with potential impact on their cancer diagnosis and prognosis (of which one case is being screened as a potential Serious Adverse Incident (SAI)); and, a further 36 patients with no record of care noted on the regional NIECR system. A further two recent cases are also being screened as potential SAIs.
5. The Trust has further advised officials that the cohort comprises approximately 230 patients who may have received sub-optimal care, and that the full scope of the Consultant's practice (i.e. work potentially carried out in other Trusts, in cross-border or in private healthcare settings) is not currently known.
6. An internal Trust meeting is planned for Monday 10 August to progress the matter and consider potential SAIs. In the meantime the following actions have been commenced.

**Current action**

7. Prior to retirement the Trust had restricted the Consultant's clinical practice and access to patient information. It has also written to the Consultant's solicitor to seek assurance that the Consultant refrains from private practice pending further investigation.

8. The Trust has notified the General Medical Counsel and held preliminary discussions with the Royal College of Surgeons Invited Review Service to understand the scope and scale of any further independent review.
9. The Trust will update the Department and HSCB in due course regarding three cases currently being screened as potential SAIs.
10. The HSCB is considering the EA and will provide further comment/advice to the Department if further escalation is deemed appropriate.

**Recommendation**

11. It is recommended that you note the details in this submission and the following:
  - **Annex A** – Early Alert notification from Southern HSC Trust; and,
  - **Annex B** – lines to take.

**Ryan Wilson****Ext no.** Personal  
Information  
redacted by**Copied to:**

Richard Pengelly  
CMO Office  
CNO  
Jackie Johnston  
Press Office  
Kim Burns  
Karen Jeffrey  
Joan Hardy  
SpAd



**Report to Department of Health on Consultant A**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| Date:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 14 October 2020                                                                           |
| Title:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Clinical Concerns within Urology – Southern Trust                                         |
| Lead Directors:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Mrs Melanie McClements – Director of Acute Services<br>Dr Maria O’Kane – Medical Director |
| <u>Key Strategic aims:</u><br><br>Delivery of safe, high quality effective care                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                           |
| <u>Key Issues/risks:</u><br><br>This report outlines a summary of the clinical concerns relating to Consultant A, the actions taken to review aspects of his practice and the development of appropriate management plans to minimise risk or harm to patients.<br><br>Consultant A is no longer employed as of 17th July 2020, having given his notice of his intention to retire from his substantive post. The Trust declined his request to return given outstanding employment matters relating to a previous MHPS case commenced on 30th December 2016.<br><br>Any patients identified where clinical concerns have been raised will be reviewed and followed-up. Due to capacity issues there is likely to be impact on other patients who are awaiting urological appointments/follow up.<br><br>Plans have been put in place to respond to primary care colleagues and to establish a targeted help line for patient concerns. |                                                                                           |

## **Background**

On 7th June 2020, the Trust became aware that 2 out of 10 patients listed for surgery under the care of Consultant A were not on the hospital's Patient Administration System at this time. As a result of these potential patient safety concerns a review of Consultant A's work was conducted to ascertain if there could be wider service impacts.

As a result of these potential patient safety concerns a review of Consultant A's work was conducted to ascertain if there were wider patient safety concerns and service impacts. The internal reviews, which considered cases over an 18 month period (period 1st January 2019 – 30 June 2020), identified the following:

- The first internal review concentrated on whether the patients who had been admitted as an emergency had had a stent inserted during procedure and if this had been removed. There were 160 emergency patients listed as being taken to theatre. 3 patients had not had their stent management plans enacted. Clinical Management has been subsequently arranged for these 3 patients.
- The second internal review was for 343 elective-in patients taken to theatre. Out of the 343 patients reviewed there have been **2 of these patients who have been identified as meeting the threshold of needing a Serious Adverse Incident Review.**

The following areas have been identified that immediately need to be reviewed and actions taken on these patients to mitigate against potentially preventable harm

1. **Jan 2019- June 2020** - Pathology and Cytology results: 168 patients with 50 patients needing reviewed. From this there has been **3 confirmed SAI with a further 5 requiring a review follow-up** to determine if they have come to harm.
2. This exercise has also now identified concerns of clinical practice in the prescribing of Bicalutamide drug has revealed examples of poor practice, delay in following up the recommendations from results/MDM's and delay in dictation to other health care professionals in the ongoing care and treatment of the patients. The full extent of this is not yet clear.
3. **Jan 2019- June2020** - Radiology results –1536 patients listed on NIECR. These patients may have had the results manually signed off and actioned but as we have identified cases where this hasn't happened we need to review all of these records to reassure ourselves that these have all been actioned. This exercise is ongoing.
4. **Jan 2019-July 2020** - MDM discussions – there are 271 patients who were patients of Consultant A and who were discussed at MDM, a review of these patient records is being undertaken. There are currently **2 confirmed SAI's and a further 2 needing a review follow-up** to determine if they have come to harm. This exercise is ongoing.

5. **Oncology Review Backlog** – 236 review oncology outpatients will be seen face to face by a retired Urologist in the independent sector. This consultant will either discharge or make appropriate plans for ongoing management and referral back the Southern Trust Urology Team MDM for further review/management. (Note to date there has been **one SAI confirmed** from this backlog as the patient presented to Emergency Department and he has been followed up as a result of this attendance).
6. **Patients on Drug “Bicalutamide” (raised in point 2 above)** - *this is an Anti-androgen that has a number of recognised short term uses in the management of prostate cancer. In men with metastatic prostate cancer NICE Guidance states;*

*‘1.5.9 For people with metastatic prostate cancer who are willing to accept the adverse impact on overall survival and gynaecomastia with the aim of retaining sexual function, offer anti-androgen monotherapy with bicalutamide<sup>[6]</sup> (150 mg). [2008]*

*1.5.10 Begin androgen deprivation therapy and stop bicalutamide treatment in people with metastatic prostate cancer who are taking bicalutamide monotherapy and who do not maintain satisfactory sexual function. [2008]’*

All patients currently receiving this treatment are being identified by a number of parallel processes utilising Trust and HSC / Primary Care systems in order to provide a review to ascertain if the ongoing treatment with this agent is indicated or if an alternative treatment / management plan should be offered.

### Summary table of Serious Adverse Incidents

| Element of Concern                                                                                                                                                                                                                                                                                                                                                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>MDM *RIP</b><br>** was diagnosed with locally advanced prostate cancer in August 2019. An MDT discussion on 31 October 2019 recommended androgen deprivation therapy (ADT) and external beam radiation therapy (EBRT). ** was not referred for EBRT and his hormone treatment was not as per guidance. In March 2020 ** PSA was rising and when restaged in June 2020 ** had developed metastatic disease |
| <b>Review Op Backlog</b><br>In May 2019 ** had an assessment which indicated he had a malignant prostate. ** was commenced on androgen deprivation therapy (ADT). Reviewed in July 2019 in outpatients and planned for repeat PSA and further review. Patient lost to review and attended Emergency Department in May 2020. Rectal mass investigated and diagnosed as locally advanced prostate cancer       |
| <b>Elective Exercise</b><br>** had a follow up CT scan of chest abdomen and pelvis performed on 17 December 2019 which was reported on 11 January 2020. The indicate for this was restaging of current renal cell carcinoma. ** had a right                                                                                                                                                                  |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| radical nephrectomy March 2019. The report noted possible sclerotic metastasis in L1 vertebral body. Result was not actioned. Patient contacted with result on 28 July 2020 and further assessment required                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Elective Exercise</b><br>Patient underwent TURP on 29/1/20. Pathology reported incidental prostate cancer. No follow-up or action from pathology result until picked up from elective exercise                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>MDM</b><br>CT renal report of 13/11/2019 unsigned on NIECR. No record of action taken recorded in NIECR. Case identified at urology MDM of 3/9/2020 following review of backlog                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Pathology</b><br>Patient diagnosed with prostate cancer Gleason 7. MDM 08/08/19- Significant Lower urinary tract symptoms but declined investigations. On maximum androgen blockade - No onward oncology referral was made.                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Pathology</b><br>Diagnosed with penile cancer, recommended by caner MDM for CT scan of Chest, Pelvis and Abdomen to complete staging. Same delayed by 3 months.                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Pathology</b><br>Patient diagnosed with a slow growing testicular cancer (Seminoma) had delayed referral to oncology and therefore delay in commencing chemotherapy.                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>MDM/ Bicalutamide (**RIP)</b><br>MDM outcome not followed and inadequate treatment given. MDM outcome = commence LHRHa. Started on low dose of bicalutamide (unlicensed and sub-therapeutic dosage), subsequently represented with local progression January 2020 and appropriate treatment (Degeralex) was given along with TUR and stent / nephrostomy. The evidence for LHRHa in context of metastatic disease is that it reduces the risk of local progression (renal failure and spinal cord compression). This man had inadequate treatment and experienced a complication likely as a result of this. |

### Immediate actions following discovery of concerns in June 2020

- Advice sought from NHS Resolutions (formerly NCAS) who recommended restrictions of clinical practice.
- Referral of these concerns in respect of Consultant A was made to the GMC. This doctor is already known to the GMC.
- In consultation with NHS Resolutions and the GMC, from discovery until the date of termination of contract, restrictions were placed by the Trust on the Consultant's practice. Consultant A was to no longer undertake clinical work and could not access or process patient information either in person or through others either in hard copy or electronically. A request was also made that he voluntarily undertake to refrain from seeing any private patients at his home or any other setting and same was confirmed in writing via Consultant A's solicitor.

- Given that Consultant A is no longer employed by the Southern Trust since the 29<sup>th</sup> July 2020, the Responsible Officer authority has now passed to the GMC. Consultant A has asked for all correspondence through his solicitor, Tughan and Company, Belfast. In keeping with the Regional Guidance, Health and Social Care Board, Procedure for the Reporting and Follow up of Serious Adverse Incidents (November 2016), the Trust together with the PHA and the Board has facilitated the establishment of a panel to undertake the Serious Adverse Incident Reviews identified in the course of reviewing Consultant A's patients. This is chaired by an independent Chair, with a Urology Consultant recommended by the Royal College of Surgeons as a Urology Subject Expert (from England).
- Early Alerts have been submitted to the Department of Health advising them of the professional performance and patient safety concerns.
- Two separate weekly meetings have been established since 11 August 2020
  - i. Internal oversight meeting - chaired by Director of Acute Services and Medical Director as Deputy Chair;
  - ii. External – Chaired by Director of HSCB with representatives from Trust, PHA, HSCB and Department of Health.

Preliminary discussions have been undertaken with the Royal College of Surgeons Invited Review Service regarding Consultant A's practice and potential scope and scale of any independent external reviews

### **Timescales**

Initial scoping exercises as outlined have been completed and initial reviews of aspects of Consultant A's work from January 2019 are underway as described. The Royal College of Surgeons has advised that any look backs required should be undertaken using a chronological and incremental approach, beginning with most recent first has been implemented. A resource plan is in development to identify clinical capacity for patient assessment and clinical management, information and communication; this will present significant challenges given the current workforce issues within the Urology speciality and in the context of an ongoing Covid 19 Pandemic

### **Previous concerns relating to Consultant A**

Previous concerns relating to Consultant A were being addressed since March 2016, and under Maintaining High Professional Standards from December 2016. The timeline for these previous concerns is included in Appendix One.

8. It was agreed that the panel established by the Trust to review the initial six SAIs should continue and that a separate clinical review panel would be established to conduct a wider review of the issues arising from this large group of SAIs which is unprecedented as a single group.

**Action: DoH** to confirm arrangements for establishing the clinical review panel prior to the Minister's Oral Statement in the Assembly.

### **Patient Records Scoping Exercise – update (Southern Trust)**

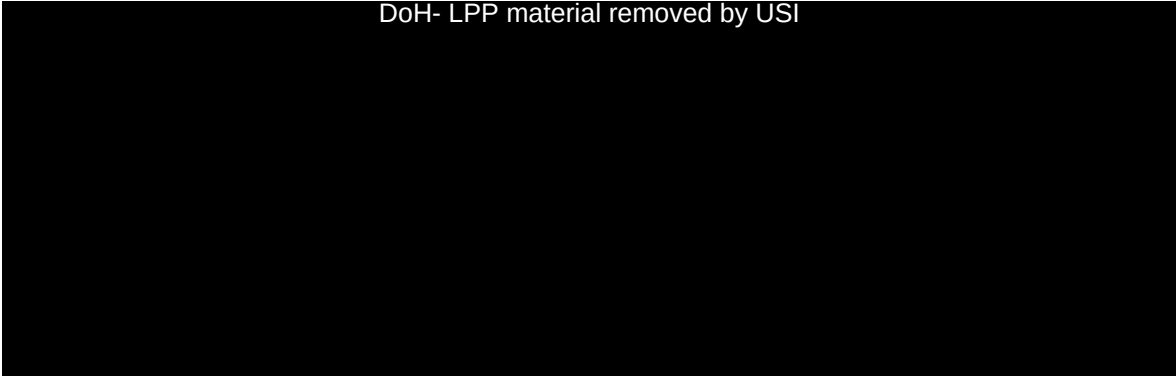
9. A detailed update on the Patient Record Scoping Exercise was provided by Maria O'Kane and Melanie McClements including:
  - the Patient Facing Information Line - a total of 151 calls received (up to and including Thursday 5 November);
  - Independent Sector Clinics –191 oncology review patients transferred to the Independent Sector; and
  - the Bicalutamide Audit - 26 patients identified from the first look into the patients and 2 all-day clinics were held in Craigavon.
10. The issue of private patients was discussed including the challenges in accessing records and information. It was agreed that BSO Internal Audit should undertake a review, as far as possible, of those patients transferring into Trust provision. Further it was agreed that efforts should be made to secure records and patient lists from the consultant and his legal advisors.
11. A review of deceased patients was discussed and it was agreed that this strand may be required but should await in the first instance further information emerging from the ongoing scoping exercise.
12. It was noted that the consultant was attached to the Craigavon Urological Research & Education (CURE) organisation and it was agreed that efforts should be made to ensure that no ongoing healthcare provision or advice was taking place.

**Action:** **Maria O’Kane** to confirm support arrangements with Royal College of Surgeons prior to the Minister’s Oral Statement in the Assembly.

**Action:** **DoH** to provide advice on engaging BSO Internal Audit to commence review.

**Action:** Southern Trust to establish if consultant has ceased activities relating to CURE. **(Maria O’Kane / Melanie McClements)**

DoH- LPP material removed by USI

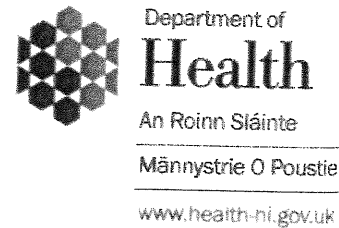


**Minister’s Oral Statement – update (Jackie Johnston)**

13. Jackie Johnston provided an update on preparations for the Minister’s Oral Assembly Statement, due to take place on Tuesday 17<sup>th</sup> November 2020. It was noted that the Urology Consultant will be named (which will likely help with the identification and engagement of relevant private patients affected) and that this may also impact the number of calls made to the helpline.
14. It was also agreed that mention should be included in the statement of the potential for redress aligned to arrangements that may develop on the Neurology side.

**Action:** Southern Trust to review statement excerpts for factual accuracy, returning to Department by 11 November 2020. **(Melanie McClements / Maria O’Kane)**

**Communications / Management Plan**



**ORAL STATEMENT TO THE ASSEMBLY BY HEALTH MINISTER ROBIN SWANN –  
TUESDAY 24 NOVEMBER 2020 – CLINICAL CONCERNS WITHIN UROLOGY AT  
SOUTHERN HEALTH AND SOCIAL CARE TRUST (EMBARGOED UNTIL  
STATEMENT IS MADE IN THE ASSEMBLY)**

Mr Speaker, it is with deep regret that I am informing the House this morning of a further occurrence of serious concerns about the clinical practice of a hospital consultant notified to my Department by one of our Health and Social Care Trusts.

This incident concerns the clinical practice of a urology consultant, Mr Aidan O'Brien, who earlier this year retired from the Southern Trust.

On 31<sup>st</sup> July 2020 the Southern Trust contacted my Department to report an Early Alert concerning the clinical practice of this consultant. The Trust informed my Department that on the 7<sup>th</sup> June 2020 it became aware of potential concerns regarding delays of treatment of surgery patients who were under the care of the consultant urologist employed by the Trust. The Trust became aware that 2 out of 10 patients listed for surgery under the care of this consultant were not on the hospital's Patient Administration System at that time.

As a result of these potential patient safety concerns, an initial lookback exercise in relation to the consultant's work was conducted, to ascertain if there were other areas of potential concern. This initial lookback, which considered cases over a 18 month period of the consultant's work in the Southern Trust (from 1<sup>st</sup> January 2019 – 30<sup>th</sup> June 2020), concentrated on whether patients had a stent inserted during a particular procedure and if this stent had been removed within the clinically recommended timeframe.

The initial lookback identified concerns with 46 cases within a total of 147 patients who had the particular procedure and were listed as being under the care of the consultant during the period addressed by the initial lookback exercise.

When my Department was contacted on the 31<sup>st</sup> July 2020, the Trust confirmed the following actions had already been taken:

- Discussions with the GMC employer liaison service had been conducted;
- The case had been discussed with NHS Resolutions who recommended restrictions of clinical practice;
- Restrictions were put in place by the Trust preventing the consultant from undertaking clinical work within the Trust and denying him access to or the ability to process patient information;
- The Trust also requested that the consultant voluntarily undertake to refrain from seeing any private patients at their home or any other setting and that he would confirm the same in writing; and
- A preliminary discussion was also undertaken with the Royal College of Surgeons Invited Review Service regarding the consultant's practice and the potential scope and scale of any further lookback exercise which may be required.



The Trust also established a Review Group to assess the further findings of the initial lookback exercise and to explore the potential need for a further lookback exercise in the context of the concerns emerging. This group has been working diligently since August and I am now in a position to inform the Assembly of its most recent findings.

Whilst Mr O'Brien has worked in the Southern Trust for 28 years, in consultation with the Royal College of Surgeons, the Review Group has looked at the timeframe from 1 January 2019 until 30 June 2020 and during this time there were a total of 2,327 patients under his care. The Review Group identified the most vulnerable group of urology patients within this cohort and has concentrated on these patients initially.

There are areas of concern relating to elective and emergency activity; radiology, pathology and cytology results; patients whose cases were considered in Multidisciplinary Team Meetings; oncology and in relation to the safe prescribing of an anti-androgen drug, outside of established NICE guidance in the management of prostate cancer.

Across those areas, to date 1,159 patients' records have initially been reviewed and 271 patients or families have been contacted by the Trust and their work continues across those areas of concern. Further details of the various review strands are appended to this oral statement.

So far 9 cases have been identified that meet the threshold for a Serious Adverse Incident (SAI) review and all 9 patients and / or their families have been contacted by the Trust to inform them of the position in relation to their respective cases. A further 6 cases are currently being reviewed in more detail to establish if those patients have come to harm.

The consultant also had a significant amount of private practice and that much of this was carried out in private domestic premises, therefore sitting outside of the regulatory framework which requires registration and external assurance of facilities in the Independent Sector in which clinicians may undertake private practice. This is also of significant concern to me as many of these patients may be unknown to the Southern Trust or the wider HSC system.

The Trust has issued a statement following a recent media report about this developing situation and has advised patients that if they are concerned about aspects of their Urology care and require further advice that they contact the Southern Trust by email or on its Urology Information Phone Line. The information line is available Monday – Friday 10:00 - 15:00 and the number is 0800 4148520.

I am sure that the House will agree with me that the issues identified by the Trust's Review Group are of the gravest concern. The impact of these concerns will be felt most severely by patients and their families affected and unfortunately we are only at the start of what is likely to become a long and detailed investigation into this matter. As Health Minister I want to firstly unreservedly apologise to these patients and their families for any upset and distress this has caused.

I would also wish to reassure them that I will endeavour to ensure that they obtain appropriate treatment, support and the care they need over the coming weeks and months.

There are a number of actions that I propose to take to uncover how this situation developed over a number of years without any apparent action being taken by the Trust to deal with the practice of this consultant before now. I need to quickly determine whether a further lookback exercise is required which might necessitate a significant review and recall of a larger group of patients than those identified to date as requiring a review of their clinical care and treatment. In addition, given the large number of cases that have been identified as meeting the threshold for an SAI review, particular action will be required to ensure that matters relating to these patients and their care and treatment are dealt with in an effective and timely way.

Mr Speaker I have therefore taken the following actions.

Firstly, I have established a Urology Assurance Group, chaired by the Permanent Secretary of my Department, to provide external oversight of the various work streams arising from the initial look back exercise initiated by the Southern Trust.

Specifically this group will review the progress of the initial look back exercise; it will consider emerging strategic issues; commission and direct further work as necessary; monitor the impact on urology and

related services in the Southern Trust; ensure coordination with other associated reviews or investigations;  
and oversee communication across all stakeholder groups, with patient care being the central focus throughout. I have published the Terms of Reference for this group alongside this statement.

Secondly, the Royal College of Surgeons has been commissioned to carry out an independent review of a sample of the clinical cases included in the initial lookback exercise to determine whether a further, more extensive, lookback or patient recall by the Trust is required.

Thirdly, in relation to his private patients who are not known to the Southern Trust, I have requested that his solicitors outline how Mr O'Brien intends to provide a similar independent process to ensure that those private patients are alerted to issues arising and that their immediate healthcare needs are being met. Whilst the Department has no explicit duty to take this particular matter forward, as part of our wider healthcare responsibilities, I want to do all I can to safeguard patients who may have received care or treatment in a private capacity from this consultant.

The remaining issues to be addressed relate to the management of all past, present and future cases that would meet the threshold for an SAI review; as well as establishing why this happened, and whether action could have been taken earlier by the Southern Trust to identify and address the apparent deficiencies in the consultant's clinical practice. Given the large number of cases already identified as meeting the threshold for an SAI review and my concerns that there may be more to come, a different and specific approach is required. The fourth action, therefore, that I intend to take is to establish a statutory public inquiry, under the Inquiries Act 2005.

I believe this is the best way to ensure that the full extent of the concerns are identified and for the patients and families affected to see these and all relevant issues are pursued in a transparent and independent way.

My officials are preparing the way to get this inquiry up and running as soon as possible. This will take some time and I would expect that the respective families and patients will have the opportunity to influence the terms of reference of the inquiry. I must also be mindful of the statutory duties placed on me to discuss these issues with the appointed Chair in advance of establishing the inquiry. Further details will be provided in this regard when they are available.

Inevitably this type of work leads to a range of statistics relating to patient numbers, records reviewed, patients contacted and so on. Members will know that behind every statistic there is a patient, a family, their story and experience. These types of exercises can cause upset, distress and anxiety. A significant element in all of this work, therefore, will be to communicate and support patients and their families as much as possible in the coming weeks and months. To help with this, the Southern Trust are developing a patient support package to include any counselling and psychological support needed, alongside provision of family liaison and related support services.

Members will be all too aware, that these significant concerns come hard on the heels of the recall of Neurology Patients by the Belfast Trust and I am sure that Members will be keen to see the outcomes of that Inquiry in due course.

I met recently with patients and families affected by the Neurology Recall and reiterated my apology to them for how they have been let down by the Health and Social Care system. To address *those* cases, as Members will know, an Independent Inquiry was initiated by the Department. That inquiry was established in the absence of Executive Ministers, when it was not possible to constitute the inquiry under the Inquiries Act. To date the work of this Independent Inquiry has been largely unaffected by that non-statutory approach and I would like to take this opportunity to thank Brett Lockhart QC and his team for their immense efforts in recent months.

However to ensure that in the closing stages of the Neurology Inquiry Mr Lockhart and his team have timely and unfettered access to all relevant information, I can announce that I also intend to convert the Independent Neurology Inquiry to a statutory public inquiry under the Inquiries Act 2005. It is important to note that the Inquiry team are at a very advanced stage of their evidence gathering process and I want to be clear that I do not intend for this decision to add to or alter the work or timescales of the Neurology Inquiry team, nor do I expect to see changes in the way that evidence has been gathered or how public access has been provided. That would not be in the interests of the patients and families

affected; they have already waited too long for answers. My officials will be in contact with Mr Lockhart as soon as possible to ensure the transition is as seamless as it can be.

Mr Speaker to conclude, this emerging situation within the Southern Trust causes me and my Department the gravest of concerns. While I remain convinced that the experience of patients who use our health services is overwhelmingly that of a safe and quality service, these incidents regrettably dent the confidence of service users. I fully acknowledge this and I will do all that I can to ensure that lessons are learnt, to prevent situations such as these occurring again.

I trust Members will agree that that what I have announced today constitutes robust and timely action to a deeply concerning situation.

I commend my statement to the Assembly.

## FACTSHEET

## ANNEX A

The Trust's review has identified that the consultant had operated on 352 elective patients between 1 January 2019 and 30 June 2020 and, out of these, 120 patients were found to have undergone delays in dictation of their discharge information, with a further 36 patients having no record of their discharge information recorded on the Trust's electronic care record (NIECR). Of these 36 patients, 2 incidents have been identified that meet the threshold for a Serious Adverse Incident (SAI) review.

The Trust's clinical review has identified that 168 patients required pathology / cytology investigations and 50 of these patients' results were unactioned and require review. Of these 50 patients, 3 incidents have been identified that meet the threshold for an SAI review with a further 5 cases requiring further information to determine if these patients have come to harm.

The Trust's review has identified a total of 1536 radiology results which require further assessment to ascertain if the appropriate action was taken. One third of these assessments have been completed and no concerns have been identified to date. Reviews of the remaining radiology results are ongoing.

There were 271 patients under the consultant's care whose cases were discussed at Multidisciplinary Team Meetings. A review of these patients' records is being undertaken. To date there are 3 cases which meet the threshold for an SAI review and a further 1 case is being reviewed. This exercise is ongoing.

A total of 236 oncology patients were deemed to be part of a backlog relating to Oncology Reviews. The Trust is arranging for these patients to be reviewed by a Consultant Urologist in the Independent Sector. To date a total 191 oncology review patients transferred to the Independent Sector and clinics are fully booked for the month of November for these patients. To date 1 case from this group has been identified as meeting the threshold for an SAI review.

The exercise also identified concerns regarding the consultant's prescribing of Bicalutamide, an anti-androgen drug, outside of established NICE guidance in the management of prostate cancer. Out of 300 patients, 26 men receiving this treatment have been identified by the Trust as needing a clinical review and are being reviewed urgently by a Consultant Urologist and Pharmacist. All 26 were contacted and invited to review appointments. The Trust is now conducting a further review to establish if there are any further patients who may need their prescribed medication revised.

## **UROLOGY ASSURANCE GROUP TERMS OF REFERENCE**

### **Background**

The Department received a confidential Early Alert (EA 182/20) from the Southern Health and Social Care Trust on 31 July 2020 regarding potential safety concerns that were initially raised on 7 June 2020 about a consultant urologist who retired at the end of June 2020.

The Trust took a number of initial actions relating to these concerns, including restricting the consultant's clinical practice and access to patient information, notifying the GMC and discussing the matters with the Royal College of Surgeons Invited Review Service to understand the scope and scale of any further independent review.

In order to fully define the areas for concern and quantify the number of patients potentially impacted, the Trust has undertaken an internal scoping exercise of all patients who were under the care of the consultant, initially for an 18 month period. This involves a review of all case notes to identify those which provide any cause for concern.

Officials from the Department, HSCB and PHA have participated in weekly progress update calls with the Trust since 10 September 2020. Upon request a report was provided to the Department on 15 October 2020 summarising the current position, including the quantity of patient case notes that need to be reviewed and progress so far, confirmed SAls to date, and advising of additional patient safety concerns identified in the course of this exercise.

### **Objectives**

In light of the concerns identified a Department-led Urology Assurance Group (UAG) will provide external oversight of the various work streams arising from the ongoing scoping exercise Trust. Specifically the Group will:

- review the progress of the initial scoping exercise;
- consider emerging strategic issues;
- commission and direct further work as necessary;
- monitor the impact on urology and related services;
- ensure coordination with other associated reviews / investigations; and
- oversee communication across all stakeholder groups.

The UAG will receive updates from the HSCB led urology working group as appropriate. The working group will continue to review the findings of the initial lookback exercise and scope the potential need for a further lookback exercise.

### **Membership**

The Group will be chaired by the Permanent Secretary. Membership will include:

- Dr Michael McBride, Chief Medical Officer, DoH
- Sharon Gallagher, Chief Executive, HSCB
- Jackie Johnston, Deputy Secretary Healthcare Policy Group, DoH
- Olive Macleod, Interim Chief Executive, PHA
- Paul Cavanagh, Director of Commissioning, HSCB
- Dr Brid Farrell, AD Service Development, Safety and Quality, PHA
- Shane Devlin, Chief Executive, Southern Trust
- Dr Maria O'Kane, Medical Director, Southern Trust
- Melanie McClements, Director of Acute Services, Southern Trust
- Dr Lourda Geoghegan, Deputy Chief Medical Officer, DoH
- David Gordon, Director of Communications, DoH
- Ryan Wilson, Acting Director of Secondary Care, DoH
- Michael O'Neill, Acting Director of General Healthcare Policy, DoH,
- Anne Marie Bovill, General Healthcare Policy

**Support**

Secretariat will be provided by General Healthcare Policy Directorate and meetings will initially be held fortnightly, but will be subject to review.

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Mrs. Vivienne Toal  
Director of Human Resources & Organisational Development  
Trust Headquarters  
Craigavon Area Hospital  
68 Lurgan Road  
Portadown  
BT63 5QQ

9 June 2020

Dear Mrs. Toal,

During January 2020, I had family reasons to consider significantly reducing my workload in order to create a better work to life balance going forward. I did so particularly in the context of the potential pension risks that prevailed at that time.

I had already consulted with Mr. Malcolm Clegg of the Directorate of Human Resources with regard to options available to reducing my workload while protecting my pension entitlement, including that of part time employment. During February 2020, I also discussed this option with Mr. Michael Young, Lead Clinician in Urology, who offered his full support to my returning to part time employment if I withdrew from full time employment. I discussed the option with Mrs. Martina Corrigan, Head of Service for Urology, who assured me of her full support to return to part time employment. I discussed the option with Mr. Mark Haynes, Assistant Medical Director, who was similarly supportive, discussing the nature and amount of clinical work which I would wish to undertake. In doing so, I assured him that I would continue to participate in the Urologist of the Week rota.

Owing to those conversations, on Friday 06 March 2020, I confidently submitted an application for scheme retirement benefits, with a proposed retirement date of Tuesday 30 June 2020, and confirmation of my availability and commitment to return to agreed part time employment from Monday 03 August 2020.

Since then, we have experienced the further disruption to urological services resulting from Covid 19. As you are aware, we had already been providing urological services with a reduced number of consultant urologists since July 2019. Covid 19 has only further exacerbated the difficulties in providing an adequate service. I was therefore prepared to offer to return to work in July 2020 to support my colleagues in providing increasing services to those in most urgent clinical need.

Having made enquiries, during the last week of May 2020, as to whom I should meet to arrange an agreed return to part time employment, I was advised by Mrs. Corrigan on Monday 01 June 2020 that she would discuss the matter with Mr. Haynes. On further enquiry on Friday 05 June 2020, she advised that Mr. Haynes would be in contact with me. Yesterday afternoon, I received a telephone call from Mr. Haynes, with Mr. Ronan Carroll in attendance, to advise that, following discussions with the Medical Director and with Human Resources, he had been instructed to advise me that "it was the 'practice' of the Trust not to re-engage people while there are ongoing HR processes". He confirmed

that these issues were those of the Formal Investigation (initiated in December 2016 and concluded in October 2018) and the Formal Grievance (submitted in November 2018).

I had not received any written or other communication since I submitted the AW6 Form on 06 March 2020 regarding confirmation of its receipt or of processing the application, until one sent at 12.39 pm today, claiming that I had telephoned the Medical HR Department yesterday, Monday 08 June 2020, with regard to Medical HR acknowledging receipt of my 'retirement letter'. This claim is untrue. I telephoned to request a copy of the AW6 Form which I had submitted on 06 March 2020. I did not mention any letter. I did not send a retirement letter to Medical HR. I sent it to whom it was addressed. I find it so distressing to be once again meet with such misrepresentations.

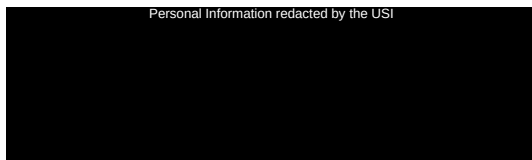
I wish to unequivocally emphasise that, until yesterday, I had not received any advice or indication that such 'ongoing HR processes' would be an impediment to my returning to part time employment, including from any of the personnel named in paragraph 2 above. It was the duty of my employer to inform me that ongoing HR processes prohibited my returning to part time employment. Had I been informed of such, I certainly would not have submitted the AW6 Form on 06 March 2020, with the self-evident pecuniary and reputational loss and damage that yesterday's development entails, in addition to disabling my ability to be appraised and revalidated. On the contrary, it was the absence of information regarding any factors prohibiting part time employment, and the support offered that underpinned my lodging the Form on 06 March 2020.

I therefore notify you that I now revoke my application for retirement benefits and indication of my withdrawal from full time employment, both with immediate effect. I will advise BSO of this notification. I therefore require, by 5.00 pm on Thursday 11 June 2020, the Trust's confirmation that my full time employment shall continue.

I also require full disclosure of all Trust policies relating to the Trust 'practice' referred to above. I require it by return by 5.00 pm on Thursday 11 June 2020.

Whilst I hope that this issue can be resolved by 05.00 pm on Thursday 11 June 2020, I must stress that otherwise all further correspondence in this matter shall immediately flow from the solicitor I have instructed to conduct proceedings.

Yours sincerely,

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Aidan O'Brien



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Mr. Shane Devlin  
Chief Executive  
Southern Health & Social Services Board  
Trust Headquarters  
Craigavon Area hospital  
68 Lurgan Road  
Portadown  
BT63 5QQ

10 June 2020

Dear Mr. Devlin,

On 27 November 2018, I lodged with you a Formal Written Grievance. I submitted it to you in person as I had already lost faith in the integrity of the Directorate of Human Resources. In lodging my grievance with you, I retained a confidence that you would ensure that the Grievance would be progressed in a timely manner, and in compliance with the Trust's Grievance Procedure. The Grievance included an appeal of the Case Manager's Outcome of the preceding Formal Investigation. Now almost 20 months later, neither the grievance nor the appeal has been addressed, even though I was assured by Mrs. Toal in writing in June 2019, and most recently on 22 May 2020, that arrangements were being made to convene the grievance hearing.

I attach a letter which I sent to Mrs. Toal last evening. It will inform you that I was advised on Monday 08 June 2020 that I would not be facilitated to return to part time employment from 3 August 2020 due to a 'practice of the Trust not to re-engage people with ongoing HR processes'. The letter to Mrs. Toal details the support which I had been given to return to part time employment and the absence of any advice from the Trust that ongoing HR processes would be an impediment to my returning to part time employment. I have notified Mrs. Toal that I revoke my application for retirement benefits and of the indication of my withdrawal from full time employment, both with immediate effect.

In making every effort to resolve this impasse, I write to ask you to ensure that the Grievance is addressed as soon as is possible, and so that it can be completed by Friday 26 June 2020. With confidence that the Grievance will be upheld, and that its included appeal will be equally so, there then would be no outstanding HR processes.

I would be grateful for an acknowledgement of receipt of this letter.

Yours sincerely,

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Aidan O'Brien

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Mrs Roberta Brownlee,  
Chair  
Southern Health & Social Care Board  
Trust Headquarters  
Craigavon Area Hospital  
Portadown  
BT63 5QQ

10 June 2020

Dear Mrs. Brownlee,

I attach a letter which I sent to Mrs. Vivienne Toal, Director of Human Resources & Organisational Development, last evening, and a letter which I sent to Mr. Shane Devlin, Chief Executive, earlier today.

The point of both letters was to advise that I had submitted, on 06 March 2020, an application for pension benefits to become payable with effect from 30 June 2020, to coincide with an intent to withdraw from full time employment from that date, and with the intent to return to part time employment from 03 August 2020, having received the assurance of support from colleagues and line managers to do so, and without being informed by the Trust of any impediment to my doing so. I was then advised by telephone on Monday 08 June 2020 that I would not be permitted to return to part time employment in August 2020 due to the 'Trust's practice of not re-engaging people with ongoing HR processes'. If I had been informed of this practice by the Trust, I most certainly would not have submitted any notification of intent to withdraw from full time employment.

You will be aware that the ongoing HR processes to which reference has been made are the Formal Investigation (initiated on 30 December 2016 and completed on 01 October 2018) and a Formal Grievance (submitted on 27 November 2018 and not yet addressed). The Formal Grievance included an appeal of the Outcome of the Formal Investigation. That appeal has not been addressed, 20 months later.

I now feel all the more aggrieved by the Trust's claim to have a practice of not re-employing personnel if there are ongoing HR processes, when the Trust has been primarily responsible for the ongoing status of those HR processes, and not having been informed by the Trust, my employer, of that practice. It is important to note that it is the same Directorate which has failed to have my grievance and appeal addressed after 20 months in contravention of its own policy, the same Directorate which has accepted and processed my intent to withdraw from full time employment, and which would have been cognisant of my intent to return to part time employment as that intent is an integral part of the application proforma, and which would have been cognisant of a Trust practice which would be an impediment to returning to part time employment, and about which I was not informed.

As a consequence, I have had no other option but to revoke my intention to withdraw from full time employment. I have already deferred payment of pension benefits earlier today.

It will have been 28 years ago tomorrow, Thursday 11 June 1992, that I was appointed to the post of Consultant Urologist at Craigavon Area Hospital. From then until 1996, I single-handedly provided a 24 hour service. From 1996, with the assistance of increasing numbers of colleagues, I have endeavoured to contribute to the development of urological services by the Trust. Nevertheless, those services remain severely inadequate. Covid-19 has further exacerbated that inadequacy. By August 2020, there will be patients waiting up to six years for admission for surgery. By then, there will be patients waiting over three years for outpatient consultations following referral, and for review following investigation or management.

Today, Mr. Robin Swann, Health Minister, referring to a framework for rebuilding health and social care services in Northern Ireland, said that 'this strategic approach is about throwing absolutely everything we can at those waiting lists and those missed diagnoses and treatments that were put on pause during the Covid-19 pandemic'. The Minister advised that Northern Ireland has the longest waiting lists in the UK and Ireland. The Southern Trust's longest, surgical waiting lists are urological. Yet, the Trust finds it appropriate to prohibit me from part time employment in the face of such need due to ongoing HR processes for which the Trust has been responsible.

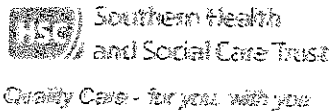
I do appreciate that you, and your non-Executive colleagues, have been appointed to the Trust Board by the Health Minister, and that the Trust is accountable to the Board, on behalf of the Minister, across a number of key areas, including the delivery of health and social care objectives, financial probity and governance. I write to ask you to bring to the attention of your non-Executive colleagues, the contents of this letter, and of those sent to Mr. Devlin and Mrs. Toal. In doing so, I have not made reference to any of the issues subject to the Investigation, or to any content of the Grievance or of the Appeal. I write to inform you and your colleagues of the severity of the lack of the Trust's compliance with its own Policies and Procedures, the severity of the impact of its lack of compliance upon a member of its staff, and the consequential impact upon the delivery of services expected by the Minister.

I hope that you and your non-Executive colleagues may be able to have some bearing in attempting to resolve this ongoing situation. For me, personally and professionally, it is very important that I can continue to work, but with a better work life balance. It is also most important for me that the Formal Grievance and its included Appeal are addressed. I am certainly prepared to work constructively with the Trust to achieve a just and satisfactory resolution, and particularly to the benefit of patients.

Yours sincerely,

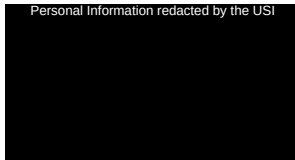
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Aidan O'Brien



# STRICTLY PRIVATE & CONFIDENTIAL

Mr Aidan O'Brien



18<sup>th</sup> June 2020

Our Ref VT/hm-c

Dear Mr O'Brien

I write in response to your letter, dated 9<sup>th</sup> June 2020, and your follow up letter, dated 12<sup>th</sup> June 2020.

The Southern HSC Trust position on this matter is as follows:

- On 6<sup>th</sup> March 2020, you submitted, for processing, to Medical Staffing Department, an Application for Scheme Retirement Benefits (AW6) with a proposed retirement date of 30<sup>th</sup> June 2020.
- All HR processes have been completed in respect of the processing of your AW6 to Pensions Branch.
- In applying for your Scheme Retirement Benefits, you signed a declaration stating that you were retiring from HSC Employment on 30<sup>th</sup> June 2020 – see the Declaration at the end of the form.
- You wrote to Ms Martina Corrigan on 26<sup>th</sup> March 2020 to confirm that you had 'submitted to the Directorate of Human Resources on Friday 06 March 2020 completed Forms of Application to Withdrawal (sic) from Full Time Employment, and with the intent that my full time employment would end on Tuesday 30 June 2020. In doing so, I formally advised that I would be prepared to return to Part Time Employment from Monday 03 August 2020. It (sic) do hope that I may be able to do so.'
- You sent a text to Ms Corrigan on 31<sup>st</sup> March 2020, asking if she had received your 'letter of notification of retirement'. Ms Corrigan replied the following day



Office of the Director of Human Resources  
Trust HQ, Craigavon Area Hospital,  
68 Lurgan Road, PORTADOWN BT63 5QQ

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to confirm that as per 'our conversation yesterday I can confirm I have received this.'

- The Trust's Employee Guide & FAQs on Retiring from the Trust states that 'Requests to return to work, immediately following retirement will be considered on an individual basis.'
- It is the Trust's position that there is no automatic right to return to part time employment following retirement.
- Mr Young, Ms Corrigan and Mr Haynes do not agree with your recollection of discussions during February 2020 when you say they confirmed their support for your return post retirement. Rather, no assurances were given to you in that regard.

Your letter of 26<sup>th</sup> March provided 3 months' notice of termination of your employment on 30<sup>th</sup> June 2020 as required by your contract of employment. Whilst you outlined a "hope" to return to work on a part time basis following your retirement, there was no suggestion whatsoever in your letter that your notice of termination was conditional or dependent on such return. The text sent by you on 31<sup>st</sup> March referred to your letter as "notification of retirement" and the Trust confirmed receipt of same.

Since receipt of your letter, the Trust has taken a number of steps on foot of your notice of termination, such as seeking College approval for the Job Description to replace your post and organisation of locum cover.

It is also clear that since March 2020 you have also proceeded on the basis that you would be retiring from your employment with the Trust on 30<sup>th</sup> June 2020. In the circumstances, the Trust considers that your employment will terminate on 30<sup>th</sup> June pursuant to the notice of termination given by you in your letter dated 26<sup>th</sup> March and it is not open to you to withdraw that notice of termination unilaterally. The Trust appreciates that you are disappointed that your "hope" to return to work on a part time basis post retirement will not be fulfilled, but this does not affect the position in relation to termination of your employment on foot of the notice given by you.

Yours sincerely

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**VIVIENNE TOAL (MRS)**  
**Director of Human Resources**  
**& Organisational Development**

Tughans

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Mrs Vivienne Toal  
 Director of Human Resources & Organisational  
 Development  
 Southern Health and Social Care Trust  
 Trust Headquarters  
 Craigavon Area Hospital  
 68 Lurgan Road  
 PORTADOWN  
 Co Armagh  
 BT63 5QQ

Our Ref: PJR/1OBR3004  
 Your Ref: VT/hm-c  
 Date: 23 June 2020

Dear Madam

**Re: Our client – Mr Aidan O'Brien**  
**Pre-action correspondence**

#### *Introduction*

1. We refer to the above matter and to your letter to our client, Mr Aidan O'Brien, dated 18 June 2020. In that correspondence, you assert that our client's employment with the Southern Health and Social Care Trust ('the Trust') "will terminate on 30th June pursuant to the notice of termination given by you in your letter dated 26th March" and, further, that it is not open to our client to withdraw that notice of termination unilaterally.

2. Our client takes issue with that analysis for the reasons set out below. The purpose of this correspondence is to advise you of our client's intention to seek urgent injunctive relief from the High Court unless the Trust alters its position that our client's employment will terminate on 30 June.

#### *Background*

3. We do not propose to rehearse in detail in the body of this correspondence the factual background to the present situation, of which you will be aware in any event. We simply provide the following short synopsis:

- a. Our client lodged a detailed grievance on 27 November 2018 which he has been seeking to have addressed for some time. The failure to address and resolve this grievance timeously is plainly a breach of the Trust's own policies.

|                    |    |                      |
|--------------------|----|----------------------|
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- b. Our client wished to move from full-time working to part-time working and discussed this with Mr Malcolm Clegg, Medical Staffing Manager of the Trust's Directorate of Human Resources (as outlined in his letter to you of 9 June 2020). Our client also discussed his plans to return to part-time employment with his managers within the Trust, Mr Michael Young, Lead Clinician of the Department of Urology; Ms Martina Corrigan, Head of Service for Urology; and Mr Mark Haynes, Assistant Medical Director for Elective and Surgical Services. All three assured our client of their support in returning to part-time employment. In pursuance of this intention, our client lodged an application for pension benefits with the intention of moving to part-time employment with the Trust shortly after his retirement (with a gap of one month in order to protect his pension benefits). At no time was any issue raised with our client by Mr Clegg, or by any other personnel in the Directorate of Human Resources, or by any of his managers, as to his part-time employment with the Trust being problematic as a result of "ongoing HR processes".
- c. Our client proceeded on the basis that he would be re-employed by the Trust, as had been discussed in detail with his managers, and as is commonplace within this and other Trusts. It was only on 8 June 2020 that our client was informed, by telephone and for the first time, that there was a "practice" of the Trust not re-engaging those whilst there are ongoing HR processes.
- d. The "ongoing HR processes" which are an apparent bar to our client's re-engagement in this case are, essentially, his grievance which was lodged in late 2018 and which ought to have been resolved by now (and resolved in his favour, we would submit).
- e. After the conversation of 8 June 2020, our client immediately, by letter of 9 June, indicated that he revoked his "application for retirement benefits and indication of [his] withdrawal from full time employment".
- f. By your letter of 18 June 2020 the Trust has maintained that our client has given notice to terminate his employment by means of his letter of 26 March 2020 and declined to permit him to revoke the indication that he wished to retire on 30 June 2020 to be re-engaged on a part time basis from August 2020.
4. The effect of the Trust's approach would be (a) to leave our client unemployed from 30 June 2020, with little or no prospect of re-employment elsewhere (and, therefore, of revalidation and continuing practice), giving rise to significant financial and reputational loss; and (b) to relieve the Trust of the obligation to deal with our client's outstanding grievance, which involves not only matters highly relevant to our client's standing and professionalism but also matters relating to the Trust's practices which require to be addressed in the public interest.

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*Our client's position*

5. Our client takes issue with the suggestion that he has terminated his employment by the giving of notice. In the alternative, if our client has given a legally effective notice (operative to terminate his employment from 30 June 2020), either the Trust is obliged to accept his revocation of that notice or it is open to him, in the circumstances of this case, to withdraw it.
6. As to your suggestion that our client has provided 3 months' notice of termination of his employment (on 30 June 2020) as required by his contract and that he did so by his letter of 26 March 2020, that is plainly wrong. On its face, our client's letter of 26 March 2020 does no such thing. It refers back to forms submitted earlier in relation to pension benefits and our client's "intent that [his] full time employment would end on Tuesday 30 June 2020". The letter neither gives notice, nor does it purport to. Indeed, the main purpose of the letter is plainly to offer to work through July in light of the increased need which has arisen from the impact of Covid-19.
7. The law is clear that any giving of notice to terminate a contract of employment requires to be unambiguous. The letter upon which you rely is plainly not an unambiguous provision of notice to terminate Mr O'Brien's employment (as required by paragraph 2 of Schedule 19 to the Terms and Conditions of Service).
8. We note that you do not purport to rely on our client's AW6 Form as the giving of his notice. That is unsurprising since it is merely an application (to his pension provider) for scheme retirement benefits. It is not, nor does it purport to be, the giving of any notice to the Trust as his employer. It sets out Mr O'Brien's (then) view of his "proposed date of retirement". In any event, the significant part of the AW6 Form is that Mr O'Brien confirmed, at part 7, that he would be employed in the HSC after retirement, namely in his current job (Consultant Urologist at Craigavon Area Hospital) from 3 August 2020.
9. Neither document is the type of document the Trust's own guidance requires (see 'Management Guidance Note: EER 14 – Retiring from the Trust: Employee Guide & FAQs'), namely a resignation in writing submitted to the employee's manager, having agreed a leaving date.
10. Our client does not accept that he has given notice under his contract in a way which complies with the applicable requirements; and the letter of 26 March 2020 on which the Trust relies in this regard is plainly not such a notice.
11. In the alternative, if the letter of 26 March 2020 was effective to give notice of termination, it is plain that it was given on the basis of our client's clear understanding, facilitated by the Directorate of Human Resources and having been assured of the support of his managers,

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that there would be no difficulty with his being re-engaged on a part-time basis, as frequently occurs with retiring consultants. The suggestion, for the first time on 8 June 2020, that our client would not be re-engaged in light of his outstanding grievance, was the very first time that there was any suggestion whatever that this issue might pose any difficulty with our client's re-engagement. To that point, he has proceeded, encouraged by Trust employees, on the basis that he would move to part-time working, as is commonplace with other retiring consultants.

12. The Trust's recent decision not to offer re-employment, on the basis of an apparent "practice" which was not made known to our client (and in respect of which there is no published policy), is patently unfair and an obvious attempt on the part of the Trust to avoid resolving the issues addressed in our client's grievance. In our view, this is entirely self-serving and manifestly not in the public interest. For the avoidance of doubt, our client's firm instructions are that if this position had been made known to him previously, he would not have contemplated retirement in the circumstances.
13. Our client considers that the Trust, by the actions of its servants and agents, has plainly misrepresented the situation to him as to the availability of re-employment.
14. In the above circumstances, the failure of the Trust to accept our client's withdrawal of any contractual notice validly given by him (which is denied), is plainly in breach of the Trust's obligations of mutual trust and confidence set out at paragraph 3 of his contract of employment. This is even more so apparent when it is recognised that the reason why there are "ongoing HR processes" is because the Trust (in further breach of contract) has failed to deal with our client's grievance timeously and in compliance with its own policy. This is in breach of the Trust's obligations to follow its own policies, also set out at paragraph 3 of our client's contract of employment. In short, had the Trust acted in compliance with its obligations, our client's grievance would have been concluded long ago. The Trust's eagerness to now seek to end our client's employment completely, in breach of the expectations which its servants and agents engendered on our client's behalf, is, our client believes, an entirely opportunistic means of seeking to avoid scrutiny of its own actions.
15. Accordingly, the Trust is obliged by virtue of its obligation of mutual trust and confidence to accept our client's withdrawal of any notice provided by him. Alternatively, the law now recognises that such notice given by an employee may be unilaterally withdrawn by him in exceptional circumstances; and the circumstances of this case, highlighted above, are within that category of case where this should be permitted.

*What the Trust is expected to do*

16. In order to avoid the need for litigation, we ask you to confirm by return that you will continue to employ our client on his current contract after 30 June 2020 (whether by treating him as

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not having provided notice of termination or agreeing to permit him to withdraw such notice).

17. If you are unwilling to take the step required at paragraph 16 above, we nonetheless request you to treat our client's employment as continuing (by way of agreed extension of his notice period – without prejudice to our client's case that he has not given any effective notice) until the subject matter of this correspondence is resolved by way of legal proceedings. Such a course would avoid the need for urgent injunctive relief in order to protect our client's position. In the event that you accede to this request, our client would be willing to engage in mediation with a view to seeking to resolve the issues between him and the Trust as to his employment without recourse to litigation.

### Conclusion

18. In the absence of confirmation that the Trust will take the steps at either paragraphs 16 or 17 above, we reserve the right to issue proceedings for breach of contract and misrepresentation, including the seeking of urgent injunctive relief, without further notice. It will be necessary to do so in advance of 30 June 2020 in order to protect our client's position and maintain his position of employment with the Trust. If such proceedings are necessary, use will be made of this correspondence on the issue of costs.
19. We look forward to hearing from you by return and, in any event, before 12.00 noon on Thursday 25 June 2020. This abbreviated timescale is unfortunately necessary in light of the lateness of the Trust's indication (on 8 June 2020) that there would be a difficulty with our client's intended re-engagement and in order to provide us time to prepare and lodge appropriate proceedings with the High Court in the event that this is necessary.

Yours faithfully,

*Patricia Rooney*

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June Turkington  
 Directorate of Legal Services  
 Business Services Organisation  
 2 Franklin Street  
 Belfast  
 BT2 8DQ

Our Ref: AFA/AK/00003911.100

Your Ref:

Date: 15 March 2021

BY EMAIL

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Dear Ms Turkington

**MR AIDAN O'BRIEN**

I refer to your letter of Friday 5 March 2021 and to our subsequent email and telephone communications.

On behalf of Mr O'Brien, I wish to express in the clearest possible terms that the Trust's proposed course of action by simultaneously publishing on Tuesday 16 March 2021 nine separate 'draft' Serious Adverse Incident (SAI) reports plus a 'draft' overarching report to nine patients/families and the Trust's clinicians, without input from him, is grossly unfair and wholly inappropriate. My client wished to co-operate fully with the SAI process and to provide his clinical input. He was in the process of doing so, but it was simply impossible to do this to a professional standard in nine separate cases within the wholly unfair and unrealistic timescale, which the Trust has determined for its own reasons, and without notification.

For the record, my client wishes to make clear that he was entirely willing to respond to the questions which the Review Team had asked and to provide a complete, professional response to each of the nine cases in which SAI reviews are underway. However, it is a matter of elementary professionalism and fairness that he should have been allowed the opportunity to do so before draft conclusions are shared with patients, families and other clinicians. His input should have formed part of the process and been capable of influencing the conclusions. It should not be as a response to conclusions that have already been formed without his input. For the Trust to devise its procedures in this way is not only grossly unfair to Mr O'Brien, but is unlikely to produce the outcomes that a proper SAI review process should be designed to achieve.

In that regard, it should be emphasised that the SAI terms of reference, detailed in each report, include the following terms:

- To carry out a systematic multidisciplinary review of the process used in the diagnosis, multidisciplinary team decision making and subsequent follow up and treatment provided for each patient identified, using a Root Cause Analysis (RCA) Methodology
- To review individually the quality of treatment and care provided to each patient identified and consider any factors that may have adversely influenced or contributed to subsequent clinical outcomes

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While a particular concern or factor may be a valid, legitimate reason to initiate a SAI review, the review should not be solely restricted to an examination of the adverse influence or contribution of that particular concern or factor to subsequent clinical outcomes. Doing so could result in a report making findings solely related to that initial concern or factor, while omitting or excluding findings which have made equally important, or even more significant, contributions to adverse clinical outcomes.

Therefore, it is a breach of the terms of reference to compile reports and arrive at findings without a report / input from all the healthcare professionals providing treatment and care to each individual patient, as all factors will not have been considered. It is improper to fail to conduct a complete investigation, as obliged by the terms of reference, and to arrive at incomplete, unreliable findings. Doing so risks the presentation of improper, incorrect or distorted findings to patients, families and clinicians.

I am aware that the background to the SAIs is very familiar to you. However, I wish to set out a number of incontrovertible aspects of the chronology of events. If the Trust proceeds with its plan to publish draft SAI reports, the patients/families/clinicians should be informed of the following key facts regarding Mr O'Brien's participation in the process.

- (i) On 11 July 2020 the Trust wrote to Mr O'Brien advising him of a number of concerns that were said to have arisen out of his practice as a consultant urologist. The Trust indicated that these concerns would be managed in line with the Maintaining High Professional Standards in the Modern HPSS Framework ("MHPS")
- (ii) The Trust made a referral to the General Medical Council ("GMC") in relation to Mr O'Brien. To date he has not received a formal letter from the GMC (known as a "Rule 7" letter) specifying allegations they invite him to respond to as their investigation is ongoing.
- (iii) On 16 July 2020 we wrote to the Trust stating that Mr O'Brien could not comment on the Trust's concerns without the underlying data upon which its concerns were based.
- (iv) Some limited data in the form of extracts of 2 sets of patient records was sent to us on 14 August 2020. However, on 29 September 2020, the Trust informed Mr O'Brien that it was not proceeding with the MHPS process while indicating that other processes such as SAI reviews would continue. By that time Mr O'Brien had retired from his post as a consultant urologist and the Trust had referred its concerns to the GMC.
- (v) By 16 October 2020, at the latest, the SAI review team was appointed, and there were proposed draft terms of reference for the review. It was noted that the review related to eight patients reported, with Datix numbers.
- (vi) On 25 October 2020, the Trust confirmed that it had identified additional concerns and was conducting nine SAI reviews.

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- (vii) On 29 October 2020, we wrote to you as the Trust's representatives, highlighting a number of issues and asking whether Mr O'Brien would be asked for his comments in relation to any of the SAIs. We asked for further details of the Trust's concerns and asked what information would be disclosed to Mr O'Brien in advance of any request for comment. We emphasised that Mr O'Brien would provide comments as long as he was provided with full information to enable him to do so.
- (viii) On 24 November 2020, the Minister for Health made a statement to the Assembly announcing that he would establish a Public Inquiry under the Inquiries Act 2005. My client's input into the SAI process is therefore of the utmost importance as it is likely to be considered in detail, in a public setting, through the inquiry.
- (ix) Mr O'Brien suffered bereavement. Personal Information redacted by USI
- (x) On 11 December 2020, the Trust requested that Mr O'Brien attend with Dr Dermot Hughes, External Chair of the SAI review team, for his input into the process, describing interviews *"based upon the patient's journey and aimed at identifying learning and making recommendations for future care"*. No other detailed agenda or background documentation was provided for that proposed meeting.
- (xi) The terms of reference for the SAIs were agreed on 12 December 2020.
- (xii) On 15 December 2020, Mr O'Brien's registration was suspended by the Interim Orders Tribunal of the Medical Practitioners Tribunal ("MPT"). It is important to note this was an interim decision and is not based on any factual determinations. Personal Information redacted by USI
- (xiii) Personal Information redacted by USI
- (xiv) On 23 December 2020, we wrote to Dr Hughes asking him to provide clarification of the input he had requested. We asked for details of the SAI terms of reference etc., and repeated our request for information, including all of the relevant medical notes and records.
- (xv) On 11 January 2021, Dr Hughes provided a list of the issues he wished to raise. These are all highly complex cases and the issues raised required careful analysis and explanation. Dr Hughes also disclosed, for the first time, a copy of the SAI review team's terms of reference, which revealed that the purpose of the review was *"to consider the quality of the treatment and care provided by Doctor 1 and to understand if actual or potential harm occurred."* This disclosure made clear that the purpose of the interview was fundamentally different to that which had been described in the 11 December request. In light of the GMC referral and the Public Inquiry, Mr O'Brien was entirely right to request clarity about the issues raised and also to be provided with complete clinical information concerning all nine patients to enable him to respond. Dr Hughes asked that he receive answers to his questions by 'close of play' on 29 January 2021.

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- (xvi) On 14 January 2021, the hospital charts of all nine patients were provided. With this incomplete information, Mr O'Brien began to prepare his reports.
- (xvii) On 18 January 2021, Mr O'Brien suffered the second bereavement of a [REDACTED]  
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- (xviii) On 22 January 2021, we requested Datix Forms and ECR records for each patient along with other information and sought clarification on the issues relating to some of the individual cases. We made clear our view that the time Dr Hughes had allowed to answer his questions was not a reasonable timescale and in doing so reminded the Trust of the history of the matter with particular reference to our requests for information. We mentioned the difficulties posed by the current pandemic.
- (xix) On 4 February 2021, I was advised that Dr Hughes was considering his response, which would follow.
- (xxi) On 8 February 2021, the Datix Forms, detailing dates on which cases were reported, and the NIECR records (by hard copy only) were received by this office.
- (xxi) On 10 February 2021, we received clarification from Dr Hughes about some of the issues raised in our letter of 22 January. The fact that Dr Hughes agreed to provide these materials illustrates how central they were to the issues he had raised concerning patient care. Neither Dr Hughes nor anyone from the SAI team raised a deadline for our submission of reports
- (xxii) Mr O'Brien received the NIECR records for all nine patients by encrypted transmission on 16 February 2021, enabling him to work on completing written responses for each patient.
- (xxiii) On 19 February 2021 we updated the Trust in relation to Mr O'Brien's progress in providing his responses, indicating that he was progressing well with comments on [REDACTED] and [REDACTED] and that we hoped to have comments on those two cases with the Trust within a week or two.
- (xxiv) We heard nothing further from the Trust until 16:30 on Friday 5 March 2021 when we were informed by telephone and then by correspondence sent by email at 17:37 that it was the Trust's intention to share the draft SAI reports and an overarching report with each patient/family and the Trust Urology and Specialist Cancer team on Monday, 8 March 2021. To suggest, as the Trust did, that Mr O'Brien "was offered the opportunity to contribute to these reviews, however to date no response has been forthcoming" fails to accurately reflect the above steps Mr O'Brien had, and was continuing to take.
- (xxv) At our request, the Trust delayed sharing the SAI reports while Mr O'Brien obtained legal advice. However, we understand that the Trust now intends to share the reports on Tuesday 16 March 2021.

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By way of summary, Mr O'Brien had only 17 days during which to examine all of the information received by him on 16 February 2021 before being informed on 5 March 2021 that the 'draft' overarching report and the 'draft' reports on all nine patients had been submitted to the Health and Social Care Board four days previously on 1 March 2021, in addition to the intent to share these reports with patients, families and clinical teams on 08 March 2021. Moreover, it is stated that the 'draft' report concerning one patient had already been shared with the family of that patient on 1 March 2021. It has caused additional distress for Mr O'Brien to learn of this fact, at a time when he was completing his report concerning that patient and addressing the questions asked of him.

While the SAI reports are marked and described as 'draft', it is clear that the review team has completed the reviews, arrived at its findings and made its recommendations with no input from Mr O'Brien. In some reports, it is recorded that the 'Final Review reports' have already been shared with the Service User/Family/Carer. We question whether these are, in any meaningful sense, draft reports. It is clear that the fact checking that has been invited will not result in any change to the findings arrived at and/or recommendations made.

Mr O'Brien was at all times willing to participate in the SAI review process. His approach to completing his reports was necessarily informed by the background of the Trust's referral to the GMC and the pending public inquiry. Mr O'Brien wanted nothing more than to ensure that his response was accurate and comprehensive. An incomplete response would not only have distorted the SAI process, but could also have been prejudicial to any investigations undertaken by the GMC and the Public Inquiry. By way of comparison, if any one of these cases had been raised in the context of an allegation of clinical negligence under the Court approved protocol for dealing with such matters, Mr O'Brien would have had four months from a detailed letter of claim and disclosure of medical records to respond. This demonstrates the complexity of investigating and responding to issues in relation to clinical care that has been criticised.

The Trust's intention to publish the SAI reports to Mr O'Brien's patients and their families and Trust clinicians in their current form, at the present time and without Mr O'Brien having had an adequate opportunity to provide input is wrong. It is of the deepest personal and professional regret to him. The reports contain criticisms of his treatment that he considers to be unjustified, unfair, mistaken and unreliable. He has grave doubts about the propriety of the Trust making personal and clinical findings without following a fair procedure. However, if the Trust is determined to do so, he considers that the responsible and professional course of action is to respond through the public inquiry and/or GMC/MPT.

I look forward to receiving your written confirmation that if the SAI reports are shared with Mr O'Brien's patients or their families, and the Trust's clinical teams, the Trust will ensure that each recipient is informed in writing that the reports have been compiled without Mr O'Brien's input, even though he was prepared to do so.

Personal Information redacted by the USI

**ANDREW ANTHONY**

Personal Information redacted by the USI

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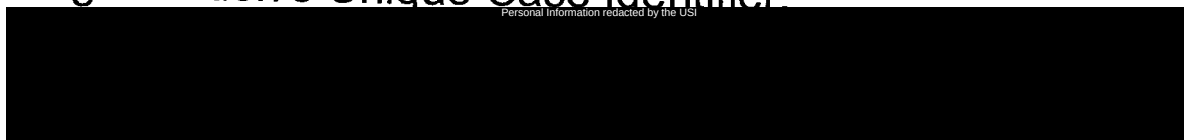
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Received from Tughans OBO Mr Aidan O'Brien on 20/12/21. Annotated by the Urology Services Inquiry.



## **Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist**

Organisation's Unique Case Identifier:



Date of Incident/Event: Multiple dates

HSCB Unique Case Identifier:

Service User Details: *(complete where relevant)*

D.O.B:                      Gender: Male              Age:

Responsible Lead Officer: Dr Dermot Hughes

Designation: Former Medical Director Western Health and Social Care Trust. Former Medical Director of the Northern Ireland Cancer Network (NICAN)

Report Author: The Review Team

Date report signed off:

Date submitted to HSCB: 1 March 2021



## **1.0 EXECUTIVE SUMMARY**

The purpose of the review is to consider the quality of treatment and the care provided by Doctor 1 to the patients identified and to understand if actual or potential harm occurred. The review findings will be used to promote learning, to understand system wide strengths and weaknesses and to improve the quality and safety of care and treatment provided. Nine patients have been identified as potentially suffering harm. This review will examine the timelines of each individual case and analyse if any deficits in treatment or care has occurred. As part of the review the cancer pathways will be used to determine where learning can be extracted.

The SHSCT recognise the life changing and devastating consequences to the 9 families. It wishes to offer an unequivocal apology to all the patients and their families involved in this review. This was not the cancer care they expected and should not have been the cancer care they received.

## **2.0 THE REVIEW TEAM**

Dr Dermot Hughes – External Independent Chair former Chair of the NICAN. Former Medical Director Western Health and Social Care Trust.

Mr Hugh Gilbert - Expert External Clinical Advisor from the British Association of Urological Surgeons BAUS

Mrs Fiona Reddick – Head of Cancer Services (SHSCT)

Ms Patricia Thompson – Clinical Nurse Specialist (Formally from SET / recently SHSCT)

Mrs Patricia Kingsnorth – Acting Acute Clinical Governance Coordinator (SHSCT)

## **3.0 SAI REVIEW TERMS OF REFERENCE**

The aims and objectives of this review are to:

- To carry out a systematic multidisciplinary review of the process used in the diagnosis, multidisciplinary team decision making and subsequent follow up and treatment provided for each patient identified, using a Root Cause Analysis (RCA) Methodology.
- To review individually the quality of treatment and care provided to each patient identified and consider any factors that may have adversely influenced or contributed to subsequent clinical outcomes.
- To engage with patients / families to ensure where possible questions presented to the review team or concerns are addressed within the review.
- To develop recommendations to establish what lessons are to be learned and how our systems can be strengthened regarding the delivery of safe, high

**3.0 SAI REVIEW TERMS OF REFERENCE**

quality care.

- Examine any areas of good practice and opportunities for sharing learning from the incidents.
- To share the report with the Director of Acute Services/ Medical Director of SHSCT/ HSCB/ Patients and families involved/ Staff involved.

**4.0 REVIEW METHODOLOGY**

The review will follow a review methodology as per the Regional Serious Adverse Incident Framework (2016) and will be cognisant of the rights of all involved to privacy and confidentiality and will follow fair procedures. The review will commence in October 2020 and will be expected to last for a period of 4 months approximately, provided unforeseen circumstances do not arise. Following completion of the review, an anonymised draft report will be prepared by the review team outlining the chronology, findings and recommendations. All who participated in the review will have an opportunity to provide input to the extracts from the report relevant to them to ensure that they are factually accurate and fair from their perspective.

Prior to finalising the report, the Lead Reviewer will ensure that the Review Team apply Trust quality assurance processes to ensure compliance of the review process with regional guidance prior to delivery of the final report to the Review Commissioner. The Review Commissioner will seek assurance that the quality assurance process has been completed.

## 5.0 DESCRIPTION OF INCIDENT/CASE

The review team conducted individual reviews on 9 patients on their treatment and care. A summary of each case is discussed within this report.

Causal deficits in their care and contributory factors were identified.

Patient 1

Patient 1 was diagnosed with prostate cancer and was started on an anti-androgen therapy as opposed to Androgen Deprivation Therapy (ADT). This did not adhere to the Northern Ireland Cancer Network (NICAN) Urology Cancer Guidelines (2016). These Guidelines had been signed off by the Southern Health and Social Care Trust (SHSCT) Urology Multi-Disciplinary Meeting (MDM), as their protocols for Cancer Peer Review (2017). This guidance was issued when Dr 1 was the regional chair of the Urology Tumour Speciality Group and should have had full knowledge of its contents. Following discussion with the families, the review team noted that there was no discussion with Patient 1 that the treatment given was at variance with regionally recommended practice. There was no evidence of informed consent to this alternative care pathway.

The review team have identified that during the MDM that a quorum had not been met. This was due to the absence of an oncologist from these meetings. Even so, the recommendations made by the MDM were not actioned by Dr 1. Members of the MDT may not have been aware of this, but similar practice in prescribing an anti-androgen had been challenged. Any challenges made regarding the appropriateness of treatment options were not minuted nor was the issue escalated.

The Review Team suggested that the initial assessment of Patient 1 was satisfactory although rather prolonged, the subsequent management with unlicensed anti-androgenic treatment (Bicalutamide) at best delayed definitive treatment. Bicalutamide (50mg) is currently only indicated before (as an anti-flare agent) or in combination with a LHRH analogue (Complete Androgen Blockade). Bicalutamide monotherapy (150mg) is not recommended for use as a continuing treatment for intermediate risk localised prostate cancer (reference is EAU guidelines), and further it decreases overall survival. Treatment for prostate cancer is based on achieving biochemical castration (Testosterone <1.7 nmol/l), which is best accomplished by the use of a LHRH analogue, by an LHRH antagonist or by bilateral subcapsular orchiectomy.

Patient 1 did not have Urology Cancer Nurse Specialist allocated to his care. The review team questioned this and it was established that whilst there were no resources for a Urology Cancer Nurse Specialist to attend any outreach clinics, their contact numbers should have been provided to the patient.

The Review Team conclude that Patient 1 received unconventional and inadequate treatment. The expected multi-professional involvement in his care was omitted. Patient 1 disease progressed whilst being inadequately treated. The opportunity to offer him radical treatment with curative intent was lost.

## 5.0 DESCRIPTION OF INCIDENT/CASE

**Patient 9** was diagnosed clinically and biochemically with prostate cancer, and was commenced on bicalutamide 50mgs. Bicalutamide (50mg) is currently only indicated as a preliminary anti-flare agent (or in combination with a LHRH analogue) and is only prescribed before definitive hormonal (LHRH analogue) treatment. The review team note that this treatment was not in adherence with the Northern Ireland Cancer Network (NICAN) Urology Cancer Guidelines (2016), which was signed off by the Southern Health and Social Care Trust (SHSCT) Urology Multi-disciplinary Meeting, as their protocols for Cancer Peer Review (2017). This guidance was issued when Doctor 1 was the chair of this group and had full knowledge of its contents. The review team note that, following discussion with **Patient 9** he was unaware that his care given was at variance with regionally recommended best practice. There was no evidence of informed consent to this alternative care pathway.

A biopsy result taken at the time of transurethral resection of prostate (TURP) showed benign disease (low volume sample 2g from central area of prostate). There were no further investigations to explore the clinical suspicion of prostate cancer.

The possibility of localised prostate cancer was considered from the time of presentation because the PSA was elevated; however, there was no record in the medical notes of any digital rectal examination (DRE) findings. During the operation further signs might have been elicited and appropriate biopsies could have been performed. TURP is not an adequate way to biopsy the prostate gland for suspected prostate cancer. The Review Team conclude that sufficient evidence of localised prostate cancer was apparent from the time of presentation. A correct course of action would have been to arrange appropriate staging scans and biopsies. **Patient 9** should have undergone investigation with a MRI scan of the prostate and pelvis and a bone scan should have been considered. A transrectal biopsy performed either at the time of the TURP or separately, would have secured the diagnosis.

Arrangement could then have been made to start conventional Androgen Deprivation Therapy (a LHRH analogue) with referral on to an oncologist for consideration of external beam radiotherapy (EBRT) potentially with radical intent. However, the patient was apparently lost to follow up after his appointment in July 2019.

**Patient 5**

**Patient 5** was referred to urology service following a visit to ED in December 2018. He was reviewed promptly by Dr 1 in January 2019. Investigations were arranged and a diagnosis of a large right-sided renal carcinoma was made. He was counselled regarding the risks and benefits of surgical intervention and chose to proceed with the high-risk surgery.

On 6 March 2019 **Patient 5** was admitted for an elective radical nephrectomy. The procedure was undertaken as planned and he was transferred to the intensive care unit (ICU) to support his blood pressure. He was later transferred to the ward. He developed a bacteraemia (infection) which was successfully managed with the advice of the microbiology team. Follow up CT scans were performed in June with a planned follow up in July 2019. This did not happen. **Patient 5** was admitted to Ward 3 North following an ED admission. He was reviewed again via telephone in November

**5.0 DESCRIPTION OF INCIDENT/CASE**

2019 by Dr 1 who arranged for a repeat CT scan to be performed on 17 December 2019 with a plan for review in January 2020. This did not happen.

The CT scan report was available on 11 January 2020 which showed a possible sclerotic metastasis in a vertebral body which had not been present on the previous CT scans. This report was not actioned until July 2020 when a new consultant reviewed the care. [Patient 5] was subsequently diagnosed with prostate cancer.

The Review Team find that the treatment and care in relation to management of the renal tumour was of a high standard. High-risk surgery was performed successfully following informed consent as to the risks and benefits of the surgery. A urology review was planned for July 2019 following the CT scan report in June but this didn't happen. [Patient 5] appeared to be lost to review. The scan performed in December 2019 with a plan to review in January was not actioned and the plan for review did not happen. This resulted in a delay in diagnosis of a prostate cancer.

[Patient 4]

[Patient 4] attended ED on 24 December 2018 with retention of urine. A urinary catheter was inserted, and a urology consultant review was planned to coincide with a trial removal of catheter with a specialist nurse. [Patient 4] was placed on the waiting list for a TURP. A normal PSA result (2.79 ng/l) was noted.

On 19 June 2019 [Patient 4] underwent a TURP. The procedure notes describe the prostate tissue as having "endoscopic appearances of prostatic carcinoma". Histology confirmed adenocarcinoma (Gleason score 5+5) in 90% of the resected tissue. His case was discussed at MDM on 25 July 2019 who noted there was no evidence of metastases on a CT abdomen and pelvis. It recommended a CT scan of chest and a bone scan to check for spread outside the prostate. Further, a LHRH agonist as ADT should be commenced. In August 2019 a bone scan and CT scan were requested together with an ultrasound scan of the urinary tract to assess bladder emptying. Doctor 1 prescribed Bicalutamide (50mgs once daily), in order to 'assess its tolerability in a generally frail man' and in the 'light of the low presenting PSA'.

The Review Team could not locate any record in the medical notes of a digital rectal examination being performed at any point during this patient's medical treatment. This may well have provided evidence to support the malignant nature of the prostate gland prompting a swifter biopsy.

The patient was discussed at MDM on 25 July 2019 when the recommendation for ADT (a LHRH analogue) was made. He should have been started on this hormonal therapy to achieve "castration testosterone levels" as soon as the diagnosis of poorly differentiated prostate cancer was made. Instead he was started on an inadequate dose of a drug (bicalutamide) which was not licensed for the treatment of prostate cancer and was contrary to the recommendations at MDM. This therapy was not in adherence with the Northern Ireland Cancer Network (NICAN) Urology Cancer Clinical Guidelines (2016) which were signed off by the Southern Health and Social Care Trust (SHSCT) Urology Multi-disciplinary Team, as their standard of care for Cancer Peer Review (2017). This guidance was issued when Dr 1 was the regional chair of the Urology Tumour Speciality Group and should have had full knowledge of its contents. There was no evidence in the medical notes or from speaking with

**5.0 DESCRIPTION OF INCIDENT/CASE**

**Patient 4** family of informed consent to this alternative care pathway.

**Patient 4** should have been referred to an oncologist to at least allow consideration of other treatment options. His care was not coordinated with the palliative care team. The diagnosis of possible metastasis which would not have changed best practice was nevertheless pursued in a dilatory fashion. The Review Team suggested that when the patient developed anaemia consideration should have been given to the possibility of this being due to malignant involvement of the bone marrow, rather than an effect of severe chronic disease, could have been considered.

The Review Team noted that **Patient 4** case was not brought back to MDM for rediscussion and multi-disciplinary input despite disease progression.

**Patient 2**

**Patient 2** was diagnosed with testicular cancer. His case was discussed at MDM. He attended for CT chest, abdomen and pelvis on 9 July 2019 which indicated no evidence of metastases (cancer spread). The following day the patient had a left inguinal orchidectomy (removal of left testicle and full spermatic cord) carried out. Pathology of the resection specimen found that the tumour was a classical seminoma measuring 2.6cm across. Although the tumour was confined to the testes, it did involve the rete testis (exit tubules from the testis) and, in addition, intratubular germ cell neoplasia was seen. These findings indicate an increased risk of spread.

**Patient 2** case was discussed at the Urology MDM on 25 July 2019. The plan was for Doctor 1 to review the patient in outpatients and refer him to oncology.

The patient was reviewed on 23 August 2019 and it was noted that **Patient 2** had an uncomplicated recovery and his operative wound had healed satisfactorily. It was agreed that he would be reviewed in SWAH again in February 2020 by Doctor 1 to determine if the patient wished to have a testicular prosthesis implanted. The referral to oncology was made on 25 September 2019.

Although, this presentation was unusual, the progress of the patient's investigation and treatment up to the orchidectomy was of a high standard. However, the 2 month delay in his referral to a Medical Oncologist complicated treatment choices. Whether this will compromise the long-term outcome is uncertain as this treatment is recommended to be given within 6 weeks as per the designated protocol.<sup>(1,2,3)</sup>

The Review Team acknowledge that there is limited oncology presence within the Urology MDT and the date when the patient's case was discussed there was no oncologist present.

The vast majority of the Urology MDMs within the Southern Trust are non-quorate due to the absence of an oncologist and does not meet the existing guidelines. (0% quorate for 2019).

Whilst it was the primary responsibility for the consultant in charge to make the referral to oncology a failsafe mechanism to ensure agreed actions took place, such as an MDM administration tracker, was not in place.

Alternatively, the allocation of a Urology Cancer Specialist Nurse as a Key Worker

**5.0 DESCRIPTION OF INCIDENT/CASE**

would have supported the patient on his journey as well as having ensured key actions had taken place. [REDACTED] Patient 2 was not referred to a Urology Cancer Nurse Specialist nor was any contact details provided to him. The MDM guidelines indicate "all newly diagnosed patients have a Key Worker appointed, a Holistic Needs Assessment conducted, adequate communication and information, advice and support given, and all recorded in a Permanent Record of Patient Management which will be shared and filed in a timely manner"<sup>(4)</sup>. This did not happen. A Key Worker/ Urology Cancer Nurse Specialist would have prompted the oncology referral sooner.

[REDACTED] Patient 6

[REDACTED] Patient 6 presented with possible prostate cancer and was commenced on bicalutamide 50mgs indefinitely or until biopsy results were available. The diagnosis of prostate cancer was confirmed by biopsy in July 2019. The patient was discussed at the MDM on 8 August 2020. The diagnosis of intermediate-risk organ confined prostate cancer was agreed. The plan was that Doctor 1 should review the patient and discuss management by surveillance or by active treatment with curative intent.

When [REDACTED] Patient 6 was reviewed by a locum consultant in October 2020 the patient did not recall any conversation about the options of external beam radiotherapy (EBRT) as a radical treatment and Active Surveillance. A Urology Cancer Nurse Specialist was appointed as the Key Worker at this review, not having one at time of diagnosis.

Bicalutamide (50mg) is currently only indicated as a preliminary anti-flare agent and is only prescribed before definitive hormonal (LHRH analogue) treatment. Bicalutamide monotherapy (150mg) is not recommended for use as a continuing treatment for intermediate risk localised prostate cancer.

The presence of a Urology Cancer Nurse Specialist would support the patient on his journey as well as ensure key actions had taken place. [REDACTED] Patient 6 was not referred to a Cancer Nurse Specialist. This is in contrast to declaration for Cancer Peer Review 2017 "all newly diagnosed patients have a Key Worker appointed, a Holistic Needs Assessment conducted, adequate communication and information, advice and support given, and all recorded in a Permanent Record of Patient Management which will be shared and filed in a timely manner"<sup>(4)</sup>. This did not happen.

[REDACTED] Patient 7

[REDACTED] Patient 7 was diagnosed in June 2016 with a renal mass measuring 2.5 cms in diameter on the anteromedial cortex of the lower pole of the left kidney. The case was presented to MDM in July 2016, and the recommendation was for active surveillance with interval CT scans. These were carried out at the scheduled times.

On 23 August 2018 his case was discussed at MDM. The July 2018 scan was reviewed and now showed the lesion to measure 3.0cm. The MDM recommended to review and discuss with the patient the options of continuing active surveillance or open partial nephrectomy. The case was to be discussed at the Regional Small Masses MDM.

**5.0 DESCRIPTION OF INCIDENT/CASE**

On 28 March 2019 at MDM the renal mass was noted to be enlarging. A further recommendation for Dr 1 to discuss the options of laparoscopic radical nephrectomy versus continued surveillance with its attendant risks was made.

On 29 March 2019 the patient was reviewed by a Locum Consultant Urologist. It was noted that the patient had a 3.1cms left sided kidney mass since July 2018 and this mass was increasing slowly in size. It was noted that the CT would be repeated in November 2019.

On 13 November 2019 a CT scan was performed which showed a further increase in size of lesion to 3.5 cms. No action was taken.

The overall progress of this patient's management was, on balance, acceptable even though the result of the November 2019 CT scan was not acted on.

The Regional Small Renal Mass MDM was developed to oversee the management of this group of patients. An appropriate referral to this group was omitted, despite the MDM's recommendation on at least two occasions.

The patient was reviewed in 29 March 2019 by locum consultant who appears not to have had an update from the MDM held on 28 March 2019.

The patient underwent laparoscopic radical nephrectomy on 25 November 2020 and was discharged on 27 November 2020 with a planned follow up. On 15 January 2021 Dr. 5 reviewed [Patient 7]. He was noted to be doing well. Histopathology confirmed the left kidney mass was pT1a grade 3 papillary carcinoma (mixed oncocytic and type 2) kidney cancer. A plan for CT chest abdomen and pelvis in 12 month was agreed.

[Patient 3]

[Patient 3]

[Patient 3] was diagnosed with penile cancer. The pathology confirmed squamous cell carcinoma of the prepuce. There was both lymphovascular invasion and perineural infiltration, both of which are associated with an increased risk of metastatic disease, at presentation and subsequently.

The MDM was a virtual meeting conducted by a single urologist. Its plan was that Doctor 2 would review the patient and arrange for a CT scan of the Service User's chest, abdomen and pelvis to complete staging. The CT scan (26 July 2019) showed a single enlarged, left inguinal lymph node measuring 1.3cms in its short axis. Otherwise, there was no evidence of metastatic disease.

At the MDM of 12 September 2019 it was agreed that the [Patient 3] should undergo a left inguinal lymphadenectomy. There does not appear to have been any discussion regarding the referral of [Patient 3] to a supra-regional penile cancer MDT.

The Review Team found that the MDM recommendations did not follow NICE guidance for the management of penile cancer<sup>(6,7,8)</sup> and that there was an opportunity at each meeting to intervene and question [Patient 3] management.



**5.0 DESCRIPTION OF INCIDENT/CASE**

The treatment provided to this patient was contrary to the NICAN Urology Cancer Clinical Guidelines (2016) for Penile Cancer where it states that local care is restricted to diagnosis. This Guidance was adopted by the SHSCT Urology MDT and evidenced by them as their protocols for cancer peer review 2017. Dr 1 was chair of the NICAN Urology Tumour Speciality Group when the guidance was issued.

The initial clinical assessment of Patient 3 would have benefited from staging imaging either before or immediately after the original circumcision. All cases of penile cancer should be discussed by the supra-network MDT as soon as the diagnosis is confirmed by biopsy.

The clinical stage G2 pT1 should have led to a consideration of surgical staging with either a bilateral inguinal lymph node dissection (ILND) or sentinel node biopsy (SNB). This omission reduced the likelihood of Patient 3 5 year survival from 90% to less than 40%. The left ILND yielded only 5 nodes, which might be considered at the lower limit of that expected in experienced hands.

The consent form signed by the surgeon and patient is inadequate as it does not state the rationale for the procedure nor the potential complications. The timings between the steps in treatment and management were unduly long and failed to show the urgency needed to manage penile cancer.

Patient 8

Service User I was seen on 27 October 2014 with lower urinary tract symptoms that continued despite medical treatment. Doctor 1 discussed options with Patient 8 and he decided to proceed to surgery (TURP).

A letter dated 11 November 2016 Patient 8 General Practitioner asked for Patient 8 TURP to be expedited.

The Patient underwent TURP on 29 January 20 and histology confirmed prostatic adenocarcinoma.

Collation of Multidisciplinary meetings should have a fail-safe whereby lists of all urological cancers by site and SNOMED code are generated weekly. This system was not in place.

Although Doctor 1 planned to review the patient in April 2020, he was not seen until August 2020 at an appointment arranged by another doctor who has continued care. The patient had done well following his TURP. The histology was explained as an incidental finding that required continuing surveillance with an up to date serum PSA level and a prostate MRI scan.

Patient 8 was informed on 9 September 2020 that the serum PSA level was within the normal range and that the MRI scan did not show any features of prostate cancer. The prostate cancer was considered unlikely to represent a threat during the patient's life expectancy and would not be anticipated to require any treatment other than surveillance with PSA monitoring.

## 6.0 FINDINGS

### Diagnosis and Staging

- 5 of the 9 patients in this review experienced significant delay in diagnosis of their cancer. This was related to patients with prostate cancer and reflected variable adherence to regionally agreed prostate cancer diagnostic pathways, NIACN Urology Cancer Clinical Guidelines (2016).
- Patient 9 had a delay of over 15 months from presentation.
- The review team could not find evidence of a Digital Rectal Examination in the notes of Patient 4 - potentially missing an opportunity to detect his high grade cancer earlier in his pathway.
- Patient 6 had a slow initial diagnostic pathway which was outside expected cancer care time-frames.
- Patient 5 had a delayed diagnosis of a metastatic prostate cancer following successful treatment of Renal Cancer. This was due to non-action on a follow-up CT scan report.
- Patient 8 had a delayed diagnosis of Prostate cancer due to non-action on a histopathology report at TURP.
- Patient 3 with penile cancer had a 5 week wait between referral and first appointment. Subsequent time to diagnosis and MDM were appropriate. He had a 17 week wait for a CT scan for staging.
- Patient 7 was on a renal mass surveillance programme - a recommendation at MDM to discuss his case with the regional small renal lesion team was not actioned and it is not known if they would have suggested earlier intervention.

### Targets

- Three of the nine patients were said to have met one of their 31 / 62 day targets.
- Patient 8 was said to have met his diagnostic target for 31 days despite his tissue cancer diagnosis being missed and the patient suffering an 8 month delay.
- Patient 3 was said to have met his 62 day (1st treatment) target but had been referred down an incorrect pathway.
- Patient 9 was said to have met his diagnostic target of 31 days despite having a delay from initial presentation of 15 months.

### Multidisciplinary Meeting

- The MDM made appropriate recommendations for 8 of the 9 patients but there was no mechanism to check actions were implemented - this included, further investigations, staging, treatment and appropriate onward referral.
- Dr 1 was present for the discussions and party to the recommendations, 8 of which were compliant with National and Regional Guidelines.

## 6.0 FINDINGS

- In the case of the 5 patients with Prostate cancer, 5 patients were referred to the Multidisciplinary Meeting and had appropriate MDM recommendations.
- <sup>Patient 1</sup> [redacted] and <sup>Patient 4</sup> [redacted] to start Androgen Deprivation Therapy with LHRHa while <sup>Patient 6</sup> [redacted] was advised to have active surveillance or curative intent radiotherapy. None of these recommendations were implemented.
- NICAN Regional Hormone Therapy Guidelines for Prostate cancer 2016 were not followed.
- <sup>Patient 9</sup> [redacted] had a delayed diagnosis of prostate cancer and was belatedly seen at the Urology MDM 15 months after his first presentation. The recommendations from this MDM were correct but not implemented. Regional NICAN Hormone Therapy Guidelines for Prostate Cancer 2016 were not followed
- <sup>Patient 8</sup> [redacted] had an unexpected diagnosis of cancer at TURP. His diagnosis on pathology report was not actioned and he was discussed at MDM 8 months after his surgery and pathological diagnosis of cancer. His subsequent MDM recommendations were correct.
- Two patients had renal cancer. <sup>Patient 5</sup> [redacted] was initially appropriately discussed at MDM with action on recommendations. However a routine CT scan in December 2019 was not actioned, leading to a delayed re-presentation to MDM with a second primary diagnosis of metastatic prostate cancer.
- <sup>Patient 7</sup> [redacted] was on a surveillance pathway for a small renal lesion he was appropriately discussed at MDM. The meetings were not always quorate but a radiologist was present on 4 out of 5 occasions. An MDM recommendation to seek input from the regional small lesion group was not actioned.
- <sup>Patient 2</sup> [redacted] had a testicular tumour and was appropriately discussed at MDM with the recommendation onward referral to the regional testicular oncology team. This recommendation was time critical but did not happen.
- <sup>Patient 3</sup> [redacted] was appropriately discussed at the local MDM at diagnostic stage. Unfortunately his treatments and further discussions were restricted to local level and did not follow agreed regional and supra-regional pathways for penile cancer.
- Collation of MDM lists did not include a fail-safe list from histopathology. This would ensure all tissue diagnoses of cancer were cross checked against clinician declared cases. This would capture unexpected cases of cancer as in <sup>Patient 8</sup> [redacted] or as in <sup>Patient 9</sup> [redacted] where a delayed diagnosis presented to the GI surgeons for initial biopsy.
- The patient's care was through a Multidisciplinary Team process but unfortunately they did not benefit from it. The Multidisciplinary Meeting failed in its primary purpose to ensure patients received best care as defined by Regional and National Guidelines.
- The Urology MDM was under resourced and frequently non quorate due to lack of professionals. The MDM had quorate rates of 11% in 2017, 22% in 2018 0% in 2019 and 5% in 2020. This was usually due to lack of clinical oncology and medical oncology. Radiology had only one Urology Cancer Specialist

**6.0 FINDINGS**

Radiologist impacting on attendance but critically meaning there was no independent Quality Assurance of images by a second radiologist prior to MDM.

- The Urology MDM was under resourced for appropriate patient pathway tracking. The Review Team found that patient tracking related only to diagnosis and first treatment (that is 31 and 62 day targets). It did not function as a whole system and whole pathway tracking process. This resulted in preventable delays and deficits in care.
- Safe cancer patient care and pathway tracking is usually delivered by a three pronged approach of MDT tracking, Consultants and their secretaries and Urology Specialist Nurses, in a Key Worker role. The Review found that these 9 patients were not referred to Specialist Nurses and telephone numbers were not given. The MDM tracking system was limited. The consultant / secretary led process was variable and resulted in deficits. The weakness of the latter component was known from previous review.
- As patients were not re-discussed at MDM and Urology Cancer Nurse Specialist were not involved in care, non implementation of these MDM recommendations was unknown to others in the MDM. One patient D presented as an emergency and his care was changed to the MDM recommendation by another consultant.

**Multidisciplinary working and referral**

- The review team noted repeated failure to appropriately refer patients
- Patient 1 [redacted] should have been referred to oncology initially and then to palliative care as his disease progressed.
- Patient 9 [redacted] should have had an earlier diagnosis and referral to oncology.
- Patient 4 [redacted] should have been referred to oncology and palliative care.
- Patient 2 [redacted] should have been referred to oncology for time critical care.
- Patient 6 [redacted] should have been referred to oncology.
- Patient 7 [redacted] should have been referred to the Small Renal Mass Team.
- Patient 3 [redacted] should have been referred to the Regional / Supra-Regional Penile Cancer Network.
- Patients were not aware that the care given varied from Regional Standards and MDM recommendations. They could not have given informed consent to this.
- All patients were not referred to Urology Cancer Nurse Specialists despite this resource being increased by the Southern Health and Social Care Trust. Peer Review 2017 was informed that this resource was available to all. Their contact numbers were not made available.
- As patients were not re-discussed at MDM and Urology Cancer Nurse Specialist were not involved in care, non referral was an unknown to others within the MDM.

**6.0 FINDINGS****Patient Support and Experience**

All patients or families reported a positive experience with their treating consultant initially.

All patients and families were unaware of the additional support available to other patients.

Where patients had disease progression, they expressed concern at the disjointed nature of service provision and the inability to access supportive care. As they were unaware of the normal support mechanisms they believed this to be the normal standard of care or a standard that had been compromised by Covid 19 Pandemic.

All patients and their families were shocked by the fact that their care was not supported and that the care did not follow MDM recommendations. This was especially true when appropriate care should have entailed onward referral to oncology or palliative care.

**Affects of Covid**

- Some patient's planned review appointments did not go ahead but were rescheduled virtually. Some of the patients did not have their planned review in March / April 2020.
- The review team after speaking with the families and hearing their stories learned that for many of these patients they could not access services in their locality due to the covid restrictions. At the time two families described having difficulty accessing district nursing services for intravenous antibiotics in the community as services were stood down. One family expressed dismay at having difficulties visiting their loved one prior to his passing in hospital due to the covid restrictions and the emotional impact this has had on their grieving process. Others described how when catheters blocked they could not access support from their GP and where hence referred to the Emergency Department which the review team agree was not the best place for them. The review team are of the opinion that access to a specialist nurse could have offered support for these families and provide direction to the appropriate services.

**Governance / Leadership**

- The review team considered the treatment and care of 9 patients who were treated under the care of Dr 1 Consultant Urologist. Individual reviews were conducted on each patient. The review team identified a number of recurrent themes following each review.
- The treatment provided to 8 out of 9 patients was contrary to the NICAN Urology Cancer Clinical Guidelines (2016). This Guidance was adopted by the Southern Health and Social Care Trust Urology Multidisciplinary Team and evidenced by them as their protocols for Cancer Peer review (2017). The Guidance was issued following Dr.1 & Chairmanship of the Northern Ireland

**6.0 FINDINGS**

Cancer Network Urology Cancer Clinical Reference Group.

- The Urology MDM made recommendations that were deemed appropriate in 8 of 9 cases and were made with contribution and knowledge of Dr.1. Many of the recommendations were not actioned or alternative therapies given. There was no system to track if recommendations were appropriately completed.
- The MDT guidelines indicate "all newly diagnosed patients have a Key Worker appointed, a Holistic Needs Assessment conducted, adequate communication and information, advice and support given, and all recorded in a Permanent Record of Patient Management which will be shared and filed in a timely manner". None of the 9 patients had access to a Key Worker or Cancer Nurse Specialist. The use of a CNS is common for all other urologists in the SHSCT urology multidisciplinary team allowing any questions or concerns that patients' have to be addressed. This did not happen.
- The review team considered if this was endemic within the Multidisciplinary Team and concluded that it was not. Patients booked under other consultant urologists had access to a specialist nurse to assist them with their cancer journey.
- Statements to Urology Cancer Peer Review (2017) indicated that all patients had access to a Key worker / Urology Cancer Nurse Specialist. This was not the case and was known to be so.
- The Urology Cancer Nurse Specialist play an integral role of the MDT and should be facilitated on all the MDM to advocate on patient's best interest throughout the patient's journey. This should include independently referring and discussing patients at MDT.
- The Review Team regard absence of Specialist Nurse from care to be a clinical risk which was not fully understood by Senior Service Managers and the Professional Leads. The Review team have heard differing reports around escalation of this issue but are clear that patients suffered significant deficit because of non inclusion of nurses in their care. While this is the primary responsibility of the referring consultant, there is a responsibility on the SHSCT to know about the issue and address it.
- Assurance audits of patient pathways within the Urology Cancer Services were limited between 2017 and 2020. They could not have provided assurance about the care delivered.
- Because of resource, the MDM was very focused on first presentation at MDM and did not have a role in tracking subsequent actions if it lay outside 31 and 62 day targets. Tracking of patients was flawed by limitations within the MDM systems and the lack of Specialist Urology Nurses from their Key Worked role. Two of the three normal safety nets for patient pathway completion were, in essence absent.
- Annual business meetings had an expressed role in identifying service deficits and drawing up an annual work plan to address them. Cancer Patient Pathway compliance audits were limited and did not identify the issues within this report.

**6.0 FINDINGS**

- Governance of professionals within the MDT ran through their own directorates but there was no functioning process within Cancer Services to at least be aware of concerns - even if the responsibility for action lay elsewhere within the Southern Health and Social Care Trust. There was disconnect between the Urology MDT and Cancer Services Management. The MDT highlighted inaction by Cancer Services on Oncology and radiology attendance at MDM, but did not escalate other issues.
- The Review team found that issues around prescribing and the use of Clinical Nurse Specialists were of long standing. They were known internally and in the case of prescribing externally (Regional Oncology Services). The Northern Ireland Cancer Network drew up specific Guidance on Hormonal Therapy in Prostate Cancer in 2016 following concerns about this issue. The Guidance was not subject to audit within the Southern Health and Social Care Trust.
- The Review team were concerned that the leadership roles focused on service delivery while having a limited process to benchmark quality, identify deficiencies and escalate concerns as appropriate. Senior managers and clinical leaders in medicine and nursing were unaware of the issues detailed in this report.
- There had been a previous SAI signed off in May 2020 regarding adherence to Cancer Red Flag referral Pathways. The SAI process started in July 2016. The review team is concerned that, as part of early learning, assurances regarding other aspects of the cancer pathway were not sought. Clinical Leadership within Cancer Services were unaware of issues leading to the SAI in 2016.
- Patients in this review were not referred back appropriately to MDM as their diseased progressed. This meant there was no access to oncology and palliative care for many patients, when needed. Care needs within the community were unmet and patients left isolated.

## 7.0 CONCLUSIONS

The Review Team would like to thank the patients and their families for their contribution to the report and their willingness to share their experiences. The process was difficult and at times traumatic for them. The review team acknowledge that this report may cause distress to the patient and their families, however the team has endeavoured to produce a complete and transparent account of each patient's journey.

The Review of nine patients has detailed significant healthcare deficits while under the care of one individual in a system. The learning and recommendations are focused on improving systems of multidisciplinary care and its governance. It is designed to deliver what was asked of the Review Team by patients and families - "to ensure that this does not happen again or that another patient suffers".

The Patients in this review received uni-professional care despite a multidisciplinary resource being available to all others. Best Practice Guidance was not followed and recommendations from MDM were frequently not implemented or alternative treatments chosen. There was knowledge of that prescribing practice varied from regional and national guidelines in the Southern Health and Social care Trust, as well as more widely across the Cancer Network. This was challenged locally and regionally, but not effectively, to provide safe care for all patients. Inappropriate non referral of patients to oncology and palliative care was unknown.

The primary duty of all doctors, nurses and healthcare professionals is for the care and safety of patients. Whatever their role, they must raise and act on concerns about patient safety. This did not happen over a period of years resulting in MDM recommendations not being actioned, off guidance therapy being given and patients not being appropriately referred to specialists for care. Patients were unaware that their care varied from recommendations and guidance. They could not and did not give informed consent to this.

The systems of governance within the Urology SHSCT Cancer Services were ineffective and did not provide assurance regarding the care and experience of the nine patients in the review. Assurance audits were limited, did not represent whole patient journey and did not focus on areas of known concern. Assurances given to Peer review were not based on systematic audit of care given by all.

While it is of little solace to the patients and families in this review, The Review team sought and received assurances that care provided to others adhered to recommendations on MDM and Regional / National Guidance.

Four of the nine patients suffered serious and significant deficits in their care. All patients had sub-optimal care that varied from regional and national guidelines.



**8.0 LESSONS LEARNED**

The review identified Cancer Care given by Dr 1 that did not follow agreed MDM recommendations nor follow regional or national best practice guidance. It was care given without other input from Cancer Specialist Nurses, Oncology and palliative care. It was inappropriate, did not meet patient need and was the antithesis of quality multidisciplinary cancer care.

Ensure all patients receive appropriately supported high quality cancer care irrespective of the professional delivering care.

Ensure all cancer care is multidisciplinary and centred on patients physical and emotional need.

Have processes in place to provide assurances to patients and public that care meets these requirements.

That the role of the Multidisciplinary Meeting Chair is defined by a Job Description with specific reference to Governance, Safe Care and Quality Care. It should be resourced to provide this needed oversight.

**9.0 RECOMMENDATIONS AND ACTION PLANNING**

*The recommendations represent an enhanced level of assurance. They are in response to findings from nine patients where Dr 1 did not adhere to agreed recommendations, varied from best practice guidance and did not involve other specialist appropriately in care. They are to address what was asked of the Review by families - "that this does not happen again".*

**Recommendation 1.**

*The Southern Health and Social Care Trust must provide high quality urological cancer care for all patients.*

This will be achieved by - Urology Cancer Care delivered through a co-operative multi-disciplinary team, which collectively and inter-dependently ensures the support of all patients and their families through, diagnosis, treatment planning and completion and survivorship.

Timescale - Immediate

Assurance - Comprehensive Pathway audit of all patients care and experience. This should be externally benchmarked within a year by Cancer Peer Review / External Service Review by Royal College.

**Recommendation 2.**

*All patients receiving care from the SHSCT Urology Cancer Services should be appropriately supported and informed about their cancer care. This should meet the standards set out in Regional and National Guidance and meet the expectation of Cancer Peer Review.*

**9.0 RECOMMENDATIONS AND ACTION PLANNING**

This will be achieved by - Ensuring all patients receive multidisciplinary, easily accessible information about the diagnosis and treatment pathway. This should be verbally and supported by documentation. Patients should understand all treatment options recommended by the MDM and be in a position to give fully informed consent.

Timescale - Immediate

Assurance - Comprehensive Cancer Pathway audit and Patient experience.

**Recommendation 3.**

*The SHSCT must promote and encourage a culture that allows all staff to raise concerns openly and safely.*

This will be achieved by - Ensuring a culture primarily focused on patient safety and respect for the opinions of all members. The SHSCT must take action if it thinks that patient safety, dignity or comfort is or may be compromised. Issues raised must be included in the Clinical Cancer Services oversight fortnightly agenda. There must be action on issues escalated.

Timescale - Immediate

Assurance - Numbers of issues raised through Cancer Services, Datix Incidents identified, numbers of issues resolved, numbers of issues outstanding.

**Recommendation 4.**

*The Trust must ensure that patients are discussed appropriately at MDM and by the appropriate professionals.*

This will be achieved by - All MDMs being quorate with professionals having appropriate time in job plans. This is not solely related to first diagnosis and treatment targets. Re-discussion of patients, as disease progresses is essential to facilitate best multidisciplinary decisions and onward referral (e.g. Oncology, Palliative care, Community Services).

Timescale - 3 months

Assurance - Quorate meetings, sufficient radiology input to facilitate pre MDM QA of images - Cancer Patient pathway Audit - Audit of Recurrent MDM discussion - Onward referral audit of patients to Oncology / Palliative Care etc.

**Recommendation 5.**

*The Southern Health and Social Care Trust must ensure that MDM meetings are resourced to provide appropriate tracking of patients and to confirm agreed recommendations / actions are completed.*

This will be achieved by - Appropriate resourcing of the MDM tracking team to encompass a new role comprising whole pathway tracking, pathway audit and pathway assurance. This should be supported by fail-safe mechanisms from laboratory services and Clinical Nurse Specialists as Key Workers. A report should be

**9.0 RECOMMENDATIONS AND ACTION PLANNING**

generated weekly and made available to the MDT. The role should reflect the enhanced need for ongoing audit / assurance. It is essential that current limited clinical resource is focused on patient care.

Timescale - 3 months

Assurance - Comprehensive Cancer care Pathway audit - Exception Reporting and escalation

**Recommendation 6.**

*The Southern Health and Social Care Trust must ensure that there is an appropriate Governance Structure supporting cancer care based on patient need, patient experience and patient outcomes.*

This will be achieved by - Developing a proactive governance structure based on comprehensive ongoing Quality Assurance Audits of care pathways and patient experience for all. It should be proactive and supported by adequate resources. This should have an exception reporting process with discussion and potential escalation of deficits. It must be multidisciplinary to reflect the nature of cancer and work with other directorates.

Timescale - 3 months

Assurance - Cancer Pathway Audit outcomes with exception discussion and escalation. Data should be declared externally to Cancer Peer Review

**Recommendation 7.**

*The role of the Chair of the MDT should be described in a Job Description, funded appropriately and have an enhanced role in Multidisciplinary Care Governance.*

Timescale - 3 months

**Recommendation 8.**

*All patients should receive cancer care based on accepted best care Guidelines (NICAN Regional Guidance, NICE Guidance, Improving Outcome Guidance).*

This will be achieved by - Ensuring the multi-disciplinary team meeting is the primary forum in which the relative merits of all appropriate treatment options for the management of their disease can be discussed. As such, a clinician should either defer to the opinion of his / her peers or justify any variation through the patient's documented informed consent.

Timescale - Immediate

Assurance - Variance from accepted Care Guidelines and MDM recommendations should form part of Cancer Pathway audit. Exception reporting and escalation would only apply to cases without appropriate peer discussion.

**9.0 RECOMMENDATIONS AND ACTION PLANNING****Recommendation 9.**

The roles of the Clinical Lead Cancer Services and Associate Medical Director Cancer Services should be reviewed. The SHSCT must consider how these roles can redress Governance and Quality Assurance deficits identified within the report.

Timescale - 3 months

**Recommendation 10.**

--This recommendation will be agreed following discussion with families.

**Recommendation 11**

*The Southern Health and Social Care Trust should consider if assurance mechanisms detailed above, should be applied to patients or a subset of patients retrospectively.*

**References:**

1. Hoffmann, R., et al. Innovations in health care and mortality trends from five cancers in seven European countries between 1970 and 2005. *Int J Public Health*, 2014. 59: 341.
2. Oliver, R.T., et al. Radiotherapy versus single-dose carboplatin in adjuvant treatment of stage I seminoma: a randomised trial. *Lancet*, 2005. 366: 293.
3. Laguna M.P., et al. EAU Guidelines: testicular cancer. [https://uroweb.org/guideline/testicular-cancer/note\\_127-129](https://uroweb.org/guideline/testicular-cancer/note_127-129) (accessed 26/02/2021)
4. Peer review Self-Assessment report for NICaN 2017
5. Northern Ireland Cancer Network (NICAN) Urology Cancer Guidelines (2016)
6. EAU guidelines for penile cancer: section 6.2.1 (2019)
7. NICE improving outcomes in urological cancer (2002)
8. NICAN Urology Cancer Clinical Guidelines (March 2016), Penile Cancer treatment Section 9.3 (3).

**10.0 DISTRIBUTION LIST**

Mr Shane Devlin – Chief Executive SHSCT

Mrs Melanie McClements – Director of Acute Services SHSCT

Dr Maria O’Kane – Medical Director SHSCT

Mrs Heather Trouton Executive Director of Nursing, Midwifery and AMPs

PHA

HSCB

## Checklist for Engagement / Communication with Service User<sup>1</sup> / Family / Carer following a Serious Adverse Incident

*(This checklist should be completed in full and submitted to the HSCB along with the completed SAI Review Report  
for all levels of SAI reviews)*

|                                               |                                          |                         |                                          |
|-----------------------------------------------|------------------------------------------|-------------------------|------------------------------------------|
| <b>Reporting Organisation SAI Ref Number:</b> | Personal Information redacted by the USI | <b>HSCB ref Number:</b> | Personal Information redacted by the USI |
|-----------------------------------------------|------------------------------------------|-------------------------|------------------------------------------|

### SECTION 1

| INFORMING THE SERVICE USER <sup>1</sup> / FAMILY / CARER                                                                                                                                                                       |                            |  |                                |          |                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--|--------------------------------|----------|------------------------------------------|
| <b>1) Please indicate if the SAI relates to a single service user, a number of service users or if the SAI relates <u>only</u> to a HSC Child Death notification (SAI criterion 4.2.2)</b><br>Please select as appropriate (✓) | <b>Single Service User</b> |  | <b>Multiple Service Users*</b> | <b>x</b> | <b>HSC Child Death Notification only</b> |
| <b>Comment:</b><br><br><i>*If multiple service users involved please indicate the number involved</i>                                                                                                                          |                            |  |                                |          |                                          |
| <b>2) Was the Service User<sup>1</sup> / Family / Carer informed the incident was being investigated as a SAI?</b><br><br>Please select as appropriate (✓)                                                                     | <b>YES</b>                 |  | <b>NO</b>                      |          |                                          |
| If YES, insert date informed:                                                                                                                                                                                                  |                            |  |                                |          |                                          |
| If NO, please select <b>only one</b> rationale from below, for <b>NOT INFORMING</b> the Service User / Family / Carer that the incident was being investigated as a SAI                                                        |                            |  |                                |          |                                          |
| <b>a) No contact or Next of Kin details or Unable to contact</b>                                                                                                                                                               |                            |  |                                |          |                                          |
| <b>b) Not applicable as this SAI is not 'patient/service user' related</b>                                                                                                                                                     |                            |  |                                |          |                                          |
| <b>c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user</b>                                                                                                    |                            |  |                                |          |                                          |
| <b>d) Case involved suspected or actual abuse by family</b>                                                                                                                                                                    |                            |  |                                |          |                                          |
| <b>e) Case identified as a result of review exercise</b>                                                                                                                                                                       |                            |  |                                |          |                                          |
| <b>f) Case is environmental or infrastructure related with no harm to patient/service user</b>                                                                                                                                 |                            |  |                                |          |                                          |
| <b>g) Other rationale</b>                                                                                                                                                                                                      |                            |  |                                |          |                                          |
| If you selected c), d), e), f) or g) above please provide further details:                                                                                                                                                     |                            |  |                                |          |                                          |
| <b>For completion by HSCB/PHA Personnel Only (Please select as appropriate (✓))</b>                                                                                                                                            |                            |  |                                |          |                                          |
| <b>Content with rationale?</b>                                                                                                                                                                                                 | <b>YES</b>                 |  | <b>NO</b>                      |          |                                          |

| SHARING THE REVIEW REPORT WITH THE SERVICE USER <sup>1</sup> / FAMILY / CARER                                                                 |            |          |           |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------|------------|----------|-----------|--|
| (complete this section where the Service User / Family / Carer has been informed the incident was being investigated as a SAI)                |            |          |           |  |
| <b>3) Has the Final Review report been shared with the Service User<sup>1</sup> / Family / Carer?</b><br><br>Please select as appropriate (✓) | <b>YES</b> | <b>x</b> | <b>NO</b> |  |
| If YES, insert date informed: <b>all informed 26 October 2020</b>                                                                             |            |          |           |  |
| If NO, please select <b>only one</b> rationale from below, for <b>NOT SHARING</b> the SAI Review Report with Service User / Family / Carer    |            |          |           |  |
| <b>a) Draft review report has been shared and further engagement planned to share final report</b>                                            |            |          |           |  |
| <b>b) Plan to share final review report at a later date and further engagement planned</b>                                                    |            |          |           |  |
| <b>c) Report not shared but contents discussed</b><br><i>(if you select this option please also complete 'I' below)</i>                       |            |          |           |  |

<sup>1</sup>Service User or their nominated representative

*This checklist should be completed in line with the HSCB Procedure for the reporting and follow up of SAIs October 2013 and the HSC Guidance for staff on engagement/communication with Service Users<sup>1</sup> / Families/Carers following a SAI*

**SHARING THE REVIEW REPORT WITH THE SERVICE USER<sup>1</sup> / FAMILY / CARER***(complete this section where the Service User / Family / Carer has been informed the incident was being investigated as a SAI)**Continued overleaf*

d) No contact or Next of Kin or Unable to contact

e) No response to correspondence

f) Withdrew fully from the SAI process

g) Participated in SAI process but declined review report

*(if you select any of the options below please also complete 'I' below)*h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user<sup>1</sup> family/ carer

i) case involved suspected or actual abuse by family

j) identified as a result of review exercise

k) other rationale

l) If you have selected c), h), i), j), or k) above please provide further details:

**For completion by HSCB/PHA Personnel Only** (Please select as appropriate (✓))

Content with rationale?

YES

NO

**SECTION 2****INFORMING THE CORONER'S OFFICE****(under section 7 of the Coroners Act (Northern Ireland) 1959)***(complete this section for all death related SAIs)*

1) Was there a Statutory Duty to notify the Coroner at the time of death?

Please select as appropriate (✓)

YES

NO

If YES, insert date informed:

If NO, please provide details:

2) Following or during the review of the SAI was there a Statutory Duty to notify the Coroner?

Please select as appropriate (✓)

YES

NO

If YES, insert date informed:

If NO, please provide details:

3) If you have selected 'YES' to any of the above '1' or '2' has the review report been shared with the Coroner?

Please select as appropriate (✓)

YES

NO

If YES, insert date report shared:

If NO, please provide details:

**DATE CHECKLIST COMPLETED****1.3.2021**<sup>1</sup>Service User or their nominated representative*This checklist should be completed in line with the HSCB Procedure for the reporting and follow up of SAIs October 2013 and the HSC Guidance for staff on engagement/communication with Service Users<sup>1</sup> / Families/Carers following a SAI*



**1.0 EXECUTIVE SUMMARY**

XX a 74 year old man was diagnosed with a Gleason 4+3 prostate cancer on 28 August 2019. There was no evidence of perineural infiltration, lymphovascular invasion or extracapsular extension.

He was discussed at MDM on 31 October 2019, his bone scan and CT scan showed no metastatic spread outside the prostate. A recommendation to commence LHRH analogue and refer for an opinion from a clinical oncologist regarding external beam radiation therapy (EBRT) was agreed. This was not actioned. XX was commenced on Bicalutamide 50mgs once daily. He was commenced on LHRH analogue on 1 June 2020 and was referred to oncology on 22 June 2020. XX's disease progressed and he passed away on 18 August 2020.

**2.0 THE REVIEW TEAM**

Dr Dermot Hughes – External Independent Chair: Former Medical Director Western Health and Social Care Trust. Former Medical Director of the Northern Ireland Cancer Network (NICAN).

Mr Hugh Gilbert - Expert External Clinical Advisor from the British Association of Urological Surgeons BAUS.

Mrs Fiona Reddick – Head of Cancer Services (SHSCT).

Ms Patricia Thompson – Clinical Nurse Specialist (Formally SET and recently SHSCT).

Mrs Patricia Kingsnorth – Acting Acute Clinical and Social Care Governance Coordinator.

**3.0 SAI REVIEW TERMS OF REFERENCE**

The aims and objectives of this review are to:

- To carry out a systematic multidisciplinary review of the process used in the diagnosis, multidisciplinary team decision making and subsequent follow up and treatment provided for each patient identified, using a Root Cause Analysis (RCA) Methodology.
- To review individually the quality of treatment and care provided to each patient identified and consider any factors that may have adversely influenced or contributed to subsequent clinical outcomes.
- To engage with patients / families to ensure where possible questions presented to the review team or concerns are addressed within the review.
- To develop recommendations to establish what lessons are to be learned and how our systems can be strengthened regarding the delivery of safe, high quality care.
- Examine any areas of good practice and opportunities for sharing learning from the incidents.
- To share the report with the Director of Acute Services/ Medical Director of SHSCT/ HSCB/Family/ staff involved.



**Urology MDM @ The Southern Trust****RE:**

Patient 1

Personal Information redacted by USI

DOB:

Personal Information  
redacted by USI

, Hospital Number:

Personal Information  
redacted by USI

, HCN:

Personal Information  
redacted by USI

Discussed at Urology MDM 31.10.19.

Review with Mr O'Brien as arranged.

Patient 1

has intermediate risk prostate cancer to start ADT and refer for ERBT.

If you have any queries or require further information, please do not hesitate to contact us.

Yours sincerely,

Chairman of Urology MDM

Mr John O'Donoghue

Consultant Urologist

**5.0 DESCRIPTION OF INCIDENT/CASE**

advised of the outcome of the MDM by letter.

XX was reviewed by Dr.1 on 23 September 2019 and was told that he had high-risk prostate cancer. No staging investigations were requested. Instead, he was prescribed Bicalutamide 150mgs once daily and Tamoxifen 10mgs once daily in order to minimise the risk of breast tenderness a possible side-effect of the anti-androgen.

XX received a follow up phone call from Dr.1 on 14 October 2019 following a request for advice regarding the potential side effects to his medication. Dr.1 reported that XX was experiencing some light headedness and dizziness, which was affecting his ability to drive. Dr.1 advised XX to cease both hormonal medications. However, although XX's PSA was noted to be rising (21.8ng/ml), a plan was made to re-check the PSA level. The bone scan and CT scans were also arranged. XX was advised to recommence Bicalutamide at a lower dose (50mgs once daily) from 1 November 2019.

XX was discussed again at MDM on 31 October 2019. His bone scan and CT scan showed no metastatic spread of disease outside the prostate. A recommendation to commence androgen deprivation therapy (a LHRH analogue) and refer for an opinion from a Clinical Oncologist regarding external beam radiation therapy (EBRT) was agreed.

XX attended his outpatient appointment with Dr.1 on 11 November 2019. His lower urinary tract symptoms were unchanged. His PSA result had fallen to 3.84ng/ml. Dr.1 described in a letter to XX's GP that if the PSA level did not decrease further at a subsequent check, *"it may be necessary to take an incremental approach to increased androgen blockade by increasing the dose of bicalutamide to 50mgs twice daily, and hopefully subsequently to taking the higher dose of 150mgs once again.... I suspect that the addition of an LHRH agonist may be more intolerable"*.

A review on 27 January 2020 took place as planned. The PSA was noted to be 2.23nmol/ml, but XX's urinary symptoms including nocturia continued. XX was asked to increase the Bicalutamide to 100mgs once daily.

On 7 March 2020, XX received a telephone call from Dr.1, who advised that the PSA level had increased to 5.37ng/ml. The dose of bicalutamide was increased to 150mgs once daily.

A planned review appointment for 27 April 2020 had been made however, on 23 March 2020 XX attended the Emergency Department in South West Acute Hospital Enniskillen (SWAH) complaining of difficulty passing urine. He was assessed and sent home. XX re-attended on 7 April 2020 and was found to be in urinary retention. A urethral catheter was fitted.

On 1 June 2020, Dr.1 informed XX in a telephone conversation that the PSA level had risen to 12.08ng/ml and advised the commencement of Leuprorelin (a LHRH analogue) subcutaneous injection be administered monthly by the practice nurse at the GP surgery.

To try and remove the urethral catheter, arrangements were made for a transurethral resection of prostate (TURP) at Daisy Hill Hospital (DHH). He was advised to self-



## 6.0 FINDINGS

This patient was investigated appropriately up to and including the original biopsies. The staging scans (bone and CT) would normally be expected to have been performed with a degree of urgency. These would have demonstrated no metastases and this should have led to a referral to a Clinical Oncologist as it would have been reasonable to consider radical treatment with external beam radiotherapy. Conventionally this would have been preceded by at least 4 months of neo-adjuvant ADT and this could have been started before the results of the scans were available.

- The review team found that the initial assessment of XX was satisfactory although rather prolonged.
- The initial treatment should have been reversible ADT – most commonly a LHRH analogue – pending the results of the staging scans.
- The prescribed hormone therapy did not conform to the Northern Ireland Cancer Network (NICAN) Urology Cancer Clinical Guidelines (2016), which was signed off by the Southern Health and Social Care Trust (SHSCT) urology multidisciplinary meeting, as their protocols for cancer care for Cancer Peer Review (2017).
- This prescribing did not conform with the NICAN "Hormone Therapy Guidelines for Prostate Cancer 2016" which was signed off by Dr 1 as Chair of the Regional Urology Cancer Clinical Reference Group.
- The subsequent management with unlicensed anti-androgenic treatment (bicalutamide) at best delayed definitive treatment. Bicalutamide (50mg) is currently only indicated as a preliminary anti-flare agent and is only prescribed before ADT. Treatment for prostate cancer is based on achieving biochemical castration (Testosterone <1.7 nmol/l), which is best accomplished with ADT through a LHRH analogue, by an LHRH antagonist or by bilateral subcapsular orchiectomy.
- Following discussion with the families, the review team have noted that the variance from regional care pathways and the anti-androgen dosage used in his case was not discussed with XX. He could not and did not give informed consent to this alternative care pathway.
- The family also informed the Review Team that Jim had not exhibited any of the vagueness implied by Dr 1.
- Of relevance to this case, the review team have identified that the MDMs were not quorate due to the absence of an oncologist at the meetings. During this timeframe 11% of meetings had oncology presence due to the lack of resource at SHSCT and a heavy clinical workload.
- The specific MDM recommendation of 31 October 2019, to prescribe a LHRH analogue and to refer to clinical oncology for external beam radiotherapy were not actioned. Dr.1 neither provided a noted rationale for this inaction nor was it



**6.0 FINDINGS**

discussed with the patient.

- XX could not and did not give informed consent for this action.
- XX did not have a Cancer Nurse Specialist (CNS) or Key Worker to support his care. The SHSCT had invested in additional resource to provide Specialist Nurses to all urology cancer patients. The SHSCT had indicated to Cancer Peer Review (2017) that all patients had access to this resource. The review team have been informed that Dr.1 excluded all CNSs from the care of his patients at clinics. This was contrary to the regional guidance and contrary to the multidisciplinary ethos of cancer care.
- The review team found that without appropriate CNS support, XX and his family had difficulties in accessing support and care, especially in the community. This resource was provided by the SHSCT but was denied to XX by the exclusion of CNS involvement. XX's family tried their best to address this deficit, with input from family, extended family and friends.
- The review team noted that XX's case was not re-discussed at the MDM despite clear progression of the disease. This meant there was no opportunity for XX to benefit from the multi-disciplinary care, other urologists, oncology and especially palliative care, that underpins Improving Outcomes Guidance (2002). The absence of any CNS input to XX's care meant that they were unaware of the disease progression and could not refer back to the MDM independently.
- The review team concluded that XX received uni-professional treatment and care despite multi-professional resources being available. His care did not follow regional guidance and treatment recommendations from the MDM were ignored. XX was denied the opportunity of multidisciplinary professional referral and care: initially from a clinical oncologist when radical therapy should have been considered; and subsequently from high quality palliative care when it became necessary.
- XX developed metastases whilst being inadequately treated for high-risk prostate cancer. The opportunity to offer him radical (with curative intent) treatment was lost.

**Family Engagement.**

- The review panel met with XX's family. They were advised that XX did not have a CNS to support him through his cancer diagnosis. XX's daughter was planning to get married next year and brought her wedding forward to November when they learned of XX disease progression. But XX died sooner than they expected.
- The family highlighted the huge impact of the indwelling catheter problems caused to Patient 1 from March/ April 2020. The family described his difficulties in trying to contact Dr 1 and his secretary. Had a CNS been introduced to Patient 1 at his initial diagnosis, he would have been provided with contact details. He



# Southern Health and Social Care Trust

## Acute Governance

The late **Patient 1**

**Monday 9 November 2020**  
**South Tyrone Hospital**

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**PRESENT:** Dr Dermot Hughes (Chair)  
Mrs Patricia Kingsnorth  
**Patient 1's Wife** (Wife)  
**Patient 1's Daughter** (daughter)

Patricia Kingsnorth introduced herself and the chair of the review Dr Dermot Hughes. Patricia offered both **Patient 1's Daughter** and **Patient 1's Wife** condolences on the loss of **Patient 1** and thanked them for meeting today.

Dr Hughes explained his role in the SAI review. He explained he was retired Medical Director of Western Trust and was Chair of the Northern Ireland Cancer Network. He was asked to Chair the review as an independent body outside the Trust. Other panel members Mr Hugh Gilbert Consultant Urologist from Bristol , an external panel member, specialist urologist nurse newly appointed to the Trust, Head of Cancer Services; Patricia Kingsnorth Clinical Governance Co-ordinator. The SAI review will involve 9 other families.

**Patient 1's Daughter** asked why are we completing the SAI review?

Dr Hughes advised that a consultant urologist recently retired and patients were picked up by other consultants who have highlighted their concerns regarding the management of some patient's care. The Trust decided to carry out a review and the number of patients identified grew. Dr Hughes advised that he was asked to chair the review and at the beginning there were 4-5 cases however this number since has increased to 9.

Dr Hughes explained there were issues in relation to cancer care but they are not exclusive to prostate cancer patients. Review will look at how patients were managed, and ask the questions: was treatment timely and appropriate? The purpose of the review is to find out what happened and why it happened? Why were things not picked up? Dr Hughes explained that patients are generally discussed at multidisciplinary team meeting (MDT). The MDT meets regularly to discuss patient's care. It follows national and regional guidelines, to ensure that treatment and care is carried out within these guidelines and done in timely fashion.

## RECORD OF SCREENING

Patient 35

Personal Information redacted by USI

HNC:

Datix :

redacted by USI

|                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|---------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Directorate:</b>             | Acute Services                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Reporting Division:</b>      | SEC/ Urology                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Date of Incident:</b>        | 23/11/21                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Date of Screening</b>        | 29/11/21                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Incident (IR1) ID:</b>       | Personal Information redacted by USI                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Grade of Incident:</b>       | moderate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Screening Team:</b>          | Dr Ted McNaboe<br>Dr Raymond McKee<br>Mr Mark Haynes<br>Mr Ronan Carroll<br>Mrs Sarah Ward<br>Mr Chris Wamsley<br>Mrs Carly Connolly                                                                                                                                                                                                                                                                                                                                                     |
| <b>Summary of Incident</b>      | Initial diagnosis in 2009 with a Gleason 7 T2 adenocarcinoma of the prostate gland. US guided biopsy in 2012 Gleason 7 was noted and a PSA of 3.9.                                                                                                                                                                                                                                                                                                                                       |
| <b>Summary of Discussions</b>   | 29/11/2021 Discussed at screening. Same as previous cases. Feb 2013 Bicalutamide 50mg, Off licence dose, later increased 150mg, no evidence offered surgery instead of hormone treatment, completed radiotherapy December 2014. FOR SJR Surgery should be a treatment option, no evidence choice offered, low dose of Bicalutamide . treatment discussion in outpatient department, should be in notes. See attached notes.07/02/2022 Discussed at screening, Bicalutamide dose. FOR SJR |
| <b>Level and Type of Review</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Review Team</b>              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

## UROLOGY PATIENT REVIEW FORM

This form is to be completed for each patient previously under the care of Mr O'Brien reviewed by the Southern Trust Urology team since Mr O'Brien's departure on 17th July 2020. This form is to be retained in the patient notes and copied to Martina Corrigan, Head of Service.

### Patient Details

|               |                                      |
|---------------|--------------------------------------|
| Name          | Patient 35                           |
| H&C Number    | Personal Information redacted by USI |
| Date of Birth | Personal Information redacted by USI |

### Patient Details

|                         |                                                                                                                                                                                         |
|-------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Presenting Condition(s) |                                                                                                                                                                                         |
| Patient Summary         | <p>Radiotherapy 2015 for Gleason 3+4 tumour</p> <p>Sudden rise in PSA in 2019</p> <p>Diffuse metastases on bone scan</p> <p>Started on bicalutamide 150</p> <p>Referred to oncology</p> |
|                         | Personal Information redacted by the USI                                                                                                                                                |

Regarding the patients current care

|   | Question                                                                                                                                                                                                                                                                                                    | Y / N / Unable to Determine | Details |
|---|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|---------|
| 1 | <p><b>Is the present diagnosis / diagnoses reasonable?</b></p> <p><i>('Reasonable' to consider if diagnosis / diagnoses is consistent with investigations and examinations carried out to date, is there a requirement for further investigations / examinations to confirm diagnosis / diagnoses?)</i></p> |                             | Yes     |
| 2 | <p><b>Are the current medications prescribed appropriate?</b></p> <p><i>('Appropriate' to consider if prescribing is consistent with current best evidence based practice, are any deviations from guidance recorded and rationale fully noted?)</i></p>                                                    |                             | N/A     |



|   |                                                                                                                                                                                                                                                  |  |     |
|---|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----|
| 3 | <b>Is a secure clinical management plan currently in place?</b><br><i>(‘Secure Clinical Management Plan’ to consider if the current patient treatment pathway is optimal and in line with current best evidence based practice and guidance)</i> |  | N/A |
| 4 | <b>If there is not a secure clinical management plan in place please document immediate actions required to be taken</b>                                                                                                                         |  |     |

Based on the information available at the time of previous reviews, please answer the following to the best of your knowledge. If a determination cannot be made please give reasons why.

| No. | Question                                                                                                                                                                                                                                                                                          | Y / N /<br>Unable to<br>Determine | Details |
|-----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|---------|
| 4   | <b>Were appropriate and complete investigations carried out for all relevant conditions?</b><br><i>(‘Appropriate’ to consider if investigations consistent with current best evidence based practice at the time of review, are deviations from guidance recorded and rationale fully noted?)</i> |                                   | Yes     |
| 5   | <b>Were the medications prescribed appropriate?</b><br><i>(‘Appropriate’ to consider if prescribing was consistent with current best evidence based practice at the time of previous review, are deviations from guidance recorded and rationale fully noted?)</i>                                |                                   | N/A     |
| 6   | <b>Were the diagnosis / diagnoses reasonable?</b><br><i>(‘Reasonable’ to consider if diagnosis / diagnoses is consistent with investigations and examinations carried at the time of review, was there a</i>                                                                                      |                                   | Yes     |



|   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |            |
|---|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------|
|   | <i>requirement for further investigations / examinations to confirm diagnosis / diagnoses?)</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |            |
| 7 | <b>Was the clinical management approach taken reasonable?</b><br><i>(‘Reasonable’ to consider if clinical management plan if the patient treatment pathway at the time was optimal and in line with best evidence based practice and guidance available at that time.)</i>                                                                                                                                                                                                                                                                                        |  | <b>Yes</b> |
| 8 | <b>Were there unreasonable delays within the Consultants control with any aspect of care (reviews, prescribing, diagnostics, dictation etc)</b><br><i>(‘Unreasonable Delays’ to consider if diagnosis required more urgent treatment / intervention that was received based on best evidence based practice and guidance available at that time. The Southern Health and Social Care Trust will consider any delays in treatment highlighted to assess if these were within the Consultants control or due to systematic issues e.g. length of waiting lists)</i> |  | <b>No</b>  |
| 9 | <b>On balance, did the patient suffer any harm or detriment as a result of any of the above questions (4-9) ?</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | <b>No</b>  |

## Clinical Professional Reviewing Care

|                            |                |
|----------------------------|----------------|
| <b>Name</b>                | Krishna Sethia |
| <b>Title</b>               | Professor      |
| <b>Date of Appointment</b> |                |

**Structured Clinical Record Review title(SCRR)**

**Section 1**

*This section should be completed as soon as is possible following identification of the incident  
If it is deemed appropriate to complete Section 2, it should be completed within 8 Weeks (56 days)*

|                                                                                                                                                                                                                                                                                           |                                                                                                          |                                |            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|--------------------------------|------------|
| <b>Patient identification number:</b>                                                                                                                                                                                                                                                     | Personal Information redacted by the USI                                                                 | <b>Gender:</b>                 | Male       |
| <b>Date of birth (dd/mm/yyyy)</b>                                                                                                                                                                                                                                                         | Personal Information redacted by the USI                                                                 | <b>Age:</b>                    | 72         |
| <b>Date of Incident</b>                                                                                                                                                                                                                                                                   | 23/11/2021                                                                                               | <b>Date Incident Reported:</b> | 23/11/2021 |
| <b>Datix Incident Number</b>                                                                                                                                                                                                                                                              | Personal Information redacted by the USI                                                                 |                                |            |
| <b>Date of death (if relevant)</b>                                                                                                                                                                                                                                                        | Personal Information redacted by the USI                                                                 |                                |            |
| <b>Location of death (if relevant)</b>                                                                                                                                                                                                                                                    | Personal Information redacted by the USI                                                                 |                                |            |
| <b>Was the patient identified as being within the last 12 months of life?</b>                                                                                                                                                                                                             | Yes palliative Prostate Cancer with multiple metastasis                                                  |                                |            |
| <b>Cause of death (if known)</b>                                                                                                                                                                                                                                                          | Metastatic Prostate Cancer                                                                               |                                |            |
| <b>Primary diagnosis, including ICD-10 code (if known)</b>                                                                                                                                                                                                                                | Prostate Cancer                                                                                          |                                |            |
| <b>Co-morbidities</b>                                                                                                                                                                                                                                                                     |                                                                                                          |                                |            |
| <b>Healthcare teams involved in the patient's care at the time of incident</b>                                                                                                                                                                                                            |                                                                                                          |                                |            |
| <b>Patient summary (can be completed by the clinical team)</b>                                                                                                                                                                                                                            |                                                                                                          |                                |            |
| <p>Highlighted by Prof</p> <p>Initial diagnosis in 2009 with a Gleason 7 T2 adenocarcinoma of the prostate gland. US guided biopsy in 2012 Gleason 7 was noted and a PSA of 3.9. Lower and unlicensed dose of Bicalutimide. No record of discussion of surgery/ delay in radiotherapy</p> |                                                                                                          |                                |            |
| <b>Concerns from family members or carers about the patient's care (please outline concerns, or state if there were no concerns)</b>                                                                                                                                                      | Wife and Son (Personal Information redacted by the USI) concerned as cause of death was prostate cancer. |                                |            |
| <b>Concerns from staff about the patient's care (please outline concerns, or state if there were no concerns)</b>                                                                                                                                                                         |                                                                                                          |                                |            |

Time taken to complete Section 1 of this form (minutes): .....

Care Review Tool for Urology

Date of completion: .....

Name of person completing Section 1: local team

Job title of person completing Section 1 .....

**Section 2**

Please state the information sources used for the review, including the names of the electronic systems accessed:

EGRESS and NIECR

**2.1. Phase of care: Triage (where relevant)**

- **Was triage conducted in a timely manner?**
- **Was the triage outcome assigned an appropriate level of priority given the information available at the time?**

Please record your explicit judgements about the triage process and whether it was in accordance with current good practice at the time the care was provided

Please also include any other information that you think is important or relevant.

Initial Triage correct following GP referral with abnormal PSA 3.47 and small volume prostate

Repeat PSA 4.22 leading to prostate biopsies performed at time of partial nephrectomy

Could have had prostate biopsies earlier as an independent procedure to ensure early diagnosis, PSA marginally elevated so delay not clinically significant

Subsequent management of prostate cancer inappropriate but no triage issues

## Care Review Tool for Urology

**Please rate the care received by the patient during this phase as:**

5 Excellent care ☐    4 Good care ☐    3 Adequate care ☐    2 Poor care ☒    1 Very poor care ☐

Section not applicable ☐

**2.2. Phase of care: Initial assessment or review (where relevant)**

- **Were the investigations, prescribing, diagnosis and clinical management approach and communications with patient, primary care and MDT teams appropriate?**
- **Were diagnostic tests or investigations requested in a timely manner and with sufficient clinical information to allow appropriate onward prioritisation?**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice at the time the care was provided

Please also include any other information that you think is important or relevant.

Initial assessment of elevated PSA inappropriate, should have had US guided biopsies but instead had delayed biopsies at time of partial nephrectomy. These biopsies were performed blind via the perineum and proved positive for cancer in 3 of 5 cores revealing Gleason 3+7 prostate cancer

The oncology MDT recommended staging but there was no management recommendation – other than OPC review. Mr O'Brien was chair of the MDT and I am not sure if an Oncologist was present.

There was no subsequent discussion of treatment options which would have included radical prostatectomy and radical radiotherapy. The patient was then age 59y and active surveillance would not be standard recommendation for Gleason 7 prostate cancer in a fit man.

This is a serious failing to provide active prostate cancer treatment option with curative intent and the MDT outcome was inadequate with no guidance.

Active surveillance was incorrect advice as was starting Bicalutamide in 2013 following a PSA rise. Hormone monotherapy for localised disease was inappropriate at that time and the dose of 50mg is not recognised or licensed for the treatment of patients with localised prostate cancer.

He finally received radical treatment in the form of radiotherapy in 2014 after further MDT review, but could have had treatment in 2009

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <p><b>Please rate the care received by the patient during this phase as:</b></p> <p>5 Excellent care <input type="checkbox"/>    4 Good care <input type="checkbox"/>    3 Adequate care <input type="checkbox"/>    2 Poor care <input type="checkbox"/>    1 Very poor care <input checked="" type="checkbox"/></p> <p>Section not applicable <input type="checkbox"/></p>                                                                                                                                                                                                                                                                                                                                                                                           |
| <p><b>2.3. Phase of care: Review of Diagnostics (where relevant)</b></p> <ul style="list-style-type: none"> <li>• <b>Were diagnostic tests or investigations reviewed in a timely manner with appropriate further actions taken?</b></li> <li>• <b>Were any required actions adequately communicated to patient / primary care / MDT teams?</b></li> <li>• <b>Please list medication if known and relevant, and comment on medication monitoring where appropriate</b></li> </ul> <p>Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice at the time the care was provided</p> <p>Please also include any other information that you think is important or relevant.</p> |

Diagnostic tests were delayed but correct. Clinical management and treatment were incorrect

No treatment outcome from MDT in 2009 at time of initial diagnosis. Finally referred in 2014 when referral for radiotherapy recommended.

No record of treatment options discussed with patient in 2009. Why he was not offered radical treatment at that time remains unexplained.

The patient had no opportunity to discuss the result of diagnostic tests and subsequent treatment options. He was denied the opportunity of curative active treatment for his localised prostate cancer.

I am concerned that Mr O'Brien was chair of the Oncology MDM at that time and was making incorrect prostate cancer recommendations without challenge.

Please rate the care received by the patient during this phase as:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☒

Section not applicable ☐

**2.4. Phase of care: Ongoing Outpatient Care (where relevant)**

- Were ongoing reviews scheduled at appropriate intervals?
- Were referrals made to other teams / professionals appropriately and in a timely manner?

- **Where any further required tests / investigations requested and performed in line with good current practice?**
- **Please list medication if known and relevant, and comment on medication monitoring where appropriate**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice at the time the care was provided

Please also include any other information that you think is important or relevant.

Review was timely but prostate cancer treatment advice fell well below that would be expected.

Active surveillance inappropriate

Standard treatment for 59-year-old man diagnosed with T2 Gleason 7 prostate cancer is active treatment (surgery or radiotherapy according to patient preference)

Age 59y at time of diagnosis in 2009

Bicalutamide 50mg monotherapy 2013 inappropriate

MDT outcome 2019 unsatisfactory



**Please rate the care received by the patient during this phase as:**

5 Excellent care ☐    4 Good care ☐    3 Adequate care ☐    2 Poor care ☐    1 Very poor care ☒

Section not applicable ☐

**2.5. Phase of care: Admission and Initial Management (approximately the first 24 hours) (where relevant)**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice at the time the care was provided

Please also include any other information that you think is important or relevant.

Not applicable

**Please rate the care received by the patient during this phase:**

5 Excellent care ☐    4 Good care ☐    3 Adequate care ☐    2 Poor care ☐    1 Very poor care ☐

Section not applicable ☒

**2.6. Phase of care: Ongoing Inpatient Care (where relevant)**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice at the time the care was provided

Please also include any other information that you think is important or relevant.

In patient care relates to partial nephrectomy and TURP  
No issues to address

**Please rate the care received by the patient during this phase:**

5 Excellent care ☐    4 Good care ☐    3 Adequate care ☐    2 Poor care ☐    1 Very poor care ☐

Section not applicable ☒

**2.7. Phase of care: Care during a procedure (excluding IV cannulation) (where relevant)**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice at the time the care was provided

Please also include any other information that you think is important or relevant.

Not Applicable

**Please rate the care received by the patient during this phase:**

5 Excellent care ☐    4 Good care ☐    3 Adequate care ☐    2 Poor care ☐    1 Very poor care ☐

Section not applicable ☒

**2.8. Phase of care: Perioperative care (where relevant)**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice at the time the care was provided  
Please also include any other information that you think is important or relevant.

Not Applicable

**Please rate the care received by the patient during this phase as:**

5 Excellent care ☐    4 Good care ☐    3 Adequate care ☐    2 Poor care ☐    1 Very poor care ☐

Section not applicable ☒

**2.9. Phase of care: Discharge plan of care (where relevant)**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice at the time the care was provided

Please also include any other information that you think is important or relevant.

Not applicable

**Please rate the care received by the patient during this phase:**

5 Excellent care ☐    4 Good care ☐    3 Adequate care ☐    2 Poor care ☐    1 Very poor care ☐

Section not applicable ☒

**2.10. Other area of care (please specify)**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.

Please also include any other information that you think is important or relevant.

Care Review Tool for Urology

Not Applicable

Please rate the care received by the patient during this phase as:

5 Excellent care ☐    4 Good care ☐    3 Adequate care ☐    2 Poor care ☐    1 Very poor care ☐

Section not applicable ☒

## Care Review Tool for Urology

**2.11. Overall care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.

Areas identified where learning could occur, including areas of good practice, should be included in addition to any potential areas of further investigation.

Please also include any other information that you think is important or relevant.

Localised Prostate cancer treatment not in accordance with standard practice

No offer of radical treatment for a fit 59yo patient with localised T2 Gleason 7 prostate cancer

Radical treatment given 5 years later in the form of radical radiotherapy

This delay may well have had a significant adverse impact on cancer specific survival

Inappropriate use of bicalutamide monotherapy

Poor communication with patient and MDT

Cancer treatment guidelines were not followed, patient denied potential curative treatment option

The patient developed metastatic disease in 2019 with bone metastases. His suboptimal management may have contributed to early progression of disease.

Please rate the care received by the patient during this phase as:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☒

Section not applicable ☐

**2.12. If care was below an acceptable standard, did it lead to harm?**

If yes, please provide details and state an action plan

Yes, 5 year delay in radical treatment reduced the chance of curative radiotherapy being successful. It is difficult to quantify the exact impact on prognosis.

Side effects of inappropriate bicalutamide monotherapy could have been avoided.

**2.13. If the patient died is it considered more likely than not to have resulted from problems in care delivery or service provision?**

If yes, please provide details and state an action plan (consider whether a serious incident investigation is required).

Patient died with metastatic prostate cancer in Personal information redacted by the USI. Although radical treatment in 2009 may not of been curative, earlier treatment would likely have improved prognosis. It is very difficult to quantify the extent which is overall survival was compromised

**2.14. If a family member, carer, or staff raised concerns, please outline any feedback provided and state who was responsible for providing this feedback. Please state further action required.**

If no feedback was provided, please consider how the outcome of this review should be fed back to the relevant people, considering the duty of candour principle.

The family should be informed that the patient did not receive standard care for localised prostate cancer diagnosed in 2009. At that point his case should have been fully discussed at the MDT meeting with and been offered active radical treatment in the form of either radical prostatectomy or radical radiotherapy. For some reason this did not take place and the patient was placed on active surveillance which would only be appropriate in the presence of extensive comorbidities limiting life expectancy.

The family should be informed that the use of bicalutamide monotherapy was inappropriate. Radiotherapy finally went ahead in 2014 but the delay in receiving radical treatment may have compromised his prognosis

**2.15. Were the patient records adequate for the purpose of the review?**

Yes ☒

No ☐

**Please outline any difficulties in accessing appropriate information:**



Time taken to complete Section 2 of this form (minutes): ...90.....

Date of completion: .....12/4/22.....

Name of person completing Section 2: .....D Thomas.....

Job title of person completing Section 2: .....Urologist.....

## Assessment of problems in healthcare for Urology patients

In this section, the reviewer is asked to comment on whether one or more specific types of problem(s) were identified and, if so, to indicate whether any led to harm. Please circle correct response.

## Problem types

|                                                      |                                                                                                                                                                                                                                                                                             |
|------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Problem in assessment, investigation or diagnosis | Yes                                                                                                                                                                                                                                                                                         |
| Did the problem lead to harm?                        | Delay to biopsy<br><br>Uncertain                                                                                                                                                                                                                                                            |
| In which phase(s) did the problem occur?             | Triage<br>Initial assessment or review    yes<br>Review of Diagnostics<br>Ongoing Outpatient Care<br>Admission and Initial Management<br>Ongoing Inpatient Care<br>Care during a procedure (excluding IV cannulation)<br>Perioperative care<br>Discharge plan of care<br>Other area of care |

## Care Review Tool for Urology

|                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>2. Problem with medication / IV fluids / electrolytes / oxygen</b></p><br><br><p><b>Did the problem lead to harm?</b></p><br><br><p><b>In which phase(s) did the problem occur?</b></p> | <p><b>Yes</b></p><br><p>Unlicensed use of Bicalutamide 50mg for localised prostate cancer</p><br><p>Uncertain</p><br><p>Triage</p> <p>Initial assessment or review</p> <p>Review of Diagnostics</p> <p>Ongoing Outpatient Care    yes</p> <p>Admission and Initial Management</p> <p>Ongoing Inpatient Care</p> <p>Care during a procedure (excluding IV cannulation)</p> <p>Perioperative care</p> <p>Discharge plan of care</p> <p>Other area of care</p> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

## Care Review Tool for Urology

|                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>3. Problem related to treatment and management plan</b></p> <p>Did the problem lead to harm?</p> <p>In which phase(s) did the problem occur?</p>                                        | <p><b>Yes</b></p> <p>Delayed radical treatment for localised prostate cancer</p> <p><b>Yes</b></p> <p>Triage<br/>Initial assessment or review<br/>Review of Diagnostics<br/>Ongoing Outpatient Care <b>yes</b><br/>Admission and Initial Management<br/>Ongoing Inpatient Care<br/>Care during a procedure (excluding IV cannulation)<br/>Perioperative care<br/>Discharge plan of care<br/>Other area of care</p> |
| <p><b>4. Problem related to operation / invasive procedure</b> <i>(other than infection control)</i></p> <p>Did the problem lead to harm?</p> <p>In which phase(s) did the problem occur?</p> | <p><b>No</b></p> <p><b>No      Uncertain      Yes</b></p> <p>Triage<br/>Initial assessment or review<br/>Review of Diagnostics<br/>Ongoing Outpatient Care<br/>Admission and Initial Management<br/>Ongoing Inpatient Care<br/>Care during a procedure (excluding IV cannulation)<br/>Perioperative care<br/>Discharge plan of care<br/>Other area of care</p>                                                     |
| <p><b>5. Problem with infection management</b></p> <p>Did the problem lead to harm?</p> <p>In which phase(s) did the problem occur?</p>                                                       | <p><b>No</b></p> <p><b>No      Uncertain      Yes</b></p> <p>Triage<br/>Initial assessment or review<br/>Review of Diagnostics<br/>Ongoing Outpatient Care<br/>Admission and Initial Management<br/>Ongoing Inpatient Care</p>                                                                                                                                                                                     |

## Care Review Tool for Urology

|                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                           | <b>Care during a procedure (excluding IV cannulation)</b><br><b>Perioperative care</b><br><b>Discharge plan of care</b><br><b>Other area of care</b>                                                                                                                                                                                                                                                                                                                        |
| <b>6. Problem in clinical monitoring</b> (including failure to plan, to undertake, or to recognise and respond to changes)<br><br><b>Did the problem lead to harm?</b><br><br><b>In which phase(s) did the problem occur?</b>                                                                             | <p style="text-align: center;"><b>No</b></p> <p><b>No      Uncertain      Yes</b></p> <p> <b>Triage</b><br/> <b>Initial assessment or review</b><br/> <b>Review of Diagnostics</b><br/> <b>Ongoing Outpatient Care</b><br/> <b>Admission and Initial Management</b><br/> <b>Ongoing Inpatient Care</b><br/> <b>Care during a procedure (excluding IV cannulation)</b><br/> <b>Perioperative care</b><br/> <b>Discharge plan of care</b><br/> <b>Other area of care</b> </p> |
| <b>7. Problem in resuscitation following a cardiac or respiratory arrest</b> (including cardiopulmonary resuscitation (CPR))<br><br><b>Did the problem lead to harm?</b><br><br><b>In which phase(s) did the problem occur?</b>                                                                           | <p style="text-align: center;"><b>No</b></p> <p><b>No      Uncertain      Yes</b></p> <p> <b>Triage</b><br/> <b>Initial assessment or review</b><br/> <b>Review of Diagnostics</b><br/> <b>Ongoing Outpatient Care</b><br/> <b>Admission and Initial Management</b><br/> <b>Ongoing Inpatient Care</b><br/> <b>Care during a procedure (excluding IV cannulation)</b><br/> <b>Perioperative care</b><br/> <b>Discharge plan of care</b><br/> <b>Other area of care</b> </p> |
| <b>8. Problem of any other type not fitting the categories above</b> (including patient records and documentation, informed consent, communication with patients and carers and organisational issues)<br><br><b>Did the problem lead to harm?</b><br><br><b>In which phase(s) did the problem occur?</b> | <p style="text-align: center;"><b>No</b></p> <p><b>No      Uncertain      Yes</b></p> <p> <b>Triage</b><br/> <b>Initial assessment or review</b><br/> <b>Review of Diagnostics</b> </p>                                                                                                                                                                                                                                                                                     |

Care Review Tool for Urology

|  |                                                                                                                                                                                                                                                                    |
|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <b>Ongoing Outpatient Care</b><br><b>Admission and Initial Management</b><br><b>Ongoing Inpatient Care</b><br><b>Care during a procedure (excluding IV cannulation)</b><br><b>Perioperative care</b><br><b>Discharge plan of care</b><br><b>Other area of care</b> |
|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|



*Quality Care - for you, with you*

**Chair**  
Eileen Mullan

**Chief Executive**  
Shane Devlin

31 December 2021

Healthcare Ref: Personal Information redacted by USI

**Private & Confidential**

Patient 35's Wife

Personal Information redacted by the USI

Dear Patient 35's Wife

**RE: Urology Record Review**

**RE:** Patient 35

On the 31st August 2021 the Minister for Health announced in the Assembly that he was commissioning a Public Inquiry under the Inquiries Act 2005 into the circumstances surrounding Urology Services in the Southern Health and Social Care Trust (Southern Trust).

As the Chief Executive of the Southern Trust I instructed that a lookback exercise of all patients under the care of Mr Aidan O'Brien for the period January 2019 to June 2020, when Mr O'Brien retired be undertaken. All the patients who were under Mr O'Brien's care during this 18 month period have been shared with the Urology Services Inquiry (USI). I advise you of this as you may receive communication from the USI.

In order to provide the necessary assurance for this lookback exercise we commissioned Consultant Urologists who were external and independent to the Trust to undertake a review of your Husband Patient 35's medical records. I can now advise following this review, aspects have been identified that require a further review. This means an independent Consultant will complete a Structured Clinical Record Review

(SCRR) of your Husband Patient  
35's care. We have included a leaflet to explain this process in further detail.

The external independent Consultant has determined that the treatment plan your Husband was given in 2009 was potentially not appropriate. This treatment plan will be reviewed in the SCRR. Once this is complete we will write to you to inform you of the outcome.

We appreciate that up until you have received this letter this may have been a worrying time. The leaflet included with this letter outlines the support services available to you. Dedicated Trust Liaison Officers who are trained professional staff are available for any queries, concerns or questions you may have. This is a strictly confidential service for the purpose of this review process.

I apologise it has taken some time to complete. This was due to the volume of patients involved and wanting to assure ourselves that every patient record was reviewed fully. Finally you have the right to expect the very best care and treatment every time you use our services, for this expectation not being met I apologise.

Yours Sincerely

Shane Devlin

CHIEF EXECUTIVE



*Quality Care - for you, with you*

23 June 2022

**Private & Confidential**

Patient 35's Wife

Personal Information  
redacted by the USI

Dear Patient 35's Wife

**RE:** Patient 35 - H&C Personal Information redacted by USI

I refer to correspondence dated 31 December 2021 from my predecessor Mr Shane Devlin, Chief Executive, advising that the Trust was undertaking a Lookback Review exercise of patients who were under the care of Mr Aidan O'Brien, Consultant Urologist.

At the outset, I would like to express my sincere condolences on the death of your beloved husband in December 2019. Losing a loved one is never easy; I recognise this must be a particularly difficult time for you and your family and receiving a letter regarding Patient 35's past medical care may cause even further distress. I apologise unreservedly if that is the case.

In reference to Mr Devlin's letter referenced above, as the Trust's Lookback Review identified concerns with Patient 35's care, we were having a Structured Clinical Record Review (SCRR) undertaken to establish if there were themes and learning from his care.

An experienced NHS Consultant Urologist from outside Northern Ireland, who is a member of the British Association of Urological Surgeons (BAUS), has completed the SCRR and has now returned his report.

I would like for the detail of this report to be shared with you in person so that it can be explained in depth and any questions that you may have can be answered directly. We will follow up that meeting with a written summary of the report for your records.

If you are agreeable to this approach we will arrange a meeting as soon as possible with Mr M Haynes, Senior Urology Consultant and Divisional Medical Director, together with a senior manager from the Trust. If you would prefer not to meet with us at this time we can provide you with written update and an open invitation to meet us at a later date.

I would be grateful if you would make contact with Sarah Ward, Head of Service for the Lookback Review on Personal Information redacted by USI and advise on how you would like to proceed.

I would also like to take the opportunity and use this correspondence to update you on an inaccuracy contained in Mr Devlin's of 31 December 2021.



Mr Devlin's letter informed you that there was to be an Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust. This was correct however, the information pertaining to the Inquiry in Mr Devlin's letter was incorrect and because of this, you have been misinformed.

I very sorry that this was the case. I would like at this time to correct the error and clarify the situation.

Mr Devlin advised that the Minister of Health, Mr Swann, announced his intention to have a public inquiry into Urology Services on 31 August 2021. This was incorrect. The actual date that Minister Swann announced to the Assembly his intent to set up a statutory public inquiry into the Urology Service in the Southern Health and Social Care Trust under the Inquiries Act 2005, was in fact 24 November 2020.

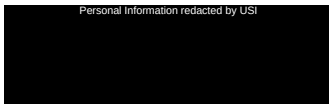
I can confirm the Urology Services Inquiry commenced on 6 September 2021. The Chair of the Inquiry is Christine Smith QC.

As **Patient 35** was patient within the timeframe of the Trust's Lookback Review we have shared his details with the Urology Services Inquiry team. Ms Smith may have already written to you directly as your husband's next-of-kin as I understand she was doing so with the next-of-kin of all deceased patient's.

If you would like further information about the Urology Services Inquiry, more detail is available on the Inquiry's website at [www.urologyservicesinquiry.org.uk](http://www.urologyservicesinquiry.org.uk).

Finally, I would like to thank you for your patience as we have progressed with the Urology Lookback Review.

Yours Sincerely

Personal Information redacted by USI  


**Dr Maria O'Kane**  
**Chief Executive**

| Information Line Contact Record Form |                                                                                                                                                                                                                                                                                                                                                                            |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Date of Call                         | 27.6.2022                                                                                                                                                                                                                                                                                                                                                                  |
| Name of Caller                       | Patient 35's Son                                                                                                                                                                                                                                                                                                                                                           |
| Patient Name                         | Patient 35                                                                                                                                                                                                                                                                                                                                                                 |
| Patient DOB                          | Personal Information redacted by USI                                                                                                                                                                                                                                                                                                                                       |
| Detail of Call                       | - Returning call on behalf of mum to letter offering f2f review to discuss findings of SCRR.                                                                                                                                                                                                                                                                               |
| Action Required/<br>Taken            | <ul style="list-style-type: none"> <li>- discussed options + agreed would like letter 1st + then will contact me to arrange review.</li> <li>- agreed to email letter to son also as lives in [Personal Information redacted by the USI] and mum lives alone.</li> <li>- advised if he cannot get home we will support virtual link to be with mum / clinician.</li> </ul> |
| Completed By                         | Personal Information redacted by USI                                                                                                                                                                                                                                                                                                                                       |

All completed forms to be retained and attached to the individual patients review form/ letters and filed.

29.6.22 - following convo with Margaret - Letter to be reviewed and signed by the chief executive @1500 to advise son of CX on leave so may take 2 weeks to get this.

1537 - son happy with explanation + offered if mum wants to chat to give my mobile number. Advised I will ring him on day of posting, + having CX oversight is priority on return.



**Southern Health  
and Social Care Trust**

*Quality Care - for you, with you*

**Chair**  
Eileen Mullan

**Chief Executive**  
Dr Maria O'Kane

27 July 2022

**PRIVATE & CONFIDENTIAL**

Patient 35's Wife

Personal Information  
redacted by USI

Dear Patient 35's Wife

**RE:** Patient 35 - H&C Personal Information redacted by USI

I refer to my letter dated 23 June 2022 regarding the Structured Clinical Record Review (SCRR) into the urology care of your late husband, Patient 35. I am sorry for the delay in me writing to you again, I was on leave for a period in July and it has taken me some time to get caught up.

I am aware your son, Personal Information redacted by USI, contacted Sarah Ward on Monday 27 June 2022 and explained that in the first instance you would like us to provide detail of the SCRR report in writing. I am aware you and family members may wish to follow this up with the meeting previously proposed, with Mr Haynes and a senior manager from the Trust.

I respect your wishes in this regard and will endeavour to summarise the SCRR report in an understandable way.

For information, a copy of this letter has been emailed to Patient 35's Son at his request.

I regret to advise that the SCRR report has highlighted that Patient 35 did not receive the correct treatment for prostate cancer when he was diagnosed with this disease in 2009.

The report states that when your husband was first diagnosed his case should have been fully discussed at a urology cancer multidisciplinary team (MDT) meeting. He should have been offered active radical treatment in the form of either a radical prostatectomy, which is surgically removing the prostate gland including the cancer, or radical radiotherapy which uses external beam radiation to kill off the cancer cells.

This did not happen and instead [Patient 35] was placed on "active surveillance" which is treatment that would only have been appropriate if your husband had extensive past medical history impacting on his life expectancy, which was not the case.

The SCRR report notes that radical radiotherapy was undertaken five years later in 2014. It states that the delay in receiving radical treatment may have compromised your husband's prognosis and that this suboptimal management may have contributed to early progression of the disease.

The report further advises that the hormone medication i.e. Bicalutamide 50mg which [Patient 35] was prescribed in 2013 was an inappropriate treatment.

To summarise, the SCRR report has highlighted that [Patient 35] did not receive treatment in accordance with standard clinical practice and that cancer guidelines for the treatment for localised prostate cancer were not followed despite him being a fit 59 year old gentleman. This resulted in your husband being denied potentially curative treatment for prostate cancer.

On behalf of the Trust I would like to offer an unreserved apology to you and your family that the service your late husband received was well below the required standard.

Furthermore, I deeply regret that [Patient 35] experienced a five year delay in receiving the appropriate treatment for his condition which may have had a bearing on how his disease progressed.

I recognise this letter must be very upsetting for you to read; I expect you and your family will have many questions about the SCRR findings and [Patient 35]'s treatment and care.

If you would like to meet with us to discuss the SCRR Report's findings Sarah will arrange that meeting. I am aware [Patient 35's Son] lives in [Personal Information redacted by the USI] and he will want to be present. We will be flexible with the date and venue (to include a zoom meeting if that is more convenient) to ensure it is as easy as possible for this meeting to take place.

For ease of reference, Sarah's mobile number is [Personal Information redacted by USI] she is currently on leave returning Monday 1 August 2022.

We are committed to supporting you and your family at this time. However, if you would like independent and confidential advice and support you can contact the Patient Client Council. Their contact number is Freephone 08009170222.

Finally, I would like to pass on my best wishes to you and your family at this very difficult time.

Yours sincerely

[Personal Information redacted by USI]

**DR MARIA O'KANE**  
**CHIEF EXECUTIVE**

| Information Line Contact Record Form |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Date of Call                         | 1 8.2022                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Name of Caller                       | Patient 35's Son                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Patient Name                         | Patient 35                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Patient DOB                          | Personal Information redacted by USI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Detail of Call                       | Received SCRR report letter. Mum flew out to [Personal Information redacted by the USI] prior to it arriving with her and they both read to emailed letter together. Keen to have a meeting with Consultant; virtually while mum is in [Personal Information redacted by USI] (until 13 <sup>th</sup> Aug) I asked if there was anything I could answer at this time; [Patient 35's Son] advised the letter was well written and easy to understand, and there was nothing particular to the letter at this time; but [Patient 35's Son] stated he |
| Action Required/<br>Taken            | did have questions for eg relating to end of life care. I suggested they make note of these and if they wish send them to me and I will aim to have info if possible (available for the meeting). I advised [Patient 35's Son] Mr Haynes would be the clinician we would advise is best placed to meet with them and I will go to secure date / time of meeting and will be in touch. [Patient 35's Son] was happy with this. I passed on my regards to [Patient 35's Son]                                                                         |
| Completed By                         | [Patient 35's Wife] and again advised [Patient 35's Son] to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

ring me et anytime.

All completed forms to be retained and attached to the individual patients review form/ letters and filed.

2.8.22 - Mr Haynes on leave until thursday. Spoke to secretary and advised in Belfast operating on thurs / fri. Updated [Patient 35's Son] on Mr Haynes unavailable until Thursday and will be in contact soon.

(S.WARD)



**Urology Services Inquiry**

# **Urology Services Inquiry Questionnaire**

[www.urologyservicesinquiry.org.uk](http://www.urologyservicesinquiry.org.uk)

## **Points to assist with completion of the USI Questionnaire**

- A helpful **Guide to Completing the USI Questionnaire** is available (see attached) and you are advised to read these guidance notes before attempting to complete this questionnaire.
- This questionnaire will assist the Inquiry to gain information from you regarding your experience of Urology services provided within the Southern Health and Social Care Trust (SHSCT).
- We appreciate that some patients/former patients or their families may have concerns about identifying themselves by name etc on the questionnaire. We would however reassure you that any personal details noted will only be seen by those parties, organisations or the core participants involved in our investigations who need to see it for the purpose of progressing Inquiry business. All core participants must adhere to the terms of our Restriction Orders which are now in place and available to view on our website. The term “core participant” is also defined on our website under the heading “Frequently Asked Questions – FAQ’s”. Our USI website address is noted below:  
[www.urologyservicesinquiry.org.uk](http://www.urologyservicesinquiry.org.uk).
- We would encourage you to fill out your personal details as fully as possible in Section A as it will increase the value of the information to our investigative work and may also enhance your potential input to the Inquiry. We would reassure you that your name and personal details will be protected and will be anonymised unless you consent to them being made public. Your personal information will be handled in compliance with the applicable legislation including the Data Protection Act 2018 and the General Data Protection Regulations 2018.
- Please note that it is not the intention of this Inquiry to publish the questionnaires that are submitted to assist us with our work, although the report may refer to some of the content.
- If you require assistance completing this questionnaire please do not hesitate to contact our office directly on telephone number: **028 90251005**.

- The work of this Inquiry is entirely independent of all other organisations including healthcare providers, regulators and government departments.
- Only certain sections of the form will apply to you. We would ask everyone to complete Section A but thereafter please only complete those sections which apply to you.
- When you have completed the relevant sections please complete Section F and then ensure you have signed the completed questionnaire at Section G.



## SECTION A – Personal Details

|                                 |                                                                               |
|---------------------------------|-------------------------------------------------------------------------------|
| <b>Name</b>                     | Patient 35's Wife & Patient 35's Son<br>(wife and son of the late Patient 35) |
| <b>Address</b>                  | Personal Information redacted by USI                                          |
| <b>Contact Telephone Number</b> | Personal Information redacted by USI                                          |
| <b>Mobile Phone Number</b>      | Personal Information redacted by USI                                          |
| <b>Email Address</b>            | Personal Information redacted by USI                                          |
| <b>HSC Number (if known)</b>    |                                                                               |

|                                                                                                                                           |               |
|-------------------------------------------------------------------------------------------------------------------------------------------|---------------|
|                                                                                                                                           | <b>Yes/No</b> |
| With regard to Section A above, have you read the ' <b>Personal Details</b> ' section of the 'Guide to Completing the USI Questionnaire'? | Yes           |
| Are you completing this questionnaire as a patient/former patient?<br>(If your answer is Yes, go to Section B)                            | No            |

|                                                                                                                                                                                                                                                                                       |     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|
| Are you completing this questionnaire as a relative of a patient/former patient?                                                                                                                                                                                                      | Yes |
| If you are completing this questionnaire as a <b>relative of a patient/former patient</b> , do you have the express authority of the patient to engage with the Inquiry and provide information that relates to their care and treatment?<br>(If your answer is Yes, go to Section B) | -   |
| If you are completing this questionnaire as a <b>relative of a deceased patient</b> , have you discussed providing information concerning the deceased patient with other relatives/former next of kin and no objection is being raised.<br>(If your answer is Yes, go to Section B)  | Yes |

|                                                                                                                                         |          |
|-----------------------------------------------------------------------------------------------------------------------------------------|----------|
| <p>If you are completing this questionnaire and you are not the patient/former patient or a relative of one please state your role.</p> | <p>-</p> |
|-----------------------------------------------------------------------------------------------------------------------------------------|----------|

**SECTION B – Contact with Urology Services**

Please complete the table below setting out details of each occasion when you accessed urology services. Provide details of the dates attended, relevant consultant, hospital/clinic etc and a brief description of the reason for the visit/treatment received. If you cannot remember exact dates then please give approximate dates where possible.

| <b>Date(s)</b>           | <b>Seen By</b><br>(e.g. name of consultant/healthcare professional) | <b>Location</b><br>(e.g. Craigavon Area Hospital) | <b>Brief description of reason for visit and/or treatment received</b> |
|--------------------------|---------------------------------------------------------------------|---------------------------------------------------|------------------------------------------------------------------------|
| We do not have this info |                                                                     |                                                   |                                                                        |
|                          |                                                                     |                                                   |                                                                        |
|                          |                                                                     |                                                   |                                                                        |
|                          |                                                                     |                                                   |                                                                        |
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|                          |                                                                     |                                                   |                                                                        |
|                          |                                                                     |                                                   |                                                                        |
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|                          |                                                                     |                                                   |                                                                        |
|                          |                                                                     |                                                   |                                                                        |
|                          |                                                                     |                                                   |                                                                        |
|                          |                                                                     |                                                   |                                                                        |
|                          |                                                                     |                                                   |                                                                        |
|                          |                                                                     |                                                   |                                                                        |

Continue on a separate sheet if necessary

## SECTION C – Details of concerns raised/complaints reported

1. Please provide full details of any concerns and/or complaints raised by you, specifying the nature of those concerns in as much detail as possible.

We did not keep a record of appointment dates or treatments received by Patient 35 so are mostly recollecting from memory.

In 2009 Mr O'Brien performed an operation on Patient 35, where he removed a lesion from his left kidney. Patient 35 was informed that he had Prostate Cancer and Mr O'Brien advised that as the cancer was not aggressive, he did not need any procedure at that time other than medication in the form of a tablet. Patient 35 suffered severe abdominal pain in his left side from the time of this operation in 2009 and was in constant pain with this until he passed away in 2019.

Patient 35 made Mr O'Brien and colleagues aware of the severe abdominal pain he was having and over the years was referred to many Pain Clinics and Doctors to try to help with his pain. He attended many Private Pain Clinics to try to get relief. As a result of this pain he was prescribed ever stronger pain killers which impaired his quality of life and, in our opinion, prevented his recognising the subsequent return of his cancer.

In 2010, Patient 35 received a letter informing that a CT scan had revealed that a lesion, similar to the one removed the year previously, had been identified. However, we have no recollection of any further treatment until 2014 when Patient 35 had Radiotherapy in Belfast City Hospital. He received daily treatments of radiotherapy from 4 November until 24 December.

In 2019 after having a series of tests and scans Patient 35 was told that his cancer had come back and spread into his bones. In Craigavon Hospital at end of August 2019, Mr O'Brien told Patient 35 and myself that the cancer had spread but he was optimistic with the treatment he had prescribed a few months prior which had reduced his PSA levels and with new medication in the form of a monthly injection he would be fine.

As a non-medical person I can only say that this injection had an adverse effect on my husband, his PSA levels went up and his movement was restricted from the second month.

The loss of my husband has been terrible and had a detrimental effect on my own health, having to witness his suffering over 10 years has been truly awful as you can imagine. The pain he endured had a massive effect on his quality of life over all those years.

Patient 35, or the family, never made a formal complaint to the Trust as at the time we had total faith in the system. It has therefore been very distressing to learn about the Inquiry into Mr O'Brien who was overseeing Patient 35's care for over 10 years. Furthermore, it came as a huge shock to learn in the recent letter that the Independent Consultant found that the treatment plan Patient 35 received in 2009 may have been inappropriate. That said, we welcome the investigation into these matters but hope that the inquiry is executed immediately and thoroughly. Also, we hope that the findings are communicated clearly and with full transparency to the relatives.

2. Please specify the date when any concern or complaint was raised and if you cannot recall date(s) please try to indicate an approximate timescale.

As stated above, we have not previously filed any form of complaint.

3. Please note the name and/or position held of the person you raised any concern with or reported any complaint to at the time.

NA

4. Please advise for each occasion a concern or complaint was raised whether this was done verbally or in writing (e.g. via letter/email etc).

NA

5. If your concern or complaint was made in writing, please provide copies of that correspondence if possible.

NA

6. Please advise if you received any acknowledgment or response (whether a holding response or a detailed response) to your complaint. If so, can you please provide copies?

NA

7. Please advise the outcome of any concern made or complaint raised by you.

NA

**SECTION D - Details of concerns held but NOT raised/reported**

1. Please provide full details of any concerns you held at the relevant time specifying the nature of those concerns in as much detail as possible.

In 2009 Mr O'Brien performed an operation on [Patient 35], where he removed a lesion from his left kidney. [Patient 35] was informed that he had Prostate Cancer and Mr O'Brien advised that as the cancer was not aggressive, he did not need any procedure at that time other than medication in the form of a tablet. [Patient 35] suffered severe abdominal pain in his left side from the time of this operation in 2009 and was in constant pain with this until he passed away in 2019.

In 2010, [Patient 35] received a letter informing that a CT scan had revealed that a lesion, similar to the one removed the year previously, had been identified. However, we have no recollection of any further treatment until 2014 when [Patient 35] had Radiotherapy in Belfast City Hospital.

In 2019 after having a series of tests and scans [Patient 35] was told that his cancer had come back and spread into his bones. In Craigavon Hospital at end of August 2019, Mr O'Brien told [Patient 35] and myself that the cancer had spread but he was optimistic with the treatment he had prescribed a few months prior which had reduced his PSA levels and with new medication in the form of a monthly injection he would be fine. As a non-medical person I can only say that this injection had an adverse effect on my husband, his PSA levels went up and his movement was restricted from the second month.

2. Please explain why you did not raise your concern(s) at the time and state if there was something that prevented you from raising your concern(s).

At the time we had no reason to suspect the treatment and advice that [Patient 35] could be incorrect.





**SECTION E – Personal impact/additional information**

Please outline the personal impact that the treatment received, which forms the basis of your complaint(s), has had on the patient/deceased patient and provide any additional information which you feel may be of assistance to this Inquiry.

Regarding the operation in 2009 – it resulted in Patient 35 being in significant pain, taking extremely strong painkillers and having much reduced quality of life until he died.

Regarding the treatment plan in 2010 – we have limited information as Patient 35 did not share everything with us

Regarding the hormone treatment injection in 2019 – the side effects of this were immediate. Patient 35's PSA went up and his mobility was reduced to zero within weeks.

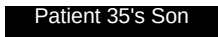
Additional sheets, if needed, can be attached

**SECTION F – Sharing information / Other related reviews**

The Inquiry may consider that the information you have provided is more relevant to one of the other organisations carrying out a review or investigation as detailed in the 'Guide to Completing the USI Questionnaire' under the heading 'Other Related Reviews'.

|                                                                                                                        | Yes/No |
|------------------------------------------------------------------------------------------------------------------------|--------|
| Would you be content for the Inquiry to share the contents of this questionnaire with other relevant organisations?    | Yes    |
| Would you like to discuss this in more detail with the Inquiry before making a decision on the sharing of information? | -      |

**SECTION G – Signature**

|                                |                                                                                      |
|--------------------------------|--------------------------------------------------------------------------------------|
| <b>Signed:</b>                 |  |
| <b>Name in Block Capitals:</b> |   |
| <b>Date:</b>                   | 31 <sup>st</sup> March 2022                                                          |

## **SECTION H - Returning your Questionnaire**

Please ensure that you have enclosed the following items:

- A fully completed questionnaire.  
(Check the questionnaire has been signed and dated).
- All supporting documentation and/or correspondence.  
(Please provide copies and **NOT** originals of your supporting material).
- If you require additional sheets to complete your responses to this questionnaire, please ensure that they are securely attached.
- If you require assistance completing this questionnaire please do not hesitate to contact our office directly on telephone number: **028 90251005**.

Completed questionnaires can be emailed to [evidence@usi.org.uk](mailto:evidence@usi.org.uk) or returned by post to:-

The Urology Services Inquiry

1<sup>st</sup> Floor Bradford Court

1 Bradford Court

Belfast

BT8 6RB

|               |  | Date     | Clinical Notes                                                                                            |
|---------------|--|----------|-----------------------------------------------------------------------------------------------------------|
| →             |  | 2/4/9    | 4/10/09 PSA<br>Dho Hsp Buer<br>Gus Kallie Lane<br>Rho BSA                                                 |
| Age           |  |          |                                                                                                           |
| URINE Protein |  |          |                                                                                                           |
| Sugar         |  |          |                                                                                                           |
| Acetone       |  |          |                                                                                                           |
| WEIGHT        |  |          | Personal Information redacted by USI                                                                      |
| kg.           |  |          |                                                                                                           |
| →             |  | 2/1/09   | Mr. A. O'BRIEN<br>BANKSIDE POLYCLINIC<br>4/10 PSA for<br>? related to gsk → XR only<br>WTS - not returned |
| Age           |  |          |                                                                                                           |
| URINE Protein |  |          |                                                                                                           |
| Sugar         |  |          |                                                                                                           |
| Acetone       |  |          | Personal Information redacted by USI                                                                      |
| WEIGHT        |  |          |                                                                                                           |
| kg.           |  | 9/7/09   | normal XR only<br>MRI discussed<br>Prob not cause of pr<br>→ Pain team                                    |
| →             |  |          |                                                                                                           |
| Age           |  |          | Personal Information redacted by the USI                                                                  |
| URINE Protein |  |          |                                                                                                           |
| Sugar         |  |          |                                                                                                           |
| Acetone       |  |          |                                                                                                           |
| WEIGHT        |  | 11.09.09 | Plan<br>FOR ADMISSION TUESDAY 03.11.09<br>FOR LEFT PARTIAL DEPHRECTOMY                                    |
| kg.           |  |          | Personal Information redacted by USI                                                                      |
| →             |  |          |                                                                                                           |
| Age           |  |          |                                                                                                           |
| URINE Protein |  |          |                                                                                                           |
| Sugar         |  |          |                                                                                                           |
| Acetone       |  |          |                                                                                                           |
| WEIGHT        |  | 27/10/09 | Attended POA - Bloods:<br>GBS, COAG, LFT, U+E, FBC<br>PSA taken. Awaiting Results.                        |
| kg.           |  |          | Personal Information redacted by USI                                                                      |

Affix Label  
or Enter in  
Block Letters  
Full Name  
Date of Birth  
Unit No.  
Ward/Dept.  
Address  
Consultant

When used for In-patient follow-up ignore left-hand column

|                                   | Date     | Clinical Notes                                  |
|-----------------------------------|----------|-------------------------------------------------|
| →                                 | 12.02.10 |                                                 |
| Age                               |          | LUTS                                            |
| URINE Protein<br>Sugar<br>Acetone |          | • NOCTURIA X 1-2.                               |
|                                   |          | • TERMINAL DRIBBLING                            |
| WEIGHT                            |          |                                                 |
| kg.                               |          | IMPROVED ON SIMSULOSIN                          |
| →                                 |          | CF • MINIMAL COMPROMISE                         |
| Age                               |          | PLAN                                            |
| URINE Protein<br>Sugar<br>Acetone |          | • PSA = 2.96.                                   |
|                                   |          | • DISCONTINUE FIRMADOL.                         |
| WEIGHT                            |          | • REVIEW IN SANDBRIDGE IN                       |
| kg.                               |          | 3 MONTHS                                        |
| →                                 |          | <div>Personal Information redacted by USI</div> |
| Age                               |          |                                                 |
| URINE Protein<br>Sugar<br>Acetone |          |                                                 |
| WEIGHT                            |          |                                                 |
| kg.                               |          |                                                 |
| →                                 | 02-6-10  | MR. A. O'BRIEN<br>UROLOGY C.D<br>CAH            |
| Age                               |          | PROBLEMS                                        |
| URINE Protein<br>Sugar<br>Acetone |          | • PERSISTENT, UNCHANGED, LEFT                   |
|                                   |          | LOIN PAIN                                       |
| WEIGHT                            |          | • NOCTURNAL PAIN                                |
| kg.                               |          |                                                 |

Affix Label  
or Enter in  
Block Letters  
Full Name  
Date of Birth  
Unit No.  
Ward/Dept.  
Address  
Consultant

## NOTES

When used for In-patient follow-up ignore left-hand column

LPC 03/08/021

|                                   |  | Date   | Clinical Notes                                                                                                                                                                             |
|-----------------------------------|--|--------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| →                                 |  | 6/9/10 | <p><b>Mr. A. O'BRIEN</b><br/> <b>BANBRIDGE POLYCLINIC</b> Cap. G2<br/>           Well (AS)<br/>           - c/o Pol. @ wound site<br/>           - O/F NAD<br/>           - PPD ↓ 2.91</p> |
| Age                               |  |        |                                                                                                                                                                                            |
| URINE Protein<br>Sugar<br>Acetone |  |        |                                                                                                                                                                                            |
| WEIGHT<br>kg.                     |  |        |                                                                                                                                                                                            |
| →                                 |  |        | <p>(P) - PPD @ 7/12<br/>           - CT<br/>           - O/D 6/12<br/>           O1</p>                                                                                                    |
| Age                               |  |        |                                                                                                                                                                                            |
| URINE Protein<br>Sugar<br>Acetone |  |        |                                                                                                                                                                                            |
| WEIGHT<br>kg.                     |  |        |                                                                                                                                                                                            |
| →                                 |  |        | <p><u>PLAN</u><br/>           • RENAL CT<br/>           • PSA<br/>           • REVIEW (HBRNDRE) Dec '10</p>                                                                                |
| Age                               |  |        |                                                                                                                                                                                            |
| URINE Protein<br>Sugar<br>Acetone |  |        |                                                                                                                                                                                            |
| WEIGHT<br>kg.                     |  |        |                                                                                                                                                                                            |
| →                                 |  |        | <p>Personal Information redacted by USI</p>                                                                                                                                                |
| Age                               |  |        |                                                                                                                                                                                            |
| URINE Protein<br>Sugar<br>Acetone |  |        |                                                                                                                                                                                            |
| WEIGHT<br>kg.                     |  |        |                                                                                                                                                                                            |



# IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label  
or Enter in  
Block Letter  
Full Name  
Date of Birth  
Unit No.  
Ward/Dep  
Address  
Consultant

CAH  
HCN

Personal Information redacted by the USI

Patient 35

BN3

Personal Information redacted by the USI

## NOTES

When used for In-patient follow-up ignore left-hand column

| Out-Patient<br>Use Only           | Date     | Clinical Notes              |
|-----------------------------------|----------|-----------------------------|
| →                                 |          |                             |
| Age                               | 30/11/42 | MR. A. O'BRIEN              |
| URINE Protein<br>Sugar<br>Acetone |          | UROLOGY OPD                 |
|                                   |          | CAH                         |
| WEIGHT                            |          | PSA WAS 3.47 OCTOBER 2008   |
| kg.                               |          | 3.99 JANUARY 2009           |
|                                   |          | 2.96 FEBRUARY 2010          |
|                                   |          | 3.25 JUNE 2011              |
| →                                 |          | 4.06 MARCH 2012             |
| Age                               |          | 3.99 NOVEMBER 2012          |
| URINE Protein<br>Sugar<br>Acetone |          |                             |
|                                   |          | LLITS                       |
| WEIGHT                            |          | • HESITANCY                 |
| kg.                               |          | • REDUCED FLOW              |
|                                   |          | • UNSATISFACTORY VOIDING    |
|                                   |          | • POSTMICTURITIONAL LEAKAGE |
| →                                 |          | • NOCTURIA X 2-4            |
| Age                               |          | • DYSURIA                   |
| URINE Protein<br>Sugar<br>Acetone |          |                             |
| WEIGHT                            |          | SYMPTOMS HAVE DETERIORATED. |
| kg.                               |          | REMAINS ON TAMSULOSIN.      |
|                                   |          | PSM                         |
|                                   |          | • TRUS BIPOLAR              |

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USI

|               |  | Date     | Clinical Notes                           |
|---------------|--|----------|------------------------------------------|
| →             |  |          | THEN TO HAVE URODYNAMIC STUDIES          |
| Age           |  |          | Personal Information redacted by the USI |
| URINE Protein |  |          |                                          |
| Sugar         |  |          |                                          |
| Acetone       |  |          |                                          |
| WEIGHT        |  |          |                                          |
| kg.           |  |          |                                          |
| →             |  | 11-12-12 | UROLOGY ICATS CLINIC                     |
| Age           |  |          | THIS PROBABLY<br>Dr. Mearns              |
| URINE Protein |  |          |                                          |
| Sugar         |  |          |                                          |
| Acetone       |  |          | 23.7cc                                   |
| WEIGHT        |  |          | 10x18cm are left                         |
| kg.           |  |          |                                          |
| →             |  |          | Personal Information redacted by USI     |
| Age           |  |          | Personal Information redacted by USI     |
| URINE Protein |  |          |                                          |
| Sugar         |  |          |                                          |
| Acetone       |  |          |                                          |
| WEIGHT        |  |          |                                          |
| kg.           |  |          |                                          |
| →             |  |          |                                          |
| Age           |  |          |                                          |
| URINE Protein |  |          |                                          |
| Sugar         |  |          |                                          |
| Acetone       |  |          |                                          |
| WEIGHT        |  |          |                                          |
| kg.           |  |          |                                          |

# IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label  
or Enter in  
Block Letters  
Full Name  
Date of Birth  
Unit No.  
Ward/Dept.  
Address  
Consultant

## NOTES

When used for In-patient follow-up ignore left-hand column

| Out-Patient<br>Use Only           | Date     | Clinical Notes                                                                                                                |
|-----------------------------------|----------|-------------------------------------------------------------------------------------------------------------------------------|
| →                                 | 28/12/12 | MR. A. O'BRIEN<br>UROLOGY OPD<br>CAH                                                                                          |
| Age                               |          |                                                                                                                               |
| URINE Protein<br>Sugar<br>Acetone |          |                                                                                                                               |
| WEIGHT<br>kg.                     |          | <ul style="list-style-type: none"> <li>PERSISTENT LEFT FLANK PAIN.</li> <li>LCIS UNCHANGED</li> </ul>                         |
| →                                 |          | Plan                                                                                                                          |
| Age                               |          |                                                                                                                               |
| URINE Protein<br>Sugar<br>Acetone |          | <ul style="list-style-type: none"> <li>U/S LOWER URINARY TRACT</li> <li>MRI PROSTATE</li> <li>CT CHEST AND ABDOMEN</li> </ul> |
| WEIGHT<br>kg.                     |          |                                                                                                                               |
| →                                 |          | Done scan                                                                                                                     |
| Age                               |          |                                                                                                                               |
| URINE Protein<br>Sugar<br>Acetone |          | <ul style="list-style-type: none"> <li>URODYNAMICS FEBRUARY '13</li> </ul>                                                    |
| WEIGHT<br>kg.                     |          | <del>RED</del>                                                                                                                |

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Date

Clinical Notes



Age

15.02.13

URINE Protein  
Sugar  
AcetoneP  
LON

WEIGHT

kg.

PSA = 3.17

R TADALAFIL 5 MGS DAILY  
REVIEW MARCH '13



Age

URINE Protein  
Sugar  
Acetone

Personal Information redacted by USI

WEIGHT

kg.

URODYNAMIC STUDIES



Age

URINE Protein  
Sugar  
Acetone

• MILDLY OVERACTIVE DETRUSOR  
• DETRUSOR HYPERCONTRACTILITY  
ON VOIDING  
• PROBABLY INADEQUATE  
BLADDER VOIDING.

WEIGHT

kg.



08/03/13

MR. A. O'BRIEN  
UROLOGY OPD

CAN

P  
LON

Age

URINE Protein  
Sugar  
Acetone

WEIGHT

kg.

R BICARUNAMIDE 50 MGS  
TAMOXIFEN 10 MGS  
TADALAFIL 5 MGS  
SOLFENACIN 5 MGS T BD

# IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label  
or Enter in  
Block Letters  
Full Name  
Date of Birth  
Unit No.  
Ward/Dept.  
Address  
Consultant

CAHE:

Personal Information redacted by the USI

HCN:

Patient 35

Personal Information redacted by USI

## NOTES

When used for In-patient follow-up ignore left-hand column

| Out-Patient<br>Use Only           | Date    | Clinical Notes                             |
|-----------------------------------|---------|--------------------------------------------|
| →                                 |         |                                            |
| Age                               |         | REVIEW JUNE 2013                           |
| URINE Protein<br>Sugar<br>Acetone |         | Personal Information redacted by USI       |
| WEIGHT<br>kg.                     |         |                                            |
| →                                 | 14/6/13 | MR. A. O'BRIEN<br>UROLOGY OPD<br>CAH       |
| Age                               |         | PSA 1.03 JUNE 2013                         |
| URINE Protein<br>Sugar<br>Acetone |         | LUTS                                       |
| WEIGHT<br>kg.                     |         | POSTMICTURITIONAL INCON.<br>NOCTURIA X 1-2 |
| →                                 |         | PSA                                        |
| Age                               |         | REFER FOR EBRT WHEN<br>PSA < 1             |
| URINE Protein<br>Sugar<br>Acetone |         | REVIEW DECEMBER 13                         |
| WEIGHT<br>kg.                     |         | Personal Information redacted by USI       |

|                                   |  | Date       | Clinical Notes                                                                                                                |
|-----------------------------------|--|------------|-------------------------------------------------------------------------------------------------------------------------------|
|                                   |  | → 09.10.13 | PSA ↑ 1.1 September 2013                                                                                                      |
| Age                               |  |            |                                                                                                                               |
| URINE Protein<br>Sugar<br>Acetone |  |            | LUTS                                                                                                                          |
| WEIGHT kg.                        |  |            | <ul style="list-style-type: none"> <li>• HESITANCY</li> <li>• POSTMICTURITIONAL DRAINING</li> <li>• NOCTURIA X 2-3</li> </ul> |
|                                   |  | →          | Plan                                                                                                                          |
| Age                               |  |            | INCREASE BICALUTAMIDE                                                                                                         |
| URINE Protein<br>Sugar<br>Acetone |  |            | TO 150 MGS DAILY                                                                                                              |
| WEIGHT kg.                        |  |            | <ul style="list-style-type: none"> <li>• U/S LOWER PROGS DECEMBER</li> <li>• REVIEW JANUARY 2014</li> </ul>                   |
|                                   |  | →          | <div>Personal Information redacted by USI</div>                                                                               |
| Age                               |  |            |                                                                                                                               |
| URINE Protein<br>Sugar<br>Acetone |  |            |                                                                                                                               |
| WEIGHT kg.                        |  |            |                                                                                                                               |
|                                   |  | →          | 07/03/14 Mr O'Brien                                                                                                           |
| Age                               |  |            | urology                                                                                                                       |
| URINE Protein<br>Sugar<br>Acetone |  |            | <div>Personal Information redacted by USI</div>                                                                               |
| WEIGHT kg.                        |  |            | DNA - SFA                                                                                                                     |

# IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label  
or Enter in  
Block Letters  
Full Name  
Date of Birth  
Unit No.  
Ward/Dept.  
Address  
Consultant

CAH  
HCN:

Personal Information redacted by the USI

Patient 35

Personal Information redacted by the USI

## NOTES

When used for In-patient follow-up ignore left-hand column

| Out-Patient<br>Use Only           | Date    | Clinical Notes                                                                                                                                                 |
|-----------------------------------|---------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| →                                 | 11/4/14 | MR. A. O'BRIEN<br>UROLOGY OPD<br>CAH                                                                                                                           |
| Age                               |         |                                                                                                                                                                |
| URINE Protein<br>Sugar<br>Acetone |         |                                                                                                                                                                |
| WEIGHT<br>kg.                     |         | PSA 0.69 DECEMBER 2013<br>0.85 MARCH 2014                                                                                                                      |
| →                                 |         | CHOLESTEROL 6.53                                                                                                                                               |
| Age                               |         |                                                                                                                                                                |
| URINE Protein<br>Sugar<br>Acetone |         | U/S: PROSTATE 18.4 MLS<br>RESIDUAL 226 MLS                                                                                                                     |
| WEIGHT<br>kg.                     |         | LUTS                                                                                                                                                           |
| →                                 |         | <ul style="list-style-type: none"> <li>• HESITANCY</li> <li>• VARIABLE, SPRAYING STREAM</li> <li>• POSTMICT. INCONTINENCE</li> <li>• NOCTURIA X 2-3</li> </ul> |
| Age                               |         |                                                                                                                                                                |
| URINE Protein<br>Sugar<br>Acetone |         | PLAN                                                                                                                                                           |
| WEIGHT<br>kg.                     |         | TLRP                                                                                                                                                           |

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78/CA.2/1

# IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label  
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Block Letters  
Full Name  
Date of Birth  
Unit No.  
Ward/Dept.  
Address  
Consultant

CAHE  
HCN:

Personal Information redacted by the USI

Patient 35

Personal Information redacted by USI

## NOTES

When used for In-patient follow-up ignore left-hand column

| Out-Patient<br>Use Only           | Date   | Clinical Notes                        |
|-----------------------------------|--------|---------------------------------------|
| →                                 | 6/6/14 | MR. A. O'BRIEN<br>UROLOGY OPD/<br>CAH |
| Age                               |        |                                       |
| URINE Protein<br>Sugar<br>Acetone |        |                                       |
| WEIGHT<br>kg.                     |        | LUTS                                  |
|                                   |        | • FLOW IMPROVED                       |
|                                   |        | • TERMINAL DYSURIA                    |
|                                   |        | • POSTMICTURITIONAL<br>INCONTINENCE   |
| →                                 |        | • NOCTURIA X 1-2                      |
| Age                               |        |                                       |
| URINE Protein<br>Sugar<br>Acetone |        |                                       |
| WEIGHT<br>kg.                     |        | PSA 0.64 May 2014                     |
|                                   |        | LOW                                   |
|                                   |        | • MSSU                                |
|                                   |        | • U/S LOWER URINARY TRACT             |
|                                   |        | • RX CIPROXIN 250 MGS                 |
|                                   |        | • REVIEW AUGUST 2014                  |
| →                                 |        | • EIBRA                               |
| Age                               |        |                                       |
| URINE Protein<br>Sugar<br>Acetone |        |                                       |
| WEIGHT<br>kg.                     |        |                                       |

Personal Information redacted by USI



|                                   |         | Date                                                                                                                                     | Clinical Notes                       |
|-----------------------------------|---------|------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|
| →                                 | 15/8/14 | MR. A. O'BRIEN<br>UROLOGY OPD<br>CAH                                                                                                     |                                      |
| Age                               |         |                                                                                                                                          |                                      |
| URINE Protein<br>Sugar<br>Acetone |         |                                                                                                                                          |                                      |
| WEIGHT                            |         | LUTS                                                                                                                                     |                                      |
| kg.                               |         | <ul style="list-style-type: none"> <li>• OCCASIONAL HESITANCY</li> <li>• MINIMAL POSTMICT. DRAINING</li> <li>• NOCTURIA X 1-3</li> </ul> |                                      |
| →                                 |         | PLAN                                                                                                                                     |                                      |
| Age                               |         |                                                                                                                                          |                                      |
| URINE Protein<br>Sugar<br>Acetone |         |                                                                                                                                          |                                      |
| WEIGHT                            |         | CBRT                                                                                                                                     |                                      |
| kg.                               |         |                                                                                                                                          | Personal Information redacted by USI |
| →                                 |         |                                                                                                                                          |                                      |
| Age                               |         | DR F HOUGHTON<br>ONCOLOGY                                                                                                                |                                      |
| URINE Protein<br>Sugar<br>Acetone | 17/9/14 |                                                                                                                                          |                                      |
| WEIGHT                            |         |                                                                                                                                          |                                      |
| kg.                               |         |                                                                                                                                          |                                      |
| →                                 | 15/4/15 | CONCT - joint oncology                                                                                                                   |                                      |
| Age                               |         |                                                                                                                                          |                                      |
| URINE Protein<br>Sugar<br>Acetone |         |                                                                                                                                          |                                      |
| WEIGHT                            |         |                                                                                                                                          |                                      |
| kg.                               |         |                                                                                                                                          |                                      |

# IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label  
or Enter in  
Block Letters  
Full Name  
Date of Birth  
Unit No.  
Ward/Dept.  
Address  
Consultant

CAHE  
Patient 35



## NOTES

When used for In-patient follow-up ignore left-hand column

| Out-Patient<br>Use Only           | Date   | Clinical Notes                       |
|-----------------------------------|--------|--------------------------------------|
| →                                 | 1/6/18 | MR. A. O'BRIEN                       |
| Age                               |        | UROLOGY OPD                          |
| URINE Protein<br>Sugar<br>Acetone |        | CAH                                  |
| WEIGHT                            |        | LUNGS                                |
| kg.                               |        | • UNSATISFACTORY VOIDING             |
|                                   |        | • OCCASIONAL PMT                     |
|                                   |        | • NOCTURIA X 2                       |
| →                                 |        | CF • INACCURATE ON TADAPAFIL         |
| Age                               |        | 10 MGS.                              |
| URINE Protein<br>Sugar<br>Acetone |        | 12.5 MGS ALPROSTADIL INJECTED        |
| WEIGHT                            |        | PW                                   |
| kg.                               |        |                                      |
| →                                 |        | • REVIEW 15 JUNE 18                  |
| Age                               |        | Personal Information redacted by USI |
| URINE Protein<br>Sugar<br>Acetone |        |                                      |
| WEIGHT                            |        |                                      |
| kg.                               |        |                                      |
|                                   |        |                                      |
|                                   |        |                                      |
|                                   |        |                                      |

|               |  | Date       | Clinical Notes               |
|---------------|--|------------|------------------------------|
|               |  | → 26/10/18 | MR. O'BRIEN                  |
| Age           |  |            | URO-ONCOLOGY CLINIC          |
| URINE Protein |  |            | CAH.                         |
| Sugar         |  |            |                              |
| Acetone       |  |            |                              |
| WEIGHT        |  |            | LLHS                         |
| kg.           |  |            | • HESITANCY                  |
|               |  |            | • UNSATISFACTORY VOIDING     |
|               |  |            | • OCCASIONAL DYSURIA, INC    |
|               |  |            | • NOCTURIA X 1-2             |
|               |  |            | • DYSURIA                    |
| Age           |  |            | PSA 0.48                     |
| URINE Protein |  |            |                              |
| Sugar         |  |            |                              |
| Acetone       |  |            |                              |
| WEIGHT        |  |            | 20 ug ApRostADIL INJECTED    |
| kg.           |  |            | PLAN                         |
|               |  |            |                              |
| Age           |  |            | • REMAIN ON TADALAFIL 20 MGS |
| URINE Protein |  |            | WHEN REQUIRED                |
| Sugar         |  |            |                              |
| Acetone       |  |            |                              |
| WEIGHT        |  |            | REVIEW 09 NOVEMBER '18       |
| kg.           |  |            |                              |
|               |  |            |                              |
|               |  |            |                              |
| Age           |  |            |                              |
| URINE Protein |  |            |                              |
| Sugar         |  |            |                              |
| Acetone       |  |            |                              |
| WEIGHT        |  |            |                              |
| kg.           |  |            |                              |
|               |  |            |                              |
|               |  |            |                              |
|               |  |            |                              |

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# IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label  
or Enter in  
Block Letters  
Full Name  
Date of Birth  
Unit No.  
Ward/Dept.  
Address  
Consultant

CAHE

Personal  
Information

Patient 35

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## NOTES

When used for In-patient follow-up ignore left-hand column

| Out-Patient<br>Use Only | Date           | Clinical Notes                       |
|-------------------------|----------------|--------------------------------------|
| → 9/11/18               | MR. A. O'BRIEN |                                      |
| Age                     | UROLOGY OPD    |                                      |
| URINE Protein           | CAH            |                                      |
| Sugar                   |                |                                      |
| Acetone                 |                |                                      |
| WEIGHT                  |                | CNA - SFA - 30 Nov 2018              |
| kg.                     |                | Personal Information redacted by USI |
| → 30/11/18              | MR. A. O'BRIEN |                                      |
| Age                     | UROLOGY OPD    |                                      |
| URINE Protein           | CAH            |                                      |
| Sugar                   |                |                                      |
| Acetone                 |                |                                      |
| WEIGHT                  |                | PSA 0.52                             |
| kg.                     |                |                                      |
| →                       |                | PLAN                                 |
| Age                     |                | R VIRIDOR 1700 40 MGS WEEKLY         |
| URINE Protein           |                | DND                                  |
| Sugar                   |                | 1000 MGS 20 MGS WEEKLY               |
| Acetone                 |                |                                      |
| WEIGHT                  |                | REVIEW JANUARY 2019                  |
| kg.                     |                | Personal Information redacted by USI |



Southern Health  
and Social Care Trust

**PAT-000863**

*Rec by fax  
14.9.08  
+ Post 8.9.08*

DAISY HILL HOSPITAL  
5 HOSPITAL ROAD  
NEWRY  
BT35 8DR  
TEL 02830835000

*11.9.08*

Department of Surgery

1 September 2008

**REQUEST FOR URGENT OUTPATIENT APPOINTMENT – LEFT  
RENAL TUMOUR**

Mr A O'Brien  
Consultant Urologist  
Craigavon Area Hospital  
Portadown

Dear Aidan

Re

Patient 35

Personal Information redacted by USI

DOB

Personal Information redacted by USI

Un

Personal Information redacted by USI

I would be grateful if you could see this man who would appear to have a small tumour in the mid-pole region of his right kidney. I have seen this man a number of times over the years with pain in his left loin and he has had several ultrasound scans, IVU's and CT scans. He had aspiration of a left renal cyst in 2005 and on this occasion I felt that his pain was probably due to recurrence of his cyst. I am never sure that renal cysts are the cause of pain, but I suspect that the small tumour which has now appeared for the first time in his left kidney is an incidental and somewhat fortuitous finding rather than the cause of the discomfort in his left renal angle. Nonetheless I would be grateful if you could arrange to see **Patient 35** for further investigation and management.

Yours sincerely

Mr R Brown  
Consultant Surgeon  
/jl

*Note  
x ray may have looked again at  
the CT and are less certain -  
Perhaps this is bleeding into a cyst -  
? does he need a biopsy*

Personal Information redacted by USI

Mr Robin Brown  
Consultant Surgeon  
Daisy Hill Hospital  
Newry

Dear Robin

**Re: Patient Name:** Patient 35  
**D.O.B.:** Personal Information redacted by USI  
**Address:** Personal Information redacted by USI  
**Hospital No:** Personal Information redacted by USI **CHI No:** Personal Information redacted by USI

|  |  |
|--|--|
|  |  |
|  |  |

You may recall writing to me on the 1<sup>st</sup> September 2008 regarding this gentleman who was considered to have a small right renal tumour. I believe that the indication in your letter that this gentleman had a small right renal lesion was an error as there has never been any indication that he had any right renal pathology. I presume that this was simply an error in dictation or in typing.

In any case, you had reported that Patient 35 had been under your care for assessment and management for left loin pain which had been considered to be due to the presence of a left renal cyst which was aspirated in 2005. On reviewing computerised data, I note that his biochemical renal function had always been normal. I noted that he was reported to have a small, simple cyst in the upper pole of the left kidney on ultrasound scanning in September 2007 and that the findings were similar on further scanning in April 2008. However, on CT scanning performed in Daisy Hill Hospital in August 2008 he was found to have a solid lesion measuring 2.3 cms in diameter, arising from the posterior cortex of the mid polar region of the left kidney. Interestingly, its density was reported to be 38 Hu whilst adjacent normal cortical tissue was found to have a density of 32 Hu units. Following injection of contrast medium enhancement resulted in its density increasing to 45 Hu units.

I arranged for Patient 35 to have further CT scanning performed here at Craigavon Area Hospital on the 21<sup>st</sup> October 2008. Dr McClure, Consultant Radiologist considered that this lesion was probably due to haemorrhage having occurred into the former cyst. On reviewing digitalised imaging, the lesion is smoothly spherical. It is largely exohytic and measured 2.5 cms in diameter. Enhancement was found to be marginal increasing by 3 Hu units.

When I met Patient 35 as an outpatient on the 24<sup>th</sup> October 2008, he reported that his left loin pain was well localised to the area of the lesion, that it was constant, variable in severity and dated back to a time prior to aspiration of a cyst in 2005. It was my impression that the lesion was probably the cause of his pain. He reported that he took co-codamol for pain. I wondered whether the codeine was the cause of his other dominant symptom which was that of fatigue. I therefore advised him to take paracetamol 1 gm twice daily instead of co-codamol and I have

2.

arranged for him to be admitted to our department on Monday 17<sup>th</sup> November 2008 for transcutaneous biopsy of the lesion the following day.

On reviewing computerised data, I also noted that Patient 35 had a serum total PSA level of 4.26 ng/ml in June 2008, and when his free to total PSA ratio was worryingly low at 5.6 %. Moreover, his serum total PSA level had increased significantly since October 2006 when it was 2.9 ng/ml.

When I met Patient 35 as an outpatient on the 24<sup>th</sup> October 2008 he reported having post micturitional dribbling and nocturia. He reported that he had to rise at least once each night to pass urine, more frequently he had to do so and not infrequently, had to rise 3 times. On clinical examination, I felt that he had a moderately enlarged and clinically benign prostate gland. It was somewhat reassuring to find that his serum total PSA level had fallen to 3.47 ng/ml and that urinary microscopy and culture were both normal. I prescribed Tamsulosin, 400 mcg daily, advising him to remain on this until advised otherwise. Patient 35 may require further assessment of his prostate in due course, and possibly inclusive of prostatic biopsies.

Lastly, I found Patient 35's serum cholesterol level to be quite significantly elevated at 7.27 umol/l, and his cholesterol HDL ratio to be elevated at 4.5. I will advise him in due course to arrange an appointment with his family doctor in order to have a fasting lipid profile performed.

Yours sincerely

Dictated but not signed by  
Aidan O'Brien FRCS  
Consultant Urologist

**Date Dictated:**

**Date Typed:** 11/11/08

**CRAIGAVON AREA HOSPITAL  
68 LURGAN ROAD  
PORTADOWN, BT63 5QQ**

**UROLOGY DEPARTMENT  
DISCHARGE LETTER**

Telephone: [Personal Information redacted by the USI]  
Fax: [Personal Information redacted by the USI]  
E mail: [Personal Information redacted by the USI]  
Secretary: **Mrs M McCorry**

DR M. MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
CO DOWN  
BT34 3JD

Dear DR MURPHY

**Re: Name:** [Patient 35]  
**D.O.B:** [Personal Information redacted by USI]  
**Address:** [Personal Information redacted by USI]  
**Hospital No:** [Personal Information redacted by USI] **CHI No:** [Personal Information redacted by USI]

|                                    |                                                |
|------------------------------------|------------------------------------------------|
| <b>Date of Admission:</b> 17/11/08 | <b>Method of Admission</b><br>BOOKED ADMISSION |
| <b>Date of Discharge:</b> 18/11/08 |                                                |
| <b>Procedure:</b> Ultrasound Scan  |                                                |

This 58-year-old gentleman was admitted on 17 November 2008 for biopsy of a renal mass noted on CT scanning. However when the radiologist scanned this with ultrasound scan, he felt this was a cyst and therefore no biopsy was done. He advised MRI of kidneys in six months to follow up this lesion.

In addition [Patient 35] is still troubled with moderate lower urinary tract symptoms despite his Flomaxtra. We have arranged for him to be reviewed at the LUTS clinic for post-void residual and flow rates.

In addition he will be reviewed in outpatients with the results of his MRI of kidneys.

Yours sincerely

**Mr Alex MacLeod  
Speciality Registrar to  
Mr A O'Brien FRCS  
Consultant Urologist**

cc Sister Jenny McMahon, Urology Nurse Specialist, Craigavon Area Hospital

|                         |                         |
|-------------------------|-------------------------|
| Date Dictated: 13/12/08 | Date Typed: 07/01/09 SC |
|-------------------------|-------------------------|



# **LOWER URINARY TRACT SYMPTOM CLINIC (LUTS)**

Jenny McMahon

Urology Nurse Specialist

Tel: Personal Information redacted by USI

Personal Information redacted by the USI

DR M. MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
CO DOWN  
BT34 3JD

Dear DR MURPHY

**Re: Patient Name:** Patient 35

**D.O.B.:** Personal Information redacted by USI

**Address:** Personal Information redacted by USI

**Hospital No:** Personal Information redacted by USI **CHI No:** Personal Information redacted by USI

**Date/Time of Clinic:** 30/01/09

**Follow Up:** Review March 2009 for repeat PSA

This gentleman attended the LUTS clinic on 30th January following a referral from Mr O'Brien. He is currently being investigated for a possible cystic lesion in his left kidney and awaits an MRI scan which is planned for June 2009. Since commencing Tamsulosin a few months ago he has noticed some improvement in his urinary symptoms however can at times be bothered by frequency, urgency, a reduced flow with post micturition dribble and a feeling of incomplete bladder emptying. Ultrasound was performed today and revealed no obstructive uropathy, there was a 2.5cm upper pole cyst on the left kidney. The bladder appeared slightly thick walled and was otherwise normal. Pre micturition volume was 537mls, post micturition of 190mls and a prostate which measured 30cc. Urine flow pattern was satisfactory though somewhat reduced with a maximum flow rate of approximately 11mls/sec however Patient 35 had mentioned that he had omitted the Tamsulosin in recent days to allow for a more thorough assessment today and he feels his bladder would normally empty better. U&E and MSSU results are below. PSA today measures 3.99 with a F/T ratio of 6.8, previous values include 3.47 ng/ml in October 2008 and 4.26 ng/ml in June 2008. A DRE was performed by Mr O'Brien previously in November 2008 which revealed a moderately enlarged benign feeling gland. I have discussed these findings today with Mr O'Brien and **he has advised that we see Patient 35 in the prostate clinic in March 2009** to repeat a PSA and counsel Patient 35 with the intention of proceeding probably to prostate biopsy. **Mr O'Brien has advised that his MRI be performed in May/June 2009 as previously arranged and he will organise an outpatient review appointment in July 2009.** Mr O'Brien has advised that if prostate biopsy were to be done and were to prove adenocarcinoma that MRI prostate could be done at the same time as the one planned for May/June time.

Yours sincerely

*dictated but not signed by*

---

**Jenny McMahon**  
**Urology Nurse Specialist**

**Results**

U&E            Normal bar Sodium 146  
MSU            Culture: Not significant <10,000 Orgs/ml

|                                |
|--------------------------------|
| <b>Date Dictated:</b> 05/02/09 |
|--------------------------------|

|                                |
|--------------------------------|
| <b>Date Typed:</b> 09/02/09-LH |
|--------------------------------|

**LOWER URINARY TRACT**  
**SYMPTOM CLINIC (LUTS)**

Jenny McMahon

Urology Nurse Specialist

Tel: Personal Information redacted by USI

Personal Information redacted by the USI

09/02/09

**CONFIDENTIAL**

Patient 35

Personal Information redacted by USI

Dear Patient 35

Further to your appointment at the Urinary Symptom Clinic on 30th January I would like to inform you that your PSA result is 3.99 ng/ml. Mr O'Brien has advised that we continue to monitor this and I have arranged a review appointment for you in March time. You will receive appointment details in due course. Mr O'Brien has also advised that your MRI scan will proceed as previously advised in May/June time and he will review you with the results of these in July. Unfortunately I was unable to contact you to discuss this by phone today but should you have any queries please do not hesitate to contact me on the number above. In the interim I would advise that you continue to take the Tamsulosin as previously prescribed.

Kind Regards,

Yours sincerely

*dictated but not signed by*

---

**Jenny McMahon**  
**Urology Nurse Specialist**

**UROLOGY  
OUTPATIENTS LETTER**

**DR RODGERS CLINIC – GP with Special Interest**

DR M. MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
CO DOWN  
BT34 3JD

Dear DR MURPHY

|                             |                                      |
|-----------------------------|--------------------------------------|
| <b>Re: Patient Name:</b>    | Patient 35                           |
| <b>D.O.B.:</b>              | Personal Information redacted by USI |
| <b>Address:</b>             | Personal Information redacted by USI |
| <b>Hospital No:</b>         | Personal Information redacted by USI |
| <b>CHI No:</b>              | Personal Information redacted by USI |
| <b>Date/Time of Clinic:</b> | 13/03/09                             |
| <b>Follow Up:</b>           | Review Mr O'Brien                    |

I reviewed this gentleman at urology outpatients on behalf of Mr O'Brien for repeat PSA check. His previous PSA was 3.99 ng/ml with a low F/T ratio of 6.8. He has been investigated extensively with regards to his kidneys and he would have pain in his left loin which aggravates with fluid intake. He is due to see Mr O'Brien in May/June time. He has pain in the left hemi-scrotum and an itch with Tramadol. Abdominal examination was unremarkable. Bowels normal. Penis NAD. Both testes NAD. He notes some pain in the left epididymis. DRE revealed a 30g prostate and no nodules. I have rechecked a PSA. **I have arranged ultrasound scan of testes.** I have checked FBC and LFT as well. **We will liaise with Mr O'Brien with regards to PSA result and if it is still up we would arrange biopsies of the prostate.**

Yours sincerely

---

**Dr P Rogers**  
**GP with Special Interest**  
**Urology Department**

**Results**

|               |            |
|---------------|------------|
| Total PSA     | 2.92 ng/ml |
| Liver profile | Normal     |
| FBC           | Normal     |

|                                |                                |
|--------------------------------|--------------------------------|
| <b>Date Dictated:</b> 13/03/09 | <b>Date Typed:</b> 19/03/09-LH |
|--------------------------------|--------------------------------|

**UROLOGY  
OUTPATIENTS LETTER**

**DR RODGERS CLINIC – GP with Special Interest**

09/04/09

DR M. MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
CO DOWN  
BT34 3JD

Dear DR MURPHY

**Re: Patient Name:** Patient 35  
**D.O.B.:** Personal Information redacted by USI  
**Address:** Personal Information redacted by USI  
**Hospital No:** Personal Information redacted by USI **CHI No:** Personal Information redacted by USI

I discussed this gentleman's PSA result with Mr O'Brien and he is happy with it at 2.92 ng/ml. He will be following up this gentleman shortly as per previous clinic notes.

Yours sincerely

---

**Dr P Rogers**  
**GP with Special Interest**  
**Urology Department**

Date Dictated: 07/04/09

Date Typed: 09/04/09-LH

**CRAIGAVON AREA HOSPITAL  
68 LURGAN ROAD  
PORTADOWN, BT63 5QQ**

**UROLOGY DEPARTMENT  
OUTPATIENT LETTER**

Telephone: Personal Information redacted by the USI  
Fax: Personal Information redacted by the USI  
E mail: Personal Information redacted by the USI  
Secretary: **Mrs M McCorry**

6 July 2009

DR M. MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
CO DOWN  
BT34 3JD

Dear DR MURPHY

**Re: Patient Name:** Patient 35  
**D.O.B.:** Personal Information redacted by USI  
**Address:** Personal Information redacted by USI  
**Hospital No:** Personal Information redacted by USI **CHI No:** Personal Information redacted by USI

|                                      |                                 |
|--------------------------------------|---------------------------------|
| <b>Date/Time of Clinic:</b> 02/07/09 | <b>Follow Up:</b> X-RAY MEETING |
| <b>Procedure (if applicable)</b>     |                                 |

I reviewed this 59-year-old gentleman today. His recent MRI has shown that the hyperdense cyst noticed on CT has the appearance of a left renal cortical haemorrhagic cyst. However he is still troubled greatly with left flank pain, which appears to be in a classic loin to groin distribution, with some left testicular pain on and off. He has no midline tenderness down his spine and mobility of his spine is very good.

Seeing that his pain is related to this cyst, despite its small size, we will review all of his films, in order to come up with a treatment plan.

In addition he has fairly severe lower urinary tract symptoms, with an IPSS score of 20 and a Q-max of only 11. His prostate was rather small at 30g and his symptoms are somewhat helped with Flomaxtra. I discussed further investigation with him today, but he is managing well with his lower urinary tract symptoms. He states that his main problem is the pain in his side and if he could get rid of this then his quality of life would be greatly improved, regardless of his symptoms. He tells me he is not interested in any further treatment for them at this minute, so we will pursue the treatment of the left flank pain only at present. In addition I have checked his PSA and he is aware, if it has climbed again, he may need prostate biopsies.

/Yours

2

Patient 35

Yours sincerely

**Mr Alex MacLeod**  
**Speciality Registrar to**  
**Mr A O'Brien FRCS**  
**Consultant Urologist**

**Result:**

PSA: Total PSA (T) 4.22; Free PSA (F) 0.23; F/T Ratio 5.5%

**Date Dictated:** 02/07/09

**Date Typed:** 06/07/09 SC

The Urology Department  
Craigavon Area Hospital  
**HSC Southern Health  
and Social Care Trust**  
3rd November 2009

DR M. MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
CO DOWN  
BT34 3JD

Dear DR MURPHY

**Re: Patient Name:** Patient 35  
**D.O.B.:** Personal Information redacted by USI  
**Address:** Personal Information redacted by USI  
**Hospital No:** Personal Information redacted by USI **CHI No:** Personal Information redacted by USI

Further to the letter of the 6<sup>th</sup> July 2009 from Mr Macleod, I write to advise you that I reviewed Patient 35 on the 11<sup>th</sup> September 2009. On doing so, I did appreciate that Patient 35 continues to have pain primarily localised to his left loin, as described by Mr Macleod. It is entirely possible that the left renal lesion is the cause of that pain. On the other hand, there is every possibility that the pain is not due to the left renal lesion at all. Ultimately, the only way of determining whether the lesion is the cause of pain is to remove that lesion. Removing a lesion from a kidney is not without risk. Whilst the lesion is reasonably exophytic it will require resection of part of the cortex on the posterior surface of the left kidney. Such partial nephrectomy is particularly accompanied by a small risk of haemorrhage which is uncontrollable and which would necessitate total nephrectomy. However, that risk is pretty small.

Another risk is that of a development of any new pain associated with the surgical wound. However, I would endeavour to keep the wound as minimal as possible in order to minimise the risk of such wound pain.

On balance, and in failing to find any other cause of his pain, I felt that it would be reasonable to proceed with open resection of this lesion from his left kidney. I therefore have arranged for him to be admitted to our department on Tuesday 3<sup>rd</sup> November 2009 for left partial nephrectomy on the 4<sup>th</sup> November 2009.

You will have noted from Mr Macleod's letter that Patient 35's serum total PSA level had remained reasonably stable at 4.22 ng/ml. This value was virtually identically to the level of 4.26 ng/ml in June 2008. The free to total PSA ratios were also identical, and worryingly low. Whilst I am pleased to note that Patient 35's serum total PSA level has fallen again to 3.57 ng/ml by the 27<sup>th</sup> October 2009, I do remain concerned by the persistently low free to total PSA ratios in the absence of any urinary microscopic or bacteriological evidence of prostatitis. I have discussed this with Patient 35 by telephone, and he would be entirely happy to have prostatic biopsies performed whilst under general anaesthesia for his left renal surgery.





Southern Health  
and Social Care Trust

2.

Therefore; I will perform cystoscopy, transperineal prostatic biopsies and left partial nephrectomy under general anaesthesia on Wednesday 4<sup>th</sup> November 2009. You will be advised of the outcome and plans for Patient 35's further management in due course.

Yours sincerely

Dictated but not signed by  
Aidan O'Brien  
Consultant Urologist

**Date Dictated: 02/11/09**

**Date Typed: 03/11/09**

|                      |                                      |                |                                      |
|----------------------|--------------------------------------|----------------|--------------------------------------|
| Patient ID           | Personal Information redacted by USI | Patient Name   | Patient 35                           |
| Sex                  | Male                                 | Date Of Birth  | Personal Information redacted by USI |
| Collected            | 04-Nov-2009 00:00                    | Reported       | 16-Nov-2009 12:30                    |
| Requested by         | MR A O'BRIEN                         | Requested from |                                      |
| Order Number         | 09K13357                             | Status         | Final                                |
| Relevant Information |                                      |                |                                      |

Comments

Amended Report Text : \*\*Supplementary Report\*\*  
Telephone to MR OBRIEN'S SEC on 16/11/09 14:41 by  
CA00286

REPORTFinal

SUPPLEMENTARY INFORMATION

Following discussion in this patient at the urology MDT I have reviewed the slides of specimen 2. Histologic examination shows the features of a benign cortical cyst. There are no features to suggest malignancy.

Dr G McClean,  
Date:15/1/13  
\*\*\*\*\*\_  
\*\*\*\*\*

FIRST ISSUED REPORT

CLINICAL DETAILS

PSA 4.22 ng/ml. Perineal prostatic biopsies. Left renal cortical lesion part 2.

PATHOLOGIST'S REPORT

Part 1  
Received five cores of prostatic tissue measuring 13, 12, 11 and 18 and 15 mm. These have been separated into parts A and B in the laboratory. Laterality was not stated. The tissue has been examined through multiple levels and with the use of special stains.

Obvious tumour is present in one of the three cores in A and in of the two cores in part B and these obvious foci are confirmed with negative staining for the basal marker 34BE12 and positive staining for the Racemase marker. In addition special stains confirm a microscopic focus of tumour in a further core with part

|                             |                                      |                       |                                      |
|-----------------------------|--------------------------------------|-----------------------|--------------------------------------|
| <b>Patient ID</b>           | Personal Information redacted by USI | <b>Patient Name</b>   | Patient 35                           |
| <b>Sex</b>                  | Male                                 | <b>Date Of Birth</b>  | Personal Information redacted by USI |
| <b>Collected</b>            | 04-Nov-2009 00:00                    | <b>Reported</b>       | 16-Nov-2009 12:30                    |
| <b>Requested by</b>         | MR A O'BRIEN                         | <b>Requested from</b> |                                      |
| <b>Order Number</b>         | 09K13357                             | <b>Status</b>         | Final                                |
| <b>Relevant Information</b> |                                      |                       |                                      |

A.

le total of three of five cores involved.

Gleason patterns 3 and 4.

Maximum tumour length in B 2 mm.

Maximum tumour length in A 1 mm.

Less than 5% of tumour involved.

#### Part 2

The cyst from the left kidney is a wedge of tumour, difficult to orientate. It is approximately 35 mm in length, 20 mm in depth and 20 mm in width and the tissue weighs 9 gm. The cortical surface was inked blue and the other margins red with the deep aspect orange. On sectioning there is slightly collapsed cyst approximately 20 mm in diameter and which focally appears to be disrupted at the cortical surface.

Virtually all of the cyst has been sampled.

Histology confirms a cystic lesion containing a small amount of blood and lined by mostly a flattened and attenuated lining epithelium but focally some papillary configuration and similar smaller cysts are present in the adjacent cortical tissue. No foci of clear cell change are present, nor is this a true multilocular cyst. There are foci of chronic inflammation in the adjacent fibrous wall of the cyst.

This is thought to be a benign cyst but the biopsy has been referred for further consultant expertise in Belfast and a supplementary report will follow.

DIAGNOSIS  
PROSTATE  
NEEDLE BIOPSY  
ADENOCARCINOMA  
LEFT KIDNEY  
CYST  
SEE ABOVE

|                      |                                      |                |                                      |
|----------------------|--------------------------------------|----------------|--------------------------------------|
| Patient ID           | Personal Information redacted by USI | Patient Name   | Patient 35                           |
| Sex                  | Male                                 | Date Of Birth  | Personal Information redacted by USI |
| Collected            | 04-Nov-2009 00:00                    | Reported       | 16-Nov-2009 12:30                    |
| Requested by         | MR A O'BRIEN                         | Requested from |                                      |
| Order Number         | 09K13357                             | Status         | Final                                |
| Relevant Information |                                      |                |                                      |

DR R CLARKE

Secretary: CT  
Date:- 16/11/09

**UROLOGY DEPARTMENT  
OUTPATIENT LETTER**

Telephone: [Personal Information redacted by USI]

Fax: [Personal Information redacted by USI]

E mail: [Personal Information redacted by the USI]

Secretary: **Mrs M McCorry**

DR M. MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
CO DOWN  
BT34 3JD

Dear DR MURPHY

**Re: Patient Name:** [Patient 35]  
**D.O.B.:** [Personal Information redacted by USI]  
**Address:** [Personal Information redacted by USI]  
**Hospital No:** [Personal Information redacted by USI] **HCN:** [Personal Information redacted by USI]

|                                      |                                |
|--------------------------------------|--------------------------------|
| <b>Date/Time of Clinic:</b> 06/09/10 | <b>Follow Up:</b> CT, 6/12 REV |
|--------------------------------------|--------------------------------|

I have reviewed this pleasant 60 year old gentleman, who has undergone left partial nephrectomy for a benign cystic lesion. In addition he had TRUS biopsy of the prostate at the same time, last year, for a moderately elevated PSA, which revealed adenocarcinoma of the prostate Gleason score of 7. Since then he has been on active surveillance, with his PSA being stable and in fact it decreased to 2.91 in June 2010.

His main problem is pain in the left flank with a feeling of bulge at the site of the wound. Clinical examination revealed no evidence of clinical hernia.

He was supposed to have a CT scan of the abdomen and pelvis, but unfortunately it was not on the system and I have therefore apologised to him for the inconvenience and I have rebooked the CT scan of abdomen and pelvis. I would be obliged if you would keep an eye on his PSA on 3 monthly basis and we have arranged to review him in 6 months' time with the CT and PSA results.

Yours sincerely,

*Dictated but not personally signed by:*

**Mr Ali Thwaini**  
**Registrar to**  
**Mr A O'Brien FRCS**  
**Consultant Urologist**

|                                |                                |
|--------------------------------|--------------------------------|
| <b>Date Dictated:</b> 06/09/10 | <b>Date Typed:</b> 30/09/10 CN |
|--------------------------------|--------------------------------|

Leame  
Curt

W.C.

Typing

Mr O'Brien

12 Nov 11

MDM Report from Urology MDM @ The Southern Trust

RE: Patient 35  
Personal Information redacted by USI  
DOB: Personal Information redacted by USI, Hospital Number: Personal Information redacted by USI, HCN: Personal Information redacted by USI  
Contact Tel: Personal Information redacted by USI

MDM Report from the Urology MDM @ The Southern Trust on 11/11/2010.

Diagnosis Uncertain at present

MDM Update

Dear Dr Murphy

Diagnosis:

CONSULTANT MR O'BRIEN:60 year old who had a left partial nephrectomy in October 09 for a benign cystic lesion. TRUSB performed at the same time for a moderately elevated PSA which revealed adenocarcinoma of the prostate Gleason score of 7. Has been on Active Surveillance, with PSA decreasing to 2.91ng/ml in June 2010. Complaining of left flank pain and bulging at the wound site. PSA of 4.31ng/ml in September 10. On examination no hernia felt.

Investigations-  
CT Abdomen & Pelvis 02.11.10-Recurrent lesion posterior cortex upper pole left kidney. Given its HU value on this single phase CT, correlation with ultrasound is advised to confirm that the lesion is cystic.

MDM Action

Discussed @ Urology MDM 11.11.10. Patient is to be contacted by telephone to be informed that PSA is to be performed by GP early December 2010. CT Renal tracts is to be requested by Mr O'Brien 12.11.10 and then is to be reviewed by Mr O'Brien with all results in December 2010. Will be rediscussed @ MDM with results.

Diagnostic/Staging details

CT Findings

Findings: Partial left nephrectomy noted. A 2 cm diameter, partially exophytic, relatively homogeneous (with some minor central low attenuation), rounded lesion arises from within the posterior aspect of the upper pole of the right kidney. This has an HU value of 44. Minor adjacent stranding of the perinephric fat in keeping with prior surgery. There is irregularity and thinning of the mid aspect of the left rectus abdominous muscle, with stranding of the adjacent subcutaneous fat, in keeping with prior surgery. No abdominal wall hernia.

Liver, gallbladder, pancreas, spleen, right kidney and adrenal glands normal. Small splenunculus. No significant abdominal or pelvic adenopathy. Urinary bladder normal. Large and small bowel unremarkable. Parenchymal bands both lung bases. Degenerative change both hips.

Conclusion:

1. Recurrent lesion posterior cortex upper pole left kidney. Given its HU value on this single phase CT, correlation with ultrasound is advised to confirm that the lesion is cystic.

MRI Findings

MDM Report from Urology MDM @ The Southern Trust

RE: Patient 35

Personal Information redacted by USI

DOB: Personal Information redacted by USI Hospital Number: Personal Information redacted by USI HCN: Personal Information redacted by USI

Contact Tel: Personal Information redacted by USI

Findings : The examination has been performed with the endorectal coil.

The bladder is moderately distended and appears diffusely thick walled. There are central BPH changes.

Much of the peripheral zone demonstrates normal T2 signal return, though there is probably some abnormal low signal both on the right and left side of the gland toward the apex (5 IMA 10 and 7 IMA 8). There is no evidence of extracapsular extension and the seminal vesicles demonstrate normal signal return.

The T1 weighted images appear rather noisy. No lymphadenopathy is seen within the scan field. Artefact from the endorectal coil limits assessment of high T1 weighted signal within the seminal vesicles and the prostate gland. Therefore, the presence of blood products is difficult to reliably exclude.

A small abnormal signal focus in the left iliac blade (9 IMA 8) is probably of doubtful significance.

Conclusion : The appearances are of T2 disease.

Comorbidity Summary

Prostate adenocarcinoma

**UROLOGY DEPARTMENT  
DISCHARGE LETTER**

Consultant Urologist: Mr A O'Brien  
 Secretary: Mrs Monica McCorry  
 Telephone: [Personal Information redacted by USI]  
 Fax: [Personal Information redacted by USI]

DR M. MURPHY  
 THE HEALTH CENTRE  
 SUMMERHILL  
 WARRENPOINT  
 CO DOWN  
 BT34 3JD

Dear DR MURPHY

**Re: Name:** Patient 35  
**D.O.B:** [Personal Information redacted by USI]  
**Address:** [Personal Information redacted by USI]  
**Hospital No:** [Personal Information redacted by USI] **H&C No:** [Personal Information redacted by USI]

|                                                                                                                         |                            |
|-------------------------------------------------------------------------------------------------------------------------|----------------------------|
| <b>Date of Admission:</b> 03/11/09                                                                                      | <b>Method of Admission</b> |
| <b>Date of Discharge:</b> 13/11/09                                                                                      | BOOKED ADMISSION           |
| <b>Diagnosis:</b> Left renal cyst<br>Prostatic carcinoma                                                                |                            |
| <b>Procedure:</b> Left partial nephrectomy 04 11 09<br>Cystoscopy 04 11 09<br>Transperineal prostatic biopsies 04 11 09 |                            |

Further to previous correspondence pertaining to this gentleman, you will be aware that Patient 35 had been admitted to our department on 3<sup>rd</sup> November 2009. At cystoscopy performed under general anaesthesia on 4<sup>th</sup> November 2009, he was found to have minimal enlargement of both lateral prostatic lobes. However, the combination of that minimal enlargement with bladder neck hypertrophy was probably causative of a degree of bladder outlet obstruction. He did have a trabeculated bladder typical of that seen in conjunction with a degree of bladder outlet obstruction. Transperineal prostatic biopsies were performed. By way of an oblique left upper abdominal incisional, the lesion arising from the cortex of the upper pole of the left kidney had all of the macroscopic features of an old cortical haemorrhagic cyst. The cyst was completely resected.

A wound drain was removed on 4<sup>th</sup> post operative day. Remarkably, and within hours of its removal, Patient 35 complained of significantly increased, left flank pain. The pain was accompanied by pyrexia and all of the appearances of a cellulitis surrounding the incisional wound. There was no evidence of any intra-abdominal collection or haematoma on CT scanning performed on 10<sup>th</sup> November 2009. Instead, significant swelling and oedema of the musculature of the left lateral abdominal wall was noted. He was recommenced on intravenous antibiotic therapy. The appearances of cellulitis had largely resolved by the time that Patient 35 was discharged on 13<sup>th</sup> November 2009.



As you are already aware, histological examination of the resected left renal lesion found the appearances of a benign cyst. Histological examination of the prostatic biopsies confirmed the presence of adenocarcinoma of gleason score 7 in 3 of 5 biopsy cores.

When I reviewed Patient 35 on 7<sup>th</sup> December 2009, I advised him of the histological findings. I found that he had had a small dehiscence of the posterior end of the incisional wound. The dehiscence was clean and had been dressed with Aquacel. At that time, Patient 35 had developed a left epididymitis, probably as a consequence of infection complicating prostatic biopsies. In addition to prescribing Ciprofloxacin then for a period of 6 weeks, I arranged for Patient 35 to have MRI scanning of his prostate performed. There was no evidence of any capsular infiltration or of any extracapsular disease.

At review in February 2010, Patient 35 reported having mild nocturia, having to rise once or twice each night to pass urine, and some terminal dribbling. He reported that his lower urinary tract symptoms had improved on Tamsulosin. He reported minimal compromise of erectile function. I was pleased to find that his serum total PSA level had fallen to 2.96 ng/ml. I advised him to discontinue taking Tramadol.

At further review in June 2010, I was disappointed, though not particularly surprised to hear him report that the pain referred to his left loin persisted unchanged. There may in addition have been some worsening of his lower urinary tract symptoms, in that he reported hesitancy of micturition and intermittency of the urinary flow. I was pleased to find that his serum total PSA level had fallen again to 2.91 ng/ml. I advised him to stop taking Tramacet and Pregabalin. Instead I prescribed Paracetamol 1g to be taken twice daily and Diclofenac 50mgs to be taken twice daily.

As you will be aware from the letter from Mr Thwaini on 30<sup>th</sup> September 2010, he arranged further CT scanning which was performed on 2<sup>nd</sup> November 2010. A lesion, measuring 2cms in diameter, partially exophytic, and relatively homogeneous, rounded in appearance, had recurred at the site of resection of the previous left renal cortical lesion. It had a moderate density of 44 hounsfield units. However, the scan was a single phase scan, rendering it impossible to determine whether the lesion was an enhancing one. In addition to the presence of the lesion, there was a mild degree of stranding of adjacent, perinephric fat. There was irregularity and thinning of the adjacent, left rectus abdominus muscle. There was no evidence of any herniation.

**The scan was discussed at our multidisciplinary meeting when it was advised that a multiphase CT scan be performed in order to determine whether the lesion is an enhancing lesion. I have requested that scan as well as ultrasound scanning** which may additionally help to determine whether it is a cystic lesion. I have written to Patient 35 advising him of the findings.

Patient 35's serum total PSA level had increased to 4.31 ng/ml by September. I have asked him to attend your surgery to have his serum total PSA level repeated, prior to his return for review on Friday 17<sup>th</sup> December 2010.

Yours sincerely

*dictated but not signed by*

---

**Mr A O'Brien**  
**Consultant Urologist**

|                         |                         |
|-------------------------|-------------------------|
| Date Dictated: 12/11/10 | Date Typed: 16/11/10-LH |
|-------------------------|-------------------------|

**UROLOGY DEPARTMENT**

Consultant Urologist: Mr A O'Brien  
Secretary: Mrs Monica McCorry  
Telephone: Personal Information  
redacted by the USI  
Fax: Personal Information  
redacted by the USI

16/11/10

**CONFIDENTIAL**

Patient 35  
Personal Information  
redacted by the USI

HCN: Personal Information  
redacted by USI

Dear Patient 35

I do hope that you are keeping reasonably well. I just write to advise you that the CT scan that you had performed recently indicated that a lesion, similar to the one that you had removed from your left kidney, had recurred at the site of resection of the previous lesion. The scan that you had performed recently was a single phase CT scan which means that all of the imaging was performed in a short period of time following injection of contrast medium. My Radiological colleagues have advised that CT scanning be repeated, availing of the opportunity of performing a multi-phase CT scan, in order to obtain further information regarding this area of your left kidney. I have requested that an appointment be arranged for you to have further CT scanning performed. In fact, I have requested that the CT scan be performed at Craigavon Area Hospital by Dr McClure who did advise that multi-phase CT scanning be repeated. I do hope that you will receive a letter of appointment in the near future. In addition, I have requested ultrasound scanning of your urinary tract.

Lastly, your serum total PSA level had increased a little to 4.31 ng/ml by September 2010. I would be grateful if you would arrange to have a serum total PSA level repeated on or after 1<sup>st</sup> December 2010.

Lastly, I do believe that an appointment has been arranged for you to return to my clinic at the Thorndale Unit at Craigavon Area Hospital on Friday 17<sup>th</sup> December 2010, by which time I do hope that you will have had CT scanning and ultrasound scanning both performed. In any case, I look forward to reviewing you then.

Kind Regards,

Yours sincerely

*dictated but not signed by*

---

**Mr A O'Brien**  
**Consultant Urologist**

**UROLOGY DEPARTMENT  
CLINIC LETTER**

Consultant Urologist: Mr A O'Brien  
Secretary: Mrs Monica McCorry  
Telephone: Personal Information redacted by the USI  
Fax: Personal Information redacted by the USI

DR M. MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
CO DOWN  
BT34 3JD

Dear DR MURPHY

**Re: Patient Name:** Patient 35  
**D.O.B.:** Personal Information redacted by USI  
**Address:** Personal Information redacted by USI  
**Hospital No:** Personal Information redacted by USI **HCN:** Personal Information redacted by USI

|                                      |                                    |
|--------------------------------------|------------------------------------|
| <b>Date/Time of Clinic:</b> 17/12/10 | <b>Follow Up:</b> Review June 2011 |
|--------------------------------------|------------------------------------|

Further to my recent letter, I write to advise you that Patient 35 did have further CT scanning performed on 23<sup>rd</sup> November 2010. This confirmed that the recurrent, exophytic lesion arising from the cortex of the left kidney, was hyperdense prior to the administration of contrast medium, and did not enhance. The appearances are considered to be entirely consistent with a hyperdense renal cyst as previously.

Patient 35 also had ultrasound scanning of his urinary tract performed on 30<sup>th</sup> November 2010. This confirmed that his prostate is of normal size with a volume of 24mls, and that bladder voiding on micturition was satisfactory, with a residual volume of 24mls.

When I reviewed Patient 35 on 17<sup>th</sup> December 2010, he reported that he still does have pain referred to his left loin as previously, and that in addition, he has pain referred to the anterior extremity of the surgical incisional scar. However, I was pleased to hear him report that he has completely discontinued taking all analgesia. I was also pleased to report to him that his serum total PSA level had fallen again to 3.55 ng/ml by 7<sup>th</sup> December 2010.

I have referred Patient 35 to the Pain Management Clinic and I have arranged to review him in June 2011. I would be grateful if he could have a serum total PSA level repeated prior to his review.

Yours sincerely

*dictated but not signed by*

---

**Mr A O'Brien**  
**Consultant Urologist**

*CC Dr P McConaghy, Consultant In Pain Management, CAHGT*

|                                |                                |
|--------------------------------|--------------------------------|
| <b>Date Dictated:</b> 17/12/10 | <b>Date Typed:</b> 22/12/10-LH |
|--------------------------------|--------------------------------|

**UROLOGY DEPARTMENT  
CLINIC LETTER**

Consultant Urologist: Mr A O'Brien  
Secretary: Mrs Monica McCorry  
Telephone: [Personal Information redacted by USI]  
Fax: [Personal Information redacted by USI]

DR PAUL MCCONAGHY  
Consultant In Chronic Pain Management  
Chronic Pain Management Clinic  
Craigavon Area Hospital

Dear Paul

**Re: Patient Name:** Patient 35  
**D.O.B.:** [Personal Information redacted by USI]  
**Address:** [Personal Information redacted by USI]  
**Hospital No:** [Personal Information redacted by USI] **HCN:** [Personal Information redacted by USI]

I would be grateful if you would arrange an appointment for this 60 year old gentleman who presented in 2009 with a history of left loin pain, and who was found to have a hyperdense cystic lesion arising from the posterior cortex of the midpole of his left kidney. Whilst it was doubted whether the lesion could have been the cause of the pain, there was some doubt as to whether it could have been neoplastic. For the latter reason, Patient 35 underwent resection of the left renal lesion in November 2009. The lesion was benign. However, the pain referred to his left loin persists. In addition, he does have some pain related to the anterior extremity of the surgical incisional scar.

Patient 35 had previously been taking Paracetamol and Tramadol regularly. The combination certainly did relieve his pain, but resulted in severe adverse toxicity, and for which reason he has since discontinued taking all analgesia.

I would be grateful if you could arrange an appointment for him to attend your clinic, as I would be appreciative of your assessment, and of any alternative suggestions for the management of his pain.

Yours sincerely

*dictated but not signed by*

---

**Mr A O'Brien**  
**Consultant Urologist**

**Date Dictated:** 17/12/10

**Date Typed:** 22/12/10-LH

9<sup>TH</sup> March 2011

DR M. MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
CO DOWN  
BT34 3JD

Dear DR MURPHY

**Re: Patient Name:** Patient 35  
**D.O.B.:** Personal Information redacted by USI  
**Address:** Personal Information redacted by USI  
**Hospital No:** **HCN:** Personal Information redacted by USI

This gentleman's CT scan on the 23<sup>rd</sup> November 2010 was reviewed at the urology x-ray meeting. He had partial left nephrectomy in November 2009 for what turned out to be benign disease. There is a question of soft tissue recurrence at the renal bed. On review of the films it was felt that it was most likely normal post op changes. He will be reviewed as previously arranged.

Yours sincerely

Dictated but not signed by  
Mr Funso Abogunrin  
LAT SAT Urology

|                              |                             |
|------------------------------|-----------------------------|
| <b>Date Dictated:</b> 2/2/11 | <b>Date Typed:</b> 09/03/11 |
|------------------------------|-----------------------------|

**UROLOGY DEPARTMENT**

Consultant Urologist: Mr A O'Brien  
Secretary: Mrs Monica McCorry  
Telephone: [Personal Information redacted by USI]  
Fax: [Personal Information redacted by USI]

DR M. MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
CO DOWN  
BT34 3JD

Dear DR MURPHY

**Re: Patient Name:** Patient 35  
**D.O.B.:** [Personal Information redacted by USI]  
**Address:** [Personal Information redacted by USI]  
**Hospital No:** [Personal Information redacted by USI] **HCN:** [Personal Information redacted by USI]

Patient 35 contacted me today to say his kidney pain had increased in recent days and was now quite severe. He is currently awaiting an MRI scan and Mr Young has expedited the urgency of this. He will be reviewed as previously arranged by Mr O'Brien.

Yours sincerely

*dictated but not signed by*

---

**Jenny McMahon**  
**Urology Nurse Specialist**

|                                |                                |
|--------------------------------|--------------------------------|
| <b>Date Dictated:</b> 15/07/11 | <b>Date Typed:</b> 18/07/11-LH |
|--------------------------------|--------------------------------|



**CRAIGAVON AREA HOSPITAL  
68 LURGAN ROAD  
PORTADOWN, BT63 5QQ**

**UROLOGY DEPARTMENT  
OUTPATIENT LETTER**

Telephone: [Personal Information redacted by USI]

Fax: [Personal Information redacted by USI]

E mail: [Personal Information redacted by the USI]

Secretary: **Mrs M McCorry**

15 December 2011

DR M. MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
CO DOWN  
BT34 3JD

Dear DR MURPHY

**Re: Patient Name:** [Patient 35]  
**D.O.B.:** [Personal Information redacted by USI]  
**Address:** [Personal Information redacted by USI]  
**Hospital No:** [Personal Information redacted by USI] **HCN:** [Personal Information redacted by USI]

|                                      |                                |
|--------------------------------------|--------------------------------|
| <b>Date/Time of Clinic:</b> 11/11/11 | <b>Follow Up:</b> REV MAY 2012 |
| <b>Procedure (if applicable)</b>     |                                |

I last wrote to you regarding [Patient 35] in December 2010, when I referred him to Dr Paul McConaghy, Consultant in Pain Management, and who was able to arrange an appointment for [Patient 35] in February 2011, when he advised [Patient 35] to restrict the use of Tramacet to taking it prior to going to bed, in order to avoid diurnal drowsiness and to try Butrans patches instead for diurnal relief of pain. However, when I reviewed [Patient 35] in June 2011, he reported that the pain remained unchanged. I was pleased to note that his serum total PSA level had decreased a little to 3.25ng/ml by March 2011. He reported that his lower urinary tract symptoms remained unchanged.

I had to confess that I was at a loss to explain the cause of [Patient 35]'s pain, or to be able to advise him on any more effective analgesia. I did wonder whether there was an element of anxiety with regard to whether the pain could be indicative of malignancy. I arranged for him to have MRI scanning of his thoraco-lumbar spine performed on 19 July 2011. His thoraco-lumbar spine was found to be entirely normal. I also arranged for him to have ultrasound scanning of his urinary tract performed more recently on 7 November 2011. This too was normal. In particular, no cystic lesion was evident at all on scanning of his left kidney.

/On

On most recent review on 11 November 2011, **Patient 35** reported that the pain persisted. On clinical reassessment, I found it impossible to arrive at any impression as to whether the pain was somatic or visceral. It remains located deep to the anterior end of his incisional wound. Even though the pain persists, I do feel that **Patient 35** has been somewhat reassured by the normality of recent scans. He has also been able to do with less analgesia. I have advised him to try Pregabalin 75mg twice daily, and I have arranged to review him in May 2012.

With regard to his prostatic carcinoma, his serum total PSA level had fallen further to 2.85ng/ml by September 2011. When I review him in May 2012, I will give consideration to having MRI scanning of his prostate gland repeated, as a component of his active surveillance.

Yours sincerely

*Dictated but not signed by*

**Mr A O'Brien FRCS**  
**Consultant Urological Surgeon**

|                      |                                      |                |                                      |
|----------------------|--------------------------------------|----------------|--------------------------------------|
| Patient ID           | Personal Information redacted by USI | Patient Name   | Patient 35                           |
| Sex                  | Male                                 | Date Of Birth  | Personal Information redacted by USI |
| Collected            | 11-Dec-2012 00:00                    | Reported       | 13-Dec-2012 17:36                    |
| Requested by         | MR A O'BRIEN                         | Requested from |                                      |
| Order Number         | 12K17485                             | Status         | Final                                |
| Relevant Information |                                      |                |                                      |

## REPORT

Final

## CLINICAL DETAILS

PSA 3.99. Prostate volume 23.7cc. Medication -- tamsulosin.

## PATHOLOGIST'S REPORT

## GROSS DESCRIPTION

NATURE OF SPECIMEN: needle core biopsy  
SITE: 1. Right base -- two cores, longer 16 mm  
SITE: 2. Right mid -- two cores, longer 15 mm  
SITE: 3. Right apex -- one core, 12 mm  
SITE: 4. Left base -- two cores, longer 16 mm  
SITE: 5. Left mid -- two cores, longer 18 mm  
SITE: 6. Left apex -- one core, 70 mm

## HISTOLOGY

HISTOLOGICAL TYPE: adenocarcinoma  
DIFFERENTIATION/GLEASON SUM SCORE: overall 3+4 =7  
NUMBER OF CORES/CHIPS INVOLVED: 8  
Right base - 2 of 2, Gleason 3+4, 8.5 mm max length, 75% of tissue  
Right mid -2 of 2, Gleason 3+4, 0.5 mm max length, 5% of tissue  
Right apex -no tumour identified  
Left base -2 of 2, Gleason 3+4, 6 mm max length, 50% of tissue  
Left mid - 2 of 2, Gleason 3+4, 8 mm max length, 75% of tissue  
Left apex -no tumour identified

## INVASION INTO:

Seminal vesicle: no  
Extracapsular fat: no

PERINEURAL INVASION: no

LYMPHOVASCULAR INVASION: no

## FURTHER COMMENTS:

Prostatic adenocarcinoma of overall Gleason sum score of 3+4=7 is present in 8 of 10 cores with a maximum tumour length of 8.5 mm.  
The tumour occupies approximately 50% of the total tissue volume.

|                      |                                      |                |                                      |
|----------------------|--------------------------------------|----------------|--------------------------------------|
| Patient ID           | Personal Information redacted by USI | Patient Name   | Patient 35                           |
| Sex                  | Male                                 | Date Of Birth  | Personal Information redacted by USI |
| Collected            | 11-Dec-2012 00:00                    | Reported       | 13-Dec-2012 17:36                    |
| Requested by         | MR A O'BRIEN                         | Requested from |                                      |
| Order Number         | 12K17485                             | Status         | Final                                |
| Relevant Information |                                      |                |                                      |

Prostate  
needle biopsy  
adenocarcinoma

DR G MCCLEAN  
Date:- 13/12/2012

**MDM Report from Urology MDM @ The Southern Trust**

---

**RE:** Patient 35  
Personal Information redacted by USI  
**DOB:** Personal Information redacted by USI **Hospital Number:** Personal Information redacted by USI **HCN:** Personal Information redacted by USI  
**Contact Tel:** Personal Information redacted by USI

---

**MDM Report from the Urology MDM @ The Southern Trust on 20/12/2012.**

|                              |                             |
|------------------------------|-----------------------------|
| <b>Diagnosis</b>             | Prostate cancer             |
| <b>Histology</b>             | Adenocarcinoma, NOS,        |
| <b>PSA</b>                   | 3.9                         |
| <b>Gleason Score</b>         | 3 + 4 In 8 out of 10 Cores. |
| <b>Longest Tumour Length</b> | 8.50 mm                     |
| <b>% Tissue Involved</b>     | 50                          |
| <b>Prostate Volume</b>       | 23                          |

**MDM Update**

CONSULTANT MR O'BRIEN: This 62 year old man was found to have Gleason 7 carcinoma in 3 of 5 transperineal prostatic biopsies performed in 2009 when undergoing left partial nephrectomy for a benign lesion. PSA was 3.47 in October 2008. Managed by Active Surveillance since. PSA 3.99 November 2012. LUTS increased in severity. For TRUS prostatic biopsies 11 December 2012.

Transrectal prostatic biopsy 11.12.12: Prostatic adenocarcinoma of Gleason score 3+4=7 is present in 8 of 10 cores with a maximum tumour length of 8.5 mm. The tumour occupies approximately 50% of the total tissue volume.

**MDM Action**

Discussed @ Urology MDM 20.12.12. 62 year old man with Gleason 7, prostate cancer in 8/10 cores. We are recommending further evaluation with staging CT C/A/P ( in view of previous renal problems) as well as a bone scan and MRI pelvis. To be reviewed by Mr O'Brien.

**Radiology****CT Findings**

## MDM Report from Urology MDM @ The Southern Trust

RE:

Patient 35

Personal Information redacted by USI

DOB:

Personal Information redacted by USI

Hospital Number:

Personal Information redacted by USI

HCN:

Personal Information redacted by USI

Contact Tel:

Personal Information redacted by USI

Latest Findings from CT performed on 02/11/2009

Findings: Partial left nephrectomy noted. A 2 cm diameter, partially exophytic, relatively homogeneous (with some minor central low attenuation), rounded lesion arises from within the posterior aspect of the upper pole of the right kidney. This has an HU value of 44. Minor adjacent stranding of the perinephric fat in keeping with prior surgery. There is irregularity and thinning of the mid aspect of the left rectus abdominous muscle, with stranding of the adjacent subcutaneous fat, in keeping with prior surgery. No abdominal wall hernia.

Liver, gallbladder, pancreas, spleen, right kidney and adrenal glands normal. Small splenunculus. No significant abdominal or pelvic adenopathy. Urinary bladder normal. Large and small bowel unremarkable. Parenchymal bands both lung bases. Degenerative change both hips.

**Conclusion:**

1. Recurrent lesion posterior cortex upper pole left kidney. Given its HU value on this single phase CT, correlation with ultrasound is advised to confirm that the lesion is cystic.

**MRI Findings**

Latest Findings from MRI performed on 03/02/2010

Findings : The examination has been performed with the endorectal coil.

The bladder is moderately distended and appears diffusely thick walled. There are central BPH changes.

Much of the peripheral zone demonstrates normal T2 signal return, though there is probably some abnormal low signal both on the right and left side of the gland toward the apex (5 IMA 10 and 7 IMA 8). There is no evidence of extracapsular extension and the seminal vesicles demonstrate normal signal return.

The T1 weighted images appear rather noisy. No lymphadenopathy is seen within the scan field. Artefact from the endorectal coil limits assessment of high T1 weighted signal within the seminal vesicles and the prostate gland. Therefore, the presence of blood products is difficult to reliably exclude.

A small abnormal signal focus in the left iliac blade (9 IMA 8) is probably of doubtful significance.

Conclusion : The appearances are of T2 disease.

**Comorbidity Summary**

Prostate adenocarcinoma

**Urology MDM @ The Southern Trust**

DR M.J. MURPHY  
THE HEALTH CENTRE  
SUMMER HILL  
WARRENPOINT  
BT34 3JD

**RE:** Patient 35

Personal Information redacted by USI

**DOB:** Personal Information redacted by USI **Hospital Number:** Personal Information redacted by USI **HCN:** Personal Information redacted by USI

Dear Dr MURPHY

This patient was discussed at the Urology MDM @ The Southern Trust  
On 20/12/2012.

**Diagnosis:** Prostate cancer  
**Gleason Score** 3 + 4

**MDM Update:**

CONSULTANT MR O'BRIEN: This 62 year old man was found to have Gleason 7 carcinoma in 3 of 5 transperineal prostatic biopsies performed in 2009 when undergoing left partial nephrectomy for a benign lesion. PSA was 3.47 in October 2008. Managed by Active Surveillance since. PSA 3.99 November 2012. LUTS increased in severity. For TRUS prostatic biopsies 11 December 2012.

Transrectal prostatic biopsy 11.12.12: Prostatic adenocarcinoma of Gleason score 3+4=7 is present in 8 of 10 cores with a maximum tumour length of 8.5 mm. The tumour occupies approximately 50% of the total tissue volume.

**MDM Plan:**

Discussed @ Urology MDM 20.12.12. 62 year old man with Gleason 7, prostate cancer in 8/10 cores. We are recommending further evaluation with staging CT C/A/P ( in view of previous renal problems) as well as a bone scan and MRI pelvis. To be reviewed by Mr O'Brien.

If you have any queries or require further information, please do not hesitate to contact us.

Yours sincerely,

Personal Information redacted by USI

|                |                                      |                |                                      |
|----------------|--------------------------------------|----------------|--------------------------------------|
| Patient ID     | Personal Information redacted by USI | Patient Name   | Patient 35                           |
| Sex            | Male                                 | Date Of Birth  | Personal Information redacted by USI |
| Time Performed | 12-Feb-2013 15:00                    | Time Reported  | 12-Feb-2013 17:24                    |
| Requested by   | Aidan O'Brien                        | Requested from | Surgical Outpatients CAH             |
| Order Number   | NIRSCR0016937710                     | Status         | Final                                |

Report

Final

12/02/2013 16:34 MRI Pelvis endocavity

History  
Cancer prostate. Gleason seven. For staging.  
Report  
Normal size and shape of the prostatic gland. Mild patchy low signal changes in the peripheral prostatic zone in the level of the gland base in keeping with the primary tumour. Intact prostatic capsule with no extracapsular disease extension. Intact neurovascular bundle and pelvic sidewalls. Normal appearance of the seminal vesicles. No significant pelvic or inguinal lymphadenopathy.  
Conclusion  
The appearance of cancer prostate stage T2 N0.

Clinical Info From Order

Final

This man has had Gleason 7 adenocarcinoma of prostate found in 8 of 10 biopsy cores on 11 December 2012 when PSA was3.99 ng/ml.  
PLEASE DO IN FEBRUARY 2013.  
scan after 22/1/13



|                |                                      |                |                                          |
|----------------|--------------------------------------|----------------|------------------------------------------|
| Patient ID     | Personal Information redacted by USI | Patient Name   | Patient 35                               |
| Sex            | Male                                 | Date Of Birth  | Personal Information redacted by the USI |
| Time Performed | 12-Feb-2013 15:00                    | Time Reported  | 12-Feb-2013 17:24                        |
| Requested by   | Aidan O'Brien                        | Requested from | Surgical Outpatients CAH                 |
| Order Number   | NIRSCR0016934204                     | Status         | Final                                    |

|                                      |       |
|--------------------------------------|-------|
| Report                               | Final |
| 12/02/2013 16:34 MRI Pelvis prostate |       |
| Please see the report of the pelvis  |       |

|                                                                                                                                                                                      |       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|
| Clinical Info From Order                                                                                                                                                             | Final |
| This man has had Gleason 7 adenocarcinoma of prostate found in 8 of 10 biopsy cores on 11 December 2012 when PSA was3.99 ng/ml.<br>PLEASE DO IN FEBRUARY 2013.<br>scan after 22/1/13 |       |

|                |                                      |                |                                          |
|----------------|--------------------------------------|----------------|------------------------------------------|
| Patient ID     | Personal Information redacted by USI | Patient Name   | Patient 35                               |
| Sex            | Male                                 | Date Of Birth  | Personal Information redacted by the USI |
| Time Performed | 12-Feb-2013 15:00                    | Time Reported  | 12-Feb-2013 17:24                        |
| Requested by   | Aidan O'Brien                        | Requested from | Surgical Outpatients CAH                 |
| Order Number   | NIRSCR0016937711                     | Status         | Final                                    |

Report

Final

12/02/2013 16:34 MRI Spine lumbar

History  
History cancer prostate. For staging.  
Sequence  
Sagittal T1 sequence  
Report  
Normal alignment. No vertebral collapse. Preserved disc space. No spinal canal stenosis or compression on the dural sac. No significant bone marrow signal changes.  
Conclusion  
No evidence of bony mets.

Clinical Info From Order

Final

This man has had Gleason 7 adenocarcinoma of prostate found in 8 of 10 biopsy cores on 11 December 2012 when PSA was3.99 ng/ml.  
PLEASE DO IN FEBRUARY 2013.  
scan after 22/1/13



**Southern Health  
and Social Care Trust**

**CRAIGAVON AREA HOSPITAL  
68 LURGAN ROAD  
PORTADOWN, BT63 5QQ**

**UROLOGY DEPARTMENT  
DISCHARGE LETTER**

Telephone: [Personal Information redacted by the USI]

Fax: [Personal Information redacted by the USI]

E mail: [Personal Information redacted by the USI]

Secretary: **Mrs M McCorry**

10 June 2013

**DR M. MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
CO DOWN  
BT34 3JD**

Dear DR MURPHY

**Re: Name:** [Patient 35]  
**D.O.B:** [Personal Information redacted by USI]  
**Address:** [Personal Information redacted by USI]  
**Hospital No:** [Personal Information redacted by USI] **H&C No:** [Personal Information redacted by USI]

|                                                                                                        |                            |
|--------------------------------------------------------------------------------------------------------|----------------------------|
| <b>Date of Admission:</b> 15/02/13                                                                     | <b>Method of Admission</b> |
| <b>Date of Discharge:</b> 15/02/13                                                                     |                            |
| <b>Diagnoses:</b> 1. Prostatic Carcinoma; 2. Chronic Urinary Retention; 3. Detrusor Hypercontractility |                            |
| <b>Procedure:</b> Urodynamics Studies                                                                  |                            |

I last wrote to you in November 2011 regarding [Patient 35]. When I reviewed [Patient 35] in November 2012, I was reassured by the stability of serum PSA levels. His serum total PSA was 3.99ng/ml in November 2012, exactly the same level as it had been almost four years previously in January 2009. However, on symptomatic review, his lower urinary tract symptoms had certainly worsened, even though he remained on Tamsulosin. He reported hesitancy of micturition, a reduced urinary flow, a sensation of unsatisfactory voiding following micturition and post-micturitional incontinence, in addition to some dysuria and varying degrees of nocturia. Whilst on occasion he would not have to rise at all to pass urine, he reported that he had to do so up to x4 on other occasions.

In my last letter I had indicated that I would consider having MRI scanning repeated as a component of active surveillance of his prostatic carcinoma. However, [Patient 35] kindly agreed to proceed to having prostatic biopsies repeated. I do hope that you received my report from the multi-disciplinary meeting of 20 December 2012, reporting that biopsies confirmed the persistence of adenocarcinoma of Gleason score 7 in 8 of 10 cores performed on 11 December 2012.



It is probably the case that there has been no pathological progression of the carcinoma since the diagnostic prostatic biopsies were performed in 2009, as he was found to have Gleason 7 adenocarcinoma in 3 of the 5, transperineal biopsies that were performed at that time. Nevertheless, and more importantly, it needs to be borne in mind that Patient 35 does have adenocarcinoma of Gleason grade IV, even though that is the lesser grade accompanying Gleason grade III, which is the predominant grade. Any inclusion of Gleason grade IV harbours the potential for disease progression.

In any case, Patient 35 proceeded to having restaging in January 2013. There was no evidence of any skeletal metastatic disease on radio-isotope bone scanning. There was no suspicion or evidence of any capsular infiltration or of any extracapsular disease, when MRI scanning was performed on 12 February 2013. There was no suspicion of any lymphadenopathy on CT scanning. However, CT scanning was primarily performed to reassess the left kidney. This was particularly reassuring, as the post-operative, soft tissue, inflammatory features that had persisted adjacent to the site of the resection of the cystic lesion from the left kidney, had improved significantly since previous imaging, to the extent that they had almost completely disappeared. I found that particularly reassuring in relation to the persistence of left hypochondrial and flank pain.

Of equal clinical relevance was repeated ultrasound scanning of his lower urinary tract in January 2013. His prostate gland was found to be minimally enlarged, with a volume of 25ml. Importantly, he was found to have sub-optimal bladder voiding on micturition, with a residual volume of 107ml.

I lastly arranged for Patient 35 to attend for urodynamic studies on 15 February 2013. On initial mictiometry, he passed 416ml of urine. His maximum flow rate was normal at 15ml/sec. However, voiding time was very prolonged at 106sec, resulting in a poor mean flow rate of 4ml/sec. More importantly, bladder voiding was found, once again, to be inadequate, with a residual volume of 130ml.

Filling cystometry was normal, his bladder having a maximum cystometric capacity of 573ml. Even though it should be regarded as normal, there was just the slightest hint of a minimal degree of detrusor instability during filling. However, that instability was certainly not enough to compromise his bladder capacity.

Voiding cystometry was helpful, in that Patient 35 was found to have quite markedly increased detrusor contractility on voiding. The maximum detrusor contractile pressure on voiding cystometry was 114cmH<sub>2</sub>O. Whilst the presence of bladder outlet obstruction was not confirmed on urethral pressure profilometry, I do suspect that Patient 35 does have bladder outlet obstruction and that the minimal degree of detrusor instability seen during filling cystometry, the hypercontractility on voiding cystometry and the inadequate bladder voiding are primarily due to bladder outlet obstruction. Moreover, the deterioration in lower urinary tract symptoms may be a further consequence of local progression of prostatic carcinoma.

**Southern Health  
and Social Care Trust**

3

Patient 35

Primarily for this reason, I felt that it was appropriate to proceed with initiation of androgen blockade. I prescribed Bicalutamide 50mg daily. I prescribed Tamoxifen 10mg daily, in order to minimise the risk of gynecomastia. I prescribed Tadalafil 5mg daily, in order to help preserve erectile function. Lastly, and even though Patient 35 was found to have inadequate bladder voiding, I prescribed Solifenacin 5mg, to be taken twice daily, as storage symptoms rather than voiding symptoms seemed to be most troublesome.

Patient 35 was rather keen to be reviewed by Dr McConaghy. I have written to Dr McConaghy, asking him to do so. I have also arranged to review Patient 35 on Friday 14 June 2013.

Androgen blockade has been initiated with neo-adjuvant intent, prior to radical radiotherapy at a later date. Androgen blockade may also result in adequate relief of bladder outlet obstruction, improved voiding and improved lower urinary tract symptoms. If this does not occur, Patient 35 may require prostatic resection prior to radical radiotherapy.

Yours sincerely

*Dictated but not signed by*

**Mr A O'Brien FRCS**  
**Consultant Urological Surgeon**

cc DR PAUL MCCONAGHY  
CONSULTANT IN CHRONIC PAIN MANAGEMENT  
PAIN MANAGEMENT CLINIC  
DAISY HILL HOSPITAL  
NEWRY  
CO DOWN

Date Dictated: 10/06/13

Date Typed: 10/06/13 SC

**PAT-000904**

**CRAIGAVON AREA HOSPITAL  
68 LURGAN ROAD  
PORTADOWN, BT63 5QQ**

**UROLOGY DEPARTMENT**

Telephone: [Personal Information redacted by USI]

Fax: [Personal Information redacted by USI]

E mail: [Personal Information redacted by the USI]

Secretary: **Mrs M McCorry**

10 June 2013

**CONFIDENTIAL**

Patient 35  
[Personal Information redacted by the USI]

HCN: [Personal Information redacted by USI]

Dear Patient 35

I write to confirm that I have written to Dr Paul McConaghy, Consultant in Chronic Pain Management, requesting that he arrange a review appointment for you at his clinic in Daisy Hill Hospital in Newry. I do hope that you will receive a letter of appointment from him in due course.

I note that you are due to return for review at my clinic in the Thorndale Unit on Friday 14 June 2013 at 2.30pm. I look forward to reviewing you then.

Whilst it is probably too late for me to remind you so close to your appointment, it would be great if you could have had a serum total PSA level repeated by the practice nurse at the Health Centre in Warrenpoint, so that the result would be available when you attend for review. However, I will not be at all surprised if you have already done so.

Yours sincerely

*Dictated but not signed by*

**Mr A O'Brien FRCS**  
**Consultant Urological Surgeon**  
/sc

**CRAIGAVON AREA HOSPITAL  
68 LURGAN ROAD  
PORTADOWN BT63 5QQ**

**UROLOGY DEPARTMENT  
CLINIC LETTER**

**CONSULTANT UROLOGIST:  
SECRETARY:  
TELEPHONE:**

Mr A O'Brien  
Monica McCorry

Personal Information redacted by USI

DR M. MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
CO DOWN  
BT34 3JD

Dear DR MURPHY

**Re: Patient Name:** Patient 35  
**D.O.B.:** Personal Information redacted by USI  
**Address:** Personal Information redacted by USI  
**Hospital No:** Personal Information redacted by USI **HCN:** Personal Information redacted by USI

|                                      |                                             |
|--------------------------------------|---------------------------------------------|
| <b>Date/Time of Clinic:</b> 14/06/13 | <b>Follow Up:</b> USS & REVIEW JANUARY 2014 |
|--------------------------------------|---------------------------------------------|

Further to my letter of 10<sup>th</sup> June 2013 I write to confirm that I reviewed Patient 35 on the 14<sup>th</sup> June 2013 as planned. On doing so, I was rather pleased to find that his serum total PSA level had fallen to 1.03ng/ml earlier that month. I had hoped that his serum PSA levels would continue to decline, so as to enable Patient 35 to proceed with radical radiotherapy, and which would have been additionally facilitated by his urinary symptoms being relatively mild, consisting only of occasional, post micturitional incontinence, and mild nocturia, having to rise once or twice each night to pass urine.

However, Patient 35's serum PSA levels did not decline further. In fact, there was a marginal increase in his serum total PSA level to 1.1ng/ml by September 2013. Moreover, there probably was some worsening in the severity of his lower urinary tract symptoms, particularly as he has to rise two or three times each night to pass urine now.

I have had the opportunity of speaking with Patient 35 by telephone. I have advised him to increase the dose of Bicalutamide to 150mg daily. I would be grateful if you would prescribe this increased dose for him. I have asked Patient 35 to pick up a prescription for that increased dose.

I have also requested further ultrasound scanning of his lower urinary tract, to be performed at Daisy Hill Hospital in Newry, in December 2013, in order to assess bladder voiding in particular.

**Re: Patient Name:** Patient 35  
**D.O.B.:** Personal Information redacted by USI  
**Address:** Personal Information redacted by USI  
**Hospital No:** Personal Information redacted by USI **HCN:** Personal Information redacted by USI

I have also asked Patient 35 to have his serum PSA level repeated by your Practice Nurse in late December 2013, and so that the result will be available with the report ultrasound scan when I review him in January 2014.

Yours sincerely

*Dictated but not signed by*

**MR A O'BRIEN FRCS**  
**CONSULTANT UROLOGIST**

|                                |                                |
|--------------------------------|--------------------------------|
| <b>Date Dictated:</b> 11/10/13 | <b>Date Typed:</b> 14/10/13-CN |
|--------------------------------|--------------------------------|



**CRAIGAVON AREA HOSPITAL  
68 LURGAN ROAD  
PORTADOWN BT63 5QQ**

**UROLOGY DEPARTMENT  
CLINIC LETTER**

**CONSULTANT UROLOGIST:  
SECRETARY:  
TELEPHONE:**

Mr A O'Brien  
Monica McCorry

Personal Information redacted by USI

14/10/13

**CONFIDENTIAL**

Patient 35

Personal Information redacted by the USI

HCN: Personal Information redacted by USI

Dear Patient 35

I was pleased to have the opportunity of speaking with you by telephone on Wednesday 9<sup>th</sup> October 2013. I write to confirm that I have written to your family Doctor, Dr Murphy, asking him to provide you with a prescription for the increased dose of Bicalutamide 150mg, to be taken once daily. You should remain on Tamoxifen 10mg daily as well as Tadalafil, 5mg daily.

I write to confirm that I have requested the Department of Radiology at Daisy Hill Hospital in Newry to arrange an appointment for you to have ultrasound scanning repeated in December 2013, particularly to reassess your bladder emptying on passing urine. I would be grateful if you would have your serum PSA level repeated in late December 2013, and so that the result will be available with the report of the ultrasound scan, when I review you in January 2014. I look forward to reviewing you then.

Kind Regards

Yours sincerely

*Dictated but not signed by*

**MR A O'BRIEN FRCS  
CONSULTANT UROLOGIST**

Write patient details or affix addressograph

Hospital Number:

Name:

Address:

Date of Birth:

Personal Information  
redacted by USI

Patient 35

Personal Information redacted by the USI



Allergies / Medicine sensitivities

Medicine / Allergen

Type of reaction

Signature

Date

No known allergies ☒

Personal Information redacted by USI

Page 2-7 = Patient

Page 8-9 = Assessment

Page 10-12 = Nursing Notes

Page 13-16 = Summary

Inpatient Waiting List Information

|                        |                                                                                                                     |                     |                                                                                                                                                                                             |
|------------------------|---------------------------------------------------------------------------------------------------------------------|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Diagnosis              | BLADDER OUTLET OBSTRUCTION                                                                                          |                     |                                                                                                                                                                                             |
| Procedure              | TURP                                                                                                                |                     |                                                                                                                                                                                             |
| Specialty              | UROLOGY                                                                                                             | Consultant          | ADAM O'BRIEN                                                                                                                                                                                |
| Urgency                | Red Flag <input checked="" type="checkbox"/><br>Urgent <input type="checkbox"/><br>Routine <input type="checkbox"/> | Intended Management | Day-Case <input type="checkbox"/><br>Inpatient <input checked="" type="checkbox"/><br>Suitable for standalone Day Surgery Unit?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Additional Information | PLANNED FOR 14.05.14 PROPOSED FOR PLAS TAPENARD                                                                     |                     |                                                                                                                                                                                             |

POA Progress

|                              |                                      |                                               |                              |
|------------------------------|--------------------------------------|-----------------------------------------------|------------------------------|
| Date Added to IPWL           |                                      | Date Health Screening Questionnaire completed |                              |
| Band 5 Appointment Date      | n/a <input type="checkbox"/>         | Band 6 Appointment Date                       | n/a <input type="checkbox"/> |
| Anaesthetic Appointment Date | n/a <input type="checkbox"/>         |                                               |                              |
| POA Hold Date                |                                      |                                               |                              |
| Waiting List Suspension(s)   | Start Date                           | End Date                                      | Reason & by whom             |
| Suspension Episode 1         |                                      |                                               |                              |
| Suspension Episode 2         |                                      |                                               |                              |
| Suspension Episode 3         |                                      |                                               |                              |
| POA Fit Date                 | 15/4/14. am 2nd GTS + mssu on resus. |                                               |                              |

POA Nursing Staff who have completed this booklet

Print Name DOUG STOWERS

Signature

Personal Information redacted by USI

Date 11-4-14

Print Name

Signature

Date

15/8/14 CA0B40  
6/6/14 "

**PAT-000909**

8186174  
2015/114

*CRAIGAVON CELLULAR PATHOLOGY*

Surname **Patient 35**  
Forename **[REDACTED]**  
Hosp. No. **[REDACTED]**  
DOB/Sex **[REDACTED]**  
Address **[REDACTED]**

**Male**

Source **CRAIGAVON AREA HOSPITAL**  
Consultant **MR A O'BRIEN**

Ward/GP **ELECTIVE ADMISSION UNIT L3**  
**CRAIGAVON AREA HOSPITAL**  
**68 LURGAN ROAD**  
**CRAIGAVON**

**BT63 5QQ**

Specimen **PROSTATIC CHIPPINGS**

**CLINICAL DETAILS**

Gleason 7. TURP.

**PATHOLOGIST'S REPORT**

Received 7 g of prostatic chippings. All tissue processed.

Histology shows prostatic parenchyma with background evidence of benign nodular hyperplasia. A small focus of prostatic adenocarcinoma of Gleason some scored 3 + 3 = 6 is present in one chip occupying less than 1% of the total tissue volume.

**PROSTATE**  
**TURP**  
**ADENOCARCINOMA**  
**BENIGN NODULAR HYPERPLASIA**

DR G MCCLEAN

Date:- 19/05/2014

*Jan*  
*21/7/14*

Reported by: Dr Gareth McClean  
Date of Specimen : 14 May 2014  
Date of report print : 19 May 2014

Sample Number: **14K06235**

|                      |                                      |                |                                      |
|----------------------|--------------------------------------|----------------|--------------------------------------|
| Patient ID           | Personal Information redacted by USI | Patient Name   | Patient 35                           |
| Sex                  | Male                                 | Date Of Birth  | Personal Information redacted by USI |
| Collected            | 14-May-2014 00:00                    | Reported       | 19-May-2014 12:02                    |
| Requested by         | MR A O'BRIEN                         | Requested from | CAH/CEAU                             |
| Order Number         | 14K06235                             | Status         | Final                                |
| Relevant Information |                                      |                |                                      |

REPORT

Final

CLINICAL DETAILS

Gleason 7. TURP.

PATHOLOGIST'S REPORT

Received 7 g of prostatic chippings. All tissue processed.

Histology shows prostatic parenchyma with background evidence of benign nodular hyperplasia. A small focus of prostatic adenocarcinoma of Gleason some scored  $3 + 3 = 6$  is present in one chip occupying less than 1% of the total tissue volume.

PROSTATE  
TURP  
adenocarcinoma  
BENIGN NODULAR HYPERPLASIA

DR G MCCLEAN  
Date:- 19/05/2014

MDM Report from Urology MDM @ The Southern Trust

**RE:****Patient 35**

Personal Information redacted by USI

**DOB:**

Personal Information redacted by USI

**Hospital Number:**

Personal Information redacted by USI

**HCN:**

Personal Information redacted by USI

**Contact Tel:**

Personal Information redacted by USI

**MDM Report from the Urology MDM @ The Southern Trust on 22/05/2014.**

|                              |                             |
|------------------------------|-----------------------------|
| <b>Diagnosis</b>             | Prostate cancer             |
| <b>Histology</b>             | Adenocarcinoma, NOS,        |
| <b>PSA</b>                   | 3.9                         |
| <b>Gleason Score</b>         | 3 + 4 In 8 out of 10 Cores. |
| <b>Longest Tumour Length</b> | 8.50 mm                     |
| <b>% Tissue Involved</b>     | 50                          |
| <b>Prostate Volume</b>       | 23                          |

**MDM Update**

CONSULTANT MR O'BRIEN: This 64 year old man was found to have Gleason 7 carcinoma in 3 of 5 transperineal prostatic biopsies performed in 2009 when undergoing left partial nephrectomy for a benign lesion. PSA was 3.47 in October 2008. Managed by Active Surveillance since. PSA 3.99 November 2012. LUTS increased in severity. Transrectal prostatic biopsy, 11.12.12 - Prostatic adenocarcinoma of Gleason score 3 + 4=7 was present in 8 of 10 cores with a maximum tumour length of 8.5 mm. The tumour occupied approximately 50% of the total tissue volume. Reviewed on 12.03.13. PSA 3.17 February 2013. Androgen blockade initiated. Review June 2013. Attended on 14.06.13. PSA 1.03 June 2013. Mild LUTS. For referral for radical radiotherapy. Review in December 2013.

Reviewed on 11.04.14. Patient continues to have moderately severe LUTS of a mixed nature, even though PSA levels have decreased to 0.85 ngs/ml since dose of Bicalutamide was increased to 150 mgs daily in October 2013. Reported to have a residual volume of 226 on ultrasound scanning in December 2013. For admission on 14 May 2014 for TURP.

Patient found to have a small but occlusive prostate, and a severely trabeculated bladder. Prostate resected. Pathology reports prostatic parenchyma with background evidence of benign nodular hyperplasia. A small focus of prostatic adenocarcinoma of Gleason score 3 + 3 = 6 is present in one chip occupying less than 1% of the total tissue volume.

**MDM Action**

Discussed @ Urology MDM, 22.05.14. This gentleman's TURP shows small volume, Gleason 3+3=6 disease. He will be reassessed by Mr O'Brien regarding his lower urinary tract symptoms and will be for consideration of onward referral for radical radiotherapy.

**Radiology****CT Findings**

## MDM Report from Urology MDM to The Southern Trust

RE:

Patient 35

Personal Information redacted by USI

DOB:

Personal Information redacted by USI

Hospital Number:

Personal Information redacted by USI

HCN:

Personal Information redacted by USI

Contact Tel:

Personal Information redacted by USI

Latest Findings from CT performed on 02/11/2009

Findings: Partial left nephrectomy noted. A 2 cm diameter, partially exophytic, relatively homogeneous (with some minor central low attenuation), rounded lesion arises from within the posterior aspect of the upper pole of the right kidney. This has an HU value of 44. Minor adjacent stranding of the perinephric fat in keeping with prior surgery. There is irregularity and thinning of the mid aspect of the left rectus abdominus muscle, with stranding of the adjacent subcutaneous fat, in keeping with prior surgery. No abdominal wall hernia.

Liver, gallbladder, pancreas, spleen, right kidney and adrenal glands normal. Small splenunculus. No significant abdominal or pelvic adenopathy. Urinary bladder normal. Large and small bowel unremarkable. Parenchymal bands both lung bases. Degenerative change both hips.

**Conclusion:**

1. Recurrent lesion posterior cortex upper pole left kidney. Given its HU value on this single phase CT, correlation with ultrasound is advised to confirm that the lesion is cystic.

**MRI Findings**

Latest Findings from MRI performed on 03/02/2010

Findings : The examination has been performed with the endorectal coil.

The bladder is moderately distended and appears diffusely thick walled. There are central BPH changes.

Much of the peripheral zone demonstrates normal T2 signal return, though there is probably some abnormal low signal both on the right and left side of the gland toward the apex (5 IMA 10 and 7 IMA 8). There is no evidence of extracapsular extension and the seminal vesicles demonstrate normal signal return.

The T1 weighted images appear rather noisy. No lymphadenopathy is seen within the scan field. Artefact from the endorectal coil limits assessment of high T1 weighted signal within the seminal vesicles and the prostate gland. Therefore, the presence of blood products is difficult to reliably exclude.

A small abnormal signal focus in the left iliac blade (9 IMA 8) is probably of doubtful significance.

Conclusion : The appearances are of T2 disease.

**Comorbidity Summary**

Prostate adenocarcinoma

**Urology MDM @ The Southern Trust**

DR M.J. MURPHY  
THE HEALTH CENTRE  
SUMMER HILL  
WARRENPOINT  
BT34 3JD

RE:

Patient 35

Personal Information redacted by USI

DOB:

Personal Information redacted by USI

Hospital Number:

Personal Information redacted by USI

HCN:

Personal Information redacted by USI

Discussed @ Urology MDM, 22.05.14. This gentleman's TURP shows small volume; Gleason 3+3=6 disease. He will be reassessed by Mr O'Brien regarding his lower urinary tract symptoms and will be for consideration of onward referral for radical radiotherapy.

If you have any queries or require further information, please do not hesitate to contact us.

Yours sincerely,

Personal Information redacted by USI



Chairman of Urology MDM

Mr Aidan O'Brien

Consultant Urological Surgeon



**Southern Health  
and Social Care Trust**

**UROLOGY DEPARTMENT  
CLINIC LETTER**

Consultant Urologist: Mr A O'Brien  
Secretary: Mrs Monica McCorry  
Telephone: Personal Information redacted by USI

09/07/14

DR M. MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
CO DOWN  
BT34 3JD

Dear DR MURPHY

**Re: Patient Name:** Personal Information redacted by USI Patient 35  
**D.O.B.:** Personal Information redacted by USI  
**Address:** Personal Information redacted by USI  
**Hospital No:** Personal Information redacted by USI **H&C No:** Personal Information redacted by USI

This gentleman contacted me by phone. He had been seen previously by Mr O'Brien and commenced on Ciproxin 250mgs nocte however found these tablets caused nausea. I discussed this with Mr O'Brien who has advised alternative Trimethoprim 200mgs nocte and I have informed Patient 35 of this by phone today. I would be grateful if you could organise a prescription. He will be seen as previously arranged by Mr O'Brien.

Yours sincerely

*dictated but not signed by*

**Jenny McMahon**  
**Urology Nurse Specialist**

Date Dictated: 08/07/14

Date Typed: 09/07/14-lh



---

**RE:****Patient 35**

Personal Information redacted by USI

**DOB:**

Personal Information redacted by USI

**Hospital Number:**

Personal Information redacted by USI

**HCN:**

Personal Information redacted by USI

**Contact Tel:**

Personal Information redacted by USI

**GP Details :**

DR M.J. MURPHY  
THE HEALTH CENTRE  
SUMMER HILL  
WARRENPOINT  
BT34 3JD

---

Dear DR HOUGHTON,

Thank you for accepting this referral from the Urology MDM @ The Southern Trust on 28/08/2014.

|                              |                             |
|------------------------------|-----------------------------|
| <b>Diagnosis</b>             | Prostate cancer             |
| <b>Histology</b>             | Adenocarcinoma, NOS,        |
| <b>PSA</b>                   | 3.9                         |
| <b>Gleason Score</b>         | 3 + 4 In 8 out of 10 Cores. |
| <b>Longest Tumour Length</b> | 8.50 mm                     |
| <b>% Tissue Involved</b>     | 50                          |
| <b>Prostate Volume</b>       | 23                          |

**MDM Update**

**RE:****Patient 35**

Personal Information redacted by USI

**DOB:**

Personal Information redacted by USI

**Hospital Number:**

Personal Information redacted by USI

**HCN:**

Personal Information redacted by USI

**Contact Tel:**

Personal Information redacted by USI

**GP Details :**

DR M.J. MURPHY  
THE HEALTH CENTRE  
SUMMER HILL  
WARRENPOINT  
BT34 3JD

CONSULTANT MR O'BRIEN: This 64 year old man was found to have Gleason 7 carcinoma in 3 of 5 transperineal prostatic biopsies performed in 2009 when undergoing left partial nephrectomy for a benign lesion. PSA was 3.47 in October 2008. Managed by Active Surveillance since. PSA 3.99 November 2012. LUTS increased in severity. Transrectal prostatic biopsy, 11.12.12 - Prostatic adenocarcinoma of Gleason score 3 + 4=7 was present in 8 of 10 cores with a maximum tumour length of 8.5 mm. The tumour occupied approximately 50% of the total tissue volume. Reviewed on 12.03.13. PSA 3.17 February 2013. Androgen blockade initiated. Review June 2013. Attended on 14.06.13. PSA 1.03 June 2013. Mild LUTS. For referral for radical radiotherapy. Review in December 2013.

Reviewed on 11.04.14. Patient continues to have moderately severe LUTS of a mixed nature, even though PSA levels have decreased to 0.85 ngs/ml since dose of Bicalutamide was increased to 150 mgs daily in October 2013. Reported to have a residual volume of 226 on ultrasound scanning in December 2013. For admission on 14 May 2014 for TURP.

Patient found to have a small but occlusive prostate, and a severely trabeculated bladder. Prostate resected. Pathology reports prostatic parenchyma with background evidence of benign nodular hyperplasia. A small focus of prostatic adenocarcinoma of Gleason score 3 + 3 = 6 is present in one chip occupying less than 1% of the total tissue volume.

Discussed @ Urology MDM, 22.05.14. This gentleman's TURP shows small volume, Gleason 3+3=6 disease. He will be reassessed by Mr O'Brien regarding his lower urinary tract symptoms and will be for consideration of onward referral for radical radiotherapy.

Clinic review 15/08/14: Patient reported that LUTS had improved, the only persistent, significant symptom being nocturia x 1 – 3. He reported persistent nausea. Bladder voiding was reported to be complete on ultrasound scanning in July 2014 when his prostatic volume was 11.7 mls only. For referral to Oncology for Radical Radiotherapy at MDM on 28 August 2014. For urological review February 2015.

**MDM Action**

Discussed at Urology MDM 28/08/14. Patient has been referred to Dr Houghton for radical radiotherapy.

**Radiology****CT Findings**

**RE:****Patient 35**

Personal Information redacted by USI

**DOB:** Personal Information redacted by USI **Hospital Number:** Personal Information redacted by USI **HCN:** Personal Information redacted by USI**Contact Tel:**

Personal Information redacted by USI

**GP Details :**

DR M.J. MURPHY  
THE HEALTH CENTRE  
SUMMER HILL  
WARRENPOINT  
BT34 3JD

Latest Findings from CT performed on 02/11/2009

Findings: Partial left nephrectomy noted. A 2 cm diameter, partially exophytic, relatively homogeneous (with some minor central low attenuation), rounded lesion arises from within the posterior aspect of the upper pole of the right kidney. This has an HU value of 44. Minor adjacent stranding of the perinephric fat in keeping with prior surgery. There is irregularity and thinning of the mid aspect of the left rectus abdominous muscle, with stranding of the adjacent subcutaneous fat, in keeping with prior surgery. No abdominal wall hernia.

Liver, gallbladder, pancreas, spleen, right kidney and adrenal glands normal. Small splenunculus. No significant abdominal or pelvic adenopathy. Urinary bladder normal. Large and small bowel unremarkable. Parenchymal bands both lung bases. Degenerative change both hips.

Conclusion:

1. Recurrent lesion posterior cortex upper pole left kidney. Given its HU value on this single phase CT, correlation with ultrasound is advised to confirm that the lesion is cystic.

**MRI Findings**

**RE:****Patient 35**

Personal Information redacted by USI

**DOB:**

Personal Information redacted by USI

**Hospital Number:**

Personal Information redacted by USI

**HCN:**

Personal Information redacted by USI

**Contact Tel:**

Personal Information redacted by USI

**GP Details :**

DR M.J. MURPHY  
THE HEALTH CENTRE  
SUMMER HILL  
WARRENPOINT  
BT34 3JD

Latest Findings from MRI performed on 03/02/2010

Findings : The examination has been performed with the endorectal coil.

The bladder is moderately distended and appears diffusely thick walled. There are central BPH changes.

Much of the peripheral zone demonstrates normal T2 signal return, though there is probably some abnormal low signal both on the right and left side of the gland toward the apex (5 IMA 10 and 7 IMA 8). There is no evidence of extracapsular extension and the seminal vesicles demonstrate normal signal return.

The T1 weighted images appear rather noisy. No lymphadenopathy is seen within the scan field. Artefact from the endorectal coil limits assessment of high T1 weighted signal within the seminal vesicles and the prostate gland. Therefore, the presence of blood products is difficult to reliably exclude.

A small abnormal signal focus in the left iliac blade (9 IMA 8) is probably of doubtful significance.

Conclusion : The appearances are of T2 disease.

**Comorbidity Summary**

Prostate adenocarcinoma

Please contact me if you require any further information

Yours sincerely,

**RE:**

**Patient 35**

Personal Information redacted by USI

**DOB:** Personal Information redacted by USI, **Hospital Number:** Personal Information redacted by USI **HCN:** Personal Information redacted by USI

**Contact Tel:**

Personal Information redacted by USI

**GP Details :**

DR M.J. MURPHY  
THE HEALTH CENTRE  
SUMMER HILL  
WARRENPOINT  
BT34 3JD

**PAT-000920**Southern Health  
and Social Care Trust

Craigavon Area Hospital, Lurgan Road, Portadown, Craigavon, County Armagh, BT63 5QQ

Tel: Personal Information redacted by the USI

Ward Tel:

THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
CO DOWN  
BT34 3JD**ECR Copy**

Date: 05/09/2014 06:48

Discharge Id: 163889

Version: 15

543

Dear Dr MURPHY

**DISCHARGE NOTIFICATION**

The patient was admitted under the care of **MR A O'BRIEN** (specialty: **UROLOGY(C)**) into **3 SOUTH ELECTIVE WARD** Ward at **CRAIGAVON AREA HOSPITAL** on **14/05/2014 09:00:00** and discharged on **16/05/2014**.

Forenames: Personal Information redacted by the USI Address: Personal Information redacted by the USI  
 Surname: **Patient 35**  
 D.O.B: Personal Information redacted by the USI  
 Hospital No: Personal Information redacted by the USI  
 NHS No: Personal Information redacted by the USI  
 Gender: Male Personal Information redacted by the USI

**Admission Reason**

Elective admission for a TURP

**Principle Discharge Diagnosis**

TURP

**Operations/Procedures/Radiology**

TURP (14/5/14)- Cystoscopy - enlarged occlusive prostate. 360 degrees resection of prostate. Ureteric orifices seen at start and end of procedure.

**Additional Information for GP****Past Medical History/Co-Morbidity**

Prostate Ca

**Changes to Medications - Start/Stop**

Tamsulosin stopped. Paracetamol and Codeine for pain relief. No other intentional changes to medication.

**Clinical Information/Comments**

64 year old gentleman admitted for a TURP on the 14/5/14. 3 way catheter inserted post procedure. No immediate complications. Catheter is now out - voiding well. Observations stable. Apyrexia

**Allergies**

Patient has no known allergies

**Discharge Date**

16/05/2014

**Discharge Time****Arrangements For Follow-Up**

Follow up with Mr O'Brien

MDT discussion in 2/52

**Further Detailed Discharge Letter To Follow** No

**Awaiting Further Results** Yes

**Awaited Results**

Histology

**Patient Aware Of Diagnosis** Yes

**Medication on discharge:**

(POD = Patient's Own Drugs, PODH = Patient's Own Drugs at Home)

| Drug                                                                  | Dose    | Frequency                  | Days | Route | GP Continue? |
|-----------------------------------------------------------------------|---------|----------------------------|------|-------|--------------|
| <b>Admission drugs (unamended)</b>                                    |         |                            |      |       |              |
| TAPENTADOL HYDROCHLORIDE (PALEXIA SR) 200 mg Modified release Tablets | 150mg   | Twice Daily                | -    | Oral  | Yes          |
| BICALUTAMIDE 150 mg Tablets                                           | 150mg   | Once Daily                 | -    | Oral  | Yes          |
| TAMOXIFEN CITRATE Tablets                                             | 10mg    | Once Daily                 | -    | Oral  | Yes          |
| TADALAFIL Tablets                                                     | 10mg    | Once Daily                 | -    | Oral  | Yes          |
| SOLIFENACIN SUCCINATE 5 mg Tablets                                    | 5mg     | Once Daily                 | -    | Oral  | Yes          |
| <b>Drugs prescribed since admission</b>                               |         |                            |      |       |              |
| PARACETAMOL 500 mg Tablets                                            | 1g      | 4 - 6 Hourly When Required | -    | Oral  | Review       |
| CODEINE PHOSPHATE Tablets                                             | 30-60mg | 4 - 6 Hourly When Required | -    | Oral  | Review       |
| <b>Admission drugs (amended)</b>                                      |         |                            |      |       |              |

**Stopped Medication:**

(POD = Patient's Own Drugs, PODH = Patient's Own Drugs at Home)

| Drug                                                | Dose           | Frequency  | Days | Route |
|-----------------------------------------------------|----------------|------------|------|-------|
| <b>Admission drugs (stopped)</b>                    |                |            |      |       |
| TAMSULOSIN 400 micrograms Modified release Capsules | 400 micrograms | Once Daily | -    | Oral  |

**PAT-000921**

| Drug                                      | Dose | Frequency | Days | Route |
|-------------------------------------------|------|-----------|------|-------|
| <i>(Change Reason: Stopped post TURP)</i> |      |           |      |       |

| Authorised Forms                  |                  |
|-----------------------------------|------------------|
| Form                              | Authorised By    |
| Adult Clinical Details (Elective) | JULIE-ANNE SCOTT |

**Prescribing Clinician:** JULIE-ANNE SCOTT      **Bleep No:** 1015

**Belfast Health and  
Social Care Trust****Cancer Centre****PRIVATE & CONFIDENTIAL**

Personal Information redacted by USI

DR M J MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT BT34 3JD

22 OCT 2014

**OUT-PATIENT REVIEW**

|                     |                                      |                  |            |
|---------------------|--------------------------------------|------------------|------------|
| <b>Consultant:</b>  | FH DR F HOUGHTON                     | <b>Dictated:</b> | 07-10-2014 |
| <b>Hospital No:</b> | Personal Information redacted by USI | <b>Typed:</b>    | 14-10-2014 |
| <b>H+C Number</b>   |                                      | <b>Typist</b>    | HC         |

Dear DR MURPHY

RE: Patient 35

Personal Information redacted by USI

DOB:

Personal Information redacted by USI

Diagnosis: Adenocarcinoma of the Prostate, Gleason 7, T2,  
N0, M0

Proposed Treatment: Radical Radiotherapy to the Prostate, delivering 74 gray in 37 fractions, hope to discontinue CASODEX and TAMOXIFEN following completion of radiation.

I reviewed this gentleman in the Radiotherapy planning clinic today. He remains well since his last review with first meeting with Dr Houghton on the 17th September. He remains on CASODEX and TAMOXIFEN along with painkillers for intermittent abdominal pain related to his previous nephrectomy. I have discussed with him today the rationale for treatment with the hope of achieving a cure. We have talked about the practicalities of treatment. He is aware that it is 37 fractions over seven and a half weeks, likely to start within the next 3-4 weeks. I have discussed the potential side effects, particularly highlighting the short term effects related to cystitis and proctitis and we have also discussed long term effects relating to bowel, bladder sexual function and risk of 2nd malignancy. He has given his consent to proceed with treatment and he will be reviewed 6 weeks post completion of radiotherapy at the Craigavon clinic.

Yours sincerely,

Personal Information redacted by USI

DR L MCLAUGHLIN SPR TO: DR F HOUGHTON MB BCh BAO MRCP FRCR  
CONSULTANT IN CLINICAL ONCOLOGY

Continued .....



--- 2 ---

cc Mr A O'Brien  
Consultant Urologist  
Craigavon Area Hospital  
68 Lurgan Road  
CRAIGAVON  
BT63 5QQ

**PRIVATE & CONFIDENTIAL**

22 JAN 2015

DR M J MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
BT34 3JD

Personal Information redacted by USI

**OUT-PATIENT REVIEW**

|                     |                                      |                  |            |
|---------------------|--------------------------------------|------------------|------------|
| <b>Consultant:</b>  | FH DR F HOUGHTON                     | <b>Dictated:</b> | 18-12-2014 |
| <b>Hospital No:</b> | Personal Information redacted by USI | <b>Typed:</b>    | 13-01-2015 |
| <b>H+C Number</b>   |                                      | <b>Typist</b>    | HC         |

Dear DR MURPHY

RE: Patient 35

Personal Information redacted by USI

DOB:

Personal Information redacted by USI

Personal Information redacted by USI

Patient 35 was reviewed today at clinic. He completes radiotherapy treatment next week and once treatment is complete he knows to discontinue his hormone treatment. We are reviewing him back at the clinic in Craigavon in 6 weeks time.

Yours sincerely

Personal Information redacted by USI

DR F HOUGHTON MB BCh BAO MRCP FRCR  
CONSULTANT IN CLINICAL ONCOLOGY

cc Mr A O'Brien  
Consultant Urologist  
Craigavon Area Hospital  
68 Lurgan Road  
CRAIGAVON  
BT63 5QQ

10 MAR 2015

Cancer Centre

**PRIVATE & CONFIDENTIAL**

DR M J MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
CO DOWN  
BT34 3JD

**OUT-PATIENT REVIEW**

|                     |                                      |                  |          |
|---------------------|--------------------------------------|------------------|----------|
| <b>Consultant:</b>  | FH DR F HOUGHTON                     | <b>Dictated:</b> | 28/01/15 |
| <b>Hospital No:</b> | Personal Information redacted by USI | <b>Typed:</b>    | 17/02/15 |
| <b>H+C Number</b>   |                                      | <b>Typist</b>    | RMU      |

Dear Dr Murphy

RE: Patient 35

Personal Information redacted by USI

DOB: Personal Information redacted by USI

Patient 35 was seen today at clinic. He is still recovering from his radiotherapy treatment and we have rechecked his PSA today. We will review him back at this clinic in 3 months' time.

Yours sincerely

Personal Information redacted by USI

N.B. PSA on 28/01/15 = 0.75 ngs/mL

DR F HOUGHTON MB BCh MRCP FRCR  
CONSULTANT IN CLINICAL ONCOLOGY

✓cc

Mr A O'Brien  
Consultant Urologist  
Craigavon Area Hospital  
68 Lurgan Road  
CRAIGAVON  
Co Armagh  
BT63 5QQ

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DR M J MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT

BT34 3JD

**OUT-PATIENT REVIEW**

|                     |                                      |                  |        |
|---------------------|--------------------------------------|------------------|--------|
| <b>Consultant:</b>  | FH DR F HOUGHTON                     | <b>Dictated:</b> | 150415 |
| <b>Hospital No:</b> | Personal Information redacted by USI | <b>Typed:</b>    | 070515 |
| <b>H+C Number</b>   |                                      | <b>Typist</b>    | AK     |

Dear DR M J MURPHY

RE: Patient 35

Personal Information redacted by USI

DOB: Personal Information redacted by USI

Please find below copy annotation from today's consultation:-

"DIAGNOSIS: T2 GLEASON 3+4 = 7 ADENOCARCINOMA OF PROSTATE

TREATMENT: Radical radiotherapy December 2014.  
Discontinued BICALUTAMIDE December 2014.

This gentleman completed radical radiotherapy just over 3 months ago. Most recent PSA is satisfactory at 0.39 and he has now discontinued his hormone therapy for more than 3 months. He continues to complain of poor energy and I note routine bloods carried out recently were satisfactory. Urine symptoms have improved following radiotherapy and no bowel symptoms or bleeding.

The patient would be suitable and agreeable for telephone nurse led review clinic which will be due in 6 months time. Patient will continue to have his PSA checked 3-6 monthly."

Yours sincerely

Personal Information redacted by USI

**DR J CARSER MB BCh MRCP PhD  
CONSULTANT IN MEDICAL ONCOLOGY**

/contd...



Belfast Health and  
Social Care Trust

Cancer Centre

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08 FEB 2016

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USI

DR M J MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT

BT34 3JD

OUT-PATIENT REVIEW

|              |                                      |           |        |
|--------------|--------------------------------------|-----------|--------|
| Consultant:  | FH DR F HOUGHTON                     | Dictated: | 231215 |
| Hospital No: | Personal Information redacted by USI | Typed:    | 250116 |
| H+C Number   |                                      | Typist    | AK     |

Dear DR M J MURPHY

RE: Patient 35

Personal Information redacted by USI

DOB: Personal Information redacted  
by USI

Please find below copy annotation from today's consultation:-

"DIAGNOSIS: INTERMEDIATE RISK PROSTATE CANCER.

TREATMENT: Radical radiotherapy with BICALUTAMIDE completed December 2014.

This pleasant gentleman attends for review and prostate cancer is well controlled with no evidence of relapse and most recent PSA on 18/11/15 was 0.32.

He did have some bleeding PR which was investigated with colonoscopy and radiation proctitis was identified but did not require any treatment. His main problem is ongoing fatigue and the specific origin of this is unknown. It may be contributed by the previous radiation or it may also be affected by his ongoing chronic pain due to partial nephrectomy.

I will review him in 6 months here in Craigavon. "

Yours sincerely

Personal Information redacted  
by USI

DR K ROONEY MB BSc (HONS) MRCP FRCR  
CONSULTANT IN CLINICAL ONCOLOGY

/contd...

**Cancer Centre** Belfast City Hospital Lisburn Road Belfast BT9 7AB Tel: Personal Information redacted by the USI<http://belfasttrust-cancerservices.hscni.net>**PRIVATE AND CONFIDENTIAL**

Dr. M J MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT NEWRY  
Northern Ireland  
BT34 3JD

**OUT-PATIENT REVIEW**

|                     |                                                                                                  |                  |        |
|---------------------|--------------------------------------------------------------------------------------------------|------------------|--------|
| <b>Consultant:</b>  | Dr. F Houghton, FRCR                                                                             | <b>Dictated:</b> | 140817 |
| <b>Hospital No:</b> | <span style="background-color: black; color: black;">Personal Information redacted by USI</span> | <b>Typed:</b>    | 310817 |
| <b>H+C Number:</b>  | <span style="background-color: black; color: black;">Personal Information redacted by USI</span> | <b>Typist:</b>   | AK     |

Dear Dr. M J MURPHY

**RE:** Patient 35, Personal Information redacted by USI**DOB:** Personal Information redacted by USI

I reviewed Patient 35 in the nurse led telephone clinic.

Initially diagnosed 2009 with an iPSA of 3.9, Gleason 7 T2 adenocarcinoma of prostate gland.

This gentleman was re-biopsied in 2012 and commenced on BICALUTAMIDE monotherapy. He was then seen by Oncology in September 2014 and had radical radiotherapy completed in December 2014. He stopped his BICALUTAMIDE in December 2014 also.

On review today Patient 35 informs me that he is keeping generally well. The pains he has had for sometime since his nephrectomy still persists and he is attending the pain clinic with regards to this. He remains on his OXYCONTIN. His appetite is good, he has gained a little bit of weight. He keeps active where possible and enjoys walking. He is not very able to do the ball sports he did in the past due to the pain. He informs me that he has noted gynecomastia in the right breast. There are no other symptoms of heat or swelling or hardness. He does not report a discharge. He knows to attend his GP for assessment if this symptom persists. His PSA is satisfactory at 0.55 and he is pleased to hear this.

/contd...

- 2- Patient 35

There is no change to his lower urinary tract symptoms with slow flow at times but this is not every day. He has no haematuria or dysuria. He remains on his SOLIFENACIN medication. Bowel function is satisfactory. He has no cramps or bloating. He would still report occasional streaking in the motion but this is more settled than before. He was investigated in the past. He has not commenced any new medication and he remains on his TADALAFIL for his sexual function.

**PLAN:**

1. Continue with 3 monthly PSA checks.
2. Please appoint back to the telephone review clinic in 6 months.

Yours sincerely

**SISTER ENDA HANNA**  
**CLINICAL ONCOLOGY NURSE SPECIALIST**

**Cancer Centre** Belfast City Hospital Lisburn Road BELFAST BT9 7AB Tel: Personal Information redacted by the USI<http://belfasttrust-cancerservices.hscni.net>**PRIVATE & CONFIDENTIAL**

DR RYAN  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
NEWRY  
BT34 3JD

**RESULTS/UPDATE LETTER**

|                     |                                                   |                  |          |
|---------------------|---------------------------------------------------|------------------|----------|
| <b>Consultant:</b>  | Dr F Houghton                                     | <b>Dictated:</b> | 08/11/17 |
| <b>Hospital No:</b> | <span>Personal Information redacted by USI</span> | <b>Typed:</b>    | 29/11/17 |
| <b>H+C Number:</b>  | <span>Personal Information redacted by USI</span> | <b>Typist:</b>   | AAD      |

Dear Dr Ryan

**RE:** Patient 35, Personal Information redacted by USI**DOB:** Personal Information redacted by USI

Thank you for your letter received at the end of October regarding Patient 35. I telephone Patient 35 on a 6-monthly basis as part of his follow-up post treatment for prostate cancer. He also contacts me periodically by phone regarding symptoms he may be experiencing.

As you know, he completed his radiotherapy in December 2014 for intermediate risk prostate cancer. Following treatment, his nadir is 0.25 in July 2015 and remains low. His most recent result of 0.7 is slightly up from July 2017 when it was 0.55 and in

April 2017 0.44, but still remains satisfactory. The trigger for concern would be if it rose to 2.29 which is 2 above its lowest point of 0.29 or if it rose dramatically.

I plan to review Patient 35 again in February 2018 and will reassess his PSA and offer assurance to Patient 35 that we are keeping a eye to things.

If you have any further queries regarding this or about Patient 35, my work mobile is

Personal Information redacted by USI

-2-

With kind regards.

Yours sincerely

SR E HANNA  
CLINICAL ONCOLOGY NURSE SPECIALIST

**Cancer Centre** Belfast City Hospital Lisburn Road Belfast BT9 7AB Tel: [Personal Information redacted by the USI]<http://belfasttrust-cancerservices.hscni.net>**PRIVATE AND CONFIDENTIAL**

Dr. M J MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT NEWRY BT34 3JD

**OUT-PATIENT REVIEW**

|                     |                                        |                  |        |
|---------------------|----------------------------------------|------------------|--------|
| <b>Consultant:</b>  | Dr. F Houghton GMC4634258, FRCR        | <b>Dictated:</b> | 010218 |
| <b>Hospital No:</b> | [Personal Information redacted by USI] | <b>Typed:</b>    | 130218 |
| <b>H+C Number:</b>  | [Personal Information redacted by USI] | <b>Typist:</b>   | SR     |

Dear Dr. M J MURPHY

**RE:** Patient 35, [Personal Information redacted by USI]**DOB:** [Personal Information redacted by USI]

Reviewed Patient 35 in the nurse led telephone clinic.

Initial diagnosis in 2009 with a Gleason 7 T2 adenocarcinoma of the prostate gland. US guided biopsy in 2012 Gleason 7 was noted and a PSA of 3.9.

**TREATMENT HISTORY:**

1. Completed radical radiotherapy in December 2014.
2. CASODEX monotherapy from December '12 and stopped completely in December 2014.

Patient 35 is recovering from flu-like symptoms which he had over the Christmas period. He had his flu vaccine but hasn't felt really well since he had this. He reports tinnitus which he was diagnosed with in 2015 but he feels that it has got worse of late. Appetite is good, his weight is steady. He still feels energy levels are under par. He is going for a 4 week holiday shortly in the [Personal Information redacted by the USI] and is looking forward to this. Remains on his OXYCONTIN for pain. From a prostate point of view his PSA has shown a small fall to 0.65 but he was pleased to hear this. He remains on his SOLIFENACIN medication for urinary function which he reports is satisfactory with good flow and nocturia anything from 1-3 times at night. Bowel function is satisfactory although he needs to take laxatives at times due to his analgesia. He reports occasional blood when constipated, nothing more than that. He remains on his TADALAFIL medication for sexual function however he feels this has not improved any. I will refer him to the ED clinic. There were no other issues.

**Plan:**

1. Continue with 3-6 monthly PSA checks.
2. Please appoint back to the telephone clinic in 6 months.

Yours sincerely.

**Sr E Hanna**  
**Clinical Oncology Nurse Specialist to**  
**Dr F Houghton MB BCh MRCP FRCR**  
**Consultant in Clinical Oncology**



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Dr Houghton  
Consultant Clinical Oncologist  
Craigavon Area Hospital  
68 Lurgan Road  
PORTADOWN  
Co Armagh  
BT63 5QQ

**BCH UROLOGY (C) CLINIC**

|                     |                                      |                     |          |
|---------------------|--------------------------------------|---------------------|----------|
| <b>Consultant:</b>  | MR HUGH O'KANE                       | <b>Dictated:</b>    | 17/08/18 |
| <b>Direct Line:</b> | Personal Information redacted by USI | <b>Typed:</b>       | 27/08/18 |
| <b>H+C Number:</b>  | Personal Information redacted by USI | <b>Clinic Date:</b> | 17/08/18 |
| <b>Hospital No:</b> | Personal Information redacted by USI | <b>Attendance:</b>  | NU       |

Dear Dr Houghton

RE: Patient 35 Personal Information redacted by USI Personal Information redacted by USI  
Personal Information redacted by USI **DOB:** Personal Information redacted by USI

Thank you for your referral regarding this gentleman who has had previous radiotherapy for prostate cancer and he has erectile dysfunction. He has recently met with Mr Aidan O'Brien in Craigavon Area Hospital and he has been instructed in intercavernosal injections of caverject and they seem to be effective. He is awaiting a further review so I will leave his further follow up in Mr O'Brien's hands.

Yours sincerely

**MR HUGH O'KANE**  
**CONSULTANT UROLOGIST**  
GMC NO: 4516686

Copy to  
**PRIVATE & CONFIDENTIAL**  
Dr M J Murphy  
The Health Centre  
Summerhill  
Warrenpoint  
Newry  
BT34 3JD

Belfast City Hospital, Urology (C) Clinic, Lisburn Road, BELFAST, BT9 7AB  
Tel: Personal Information redacted by USI

Patient 35

H+C No:

Personal Information redacted by USI

Hosp. No:

Personal Information redacted by USI

**Cancer Centre** Belfast City Hospital Lisburn Road Belfast BT9 7AB Tel: Personal Information redacted by the USI<http://belfasttrust-cancerservices.hscni.net>**PRIVATE AND CONFIDENTIAL**

Dr. M J MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT NEWRY  
BT34 3JD

**OUT-PATIENT REVIEW**

|                     |                                                   |                  |          |
|---------------------|---------------------------------------------------|------------------|----------|
| <b>Consultant:</b>  | Dr. F Houghton GMC4634258, FRCR                   | <b>Dictated:</b> | 23/08/18 |
| <b>Hospital No:</b> | <span>Personal Information redacted by USI</span> | <b>Typed:</b>    | 24/08/18 |
| <b>H+C Number:</b>  | <span>Personal Information redacted by USI</span> | <b>Typist:</b>   | NP       |

Dear Dr. MURPHY

**RE:** Patient 35, Personal Information redacted by USI**DOB:** Personal Information redacted by USI

Reviewed Patient 35 in the nurse led telephone clinic.

Initial diagnosis in 2009 with a Gleason 7 T2 adenocarcinoma of the prostate gland. US guided biopsy in 2012 Gleason 7 was noted and a PSA of 3.9.

**TREATMENT HISTORY:**

1. Completed radical radiotherapy in December 2014.
2. CASODEX monotherapy from December '12 and stopped completely in December 2014.

There is no real change to Patient 35's general health he informs me. He still attends the pain clinic and had a recent treatment of pulse radiofrequency but unfortunately hasn't helped his symptoms tremendously yet. His appetite is good and his weight is stable. From prostate point of view a PSA in June is very satisfactory at 0.53 and he is pleased to hear this. He will have it re-checked again at the end of August. Continues on Solifenacin medication for urinary symptoms and reports a reasonably good flow and nocturia unchanged at twice at night. Bowels move regularly and he monitors his diet due to being on Analgesia. He still experiences slight PR blood when constipated. Sexual function is suboptimal and he is seeing Mr O'Brian in Craigavon with regards to this. There were no other issues.

Plan - Continue with 6 monthly PSA checks.

Yours sincerely

Sister Enda Hanna  
Clinical Oncology Nurse Specialist



**Southern Health  
and Social Care Trust**

**CRAIGAVON AREA HOSPITAL  
68 LURGAN ROAD  
PORTADOWN, BT63 5QQ**

**UROLOGY DEPARTMENT**

**Telephone:** [Personal Information redacted by the USI]

**E mail:** [Personal Information redacted by the USI]

**Secretary:** Mrs N. Elliott

DR M. MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
NEWRY  
BT34 3JD

Dear DR MURPHY

**Re: Patient Name:** Patient 35

**D.O.B.:** [Personal Information redacted by USI]

**Address:** [Personal Information redacted by USI]

**Hospital No:** [Personal Information redacted by USI] **HCN:** [Personal Information redacted by USI]

**Date/Time of Clinic:** 01/06/18

**Follow Up:**

I write to you regarding this 68 year old man whom I reviewed on the 1<sup>st</sup> of June 2018 when I found him to be keeping reasonably well, he reporting relatively mild and tolerable urinary symptoms, consisting of an occasional sensation of unsatisfactory voiding following micturition, occasional post micturitional incontinence and nocturia, having to rise twice each night to pass urine. His dominant concern at that time was that taking Tadalafil 10mgs daily had more recently proven to be inadequate in maintaining erectile function adequate for intercourse. I therefore performed an intracavernosal injection of 12.5micrograms of Alprostadil that day. On speaking with Patient 35 by telephone recently, he reported that it did result in an improved erectile response, though it was still doubtful as to whether it would have been adequate for penetrative intercourse.

In any case, Patient 35 will be abroad for long periods on holiday during the coming 2 months. I have arranged to review him on Friday the 26<sup>th</sup> of October 2018 following his return. I have advised him to continue to take Tadalafil 10mgs daily until he attends.

Yours sincerely

*Dictated but not signed by*

**Mr A O'Brien FRCS  
Consultant Urological Surgeon**

**Date Dictated:** 04/09/18

**Date Typed:** 05/09/18-NE



Southern Health  
and Social Care Trust

CRAIGAVON AREA HOSPITAL  
68 LURGAN ROAD  
PORTADOWN, BT63 5QQ

**UROLOGY DEPARTMENT****Telephone:**

Personal Information  
redacted by the USI

**E mail:**

Personal Information redacted by the USI

**Secretary:**

Mrs N. Elliott

DR M. MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
NEWRY  
BT34 3JD

Dear DR MURPHY

**Re: Patient Name:**

Patient 35

**D.O.B.:**

Personal Information redacted by USI

**Address:**

Personal Information redacted by USI

**Hospital No:**

Personal Information redacted by USI

**HCN:**

Personal Information redacted by USI

**Date/Time of Clinic:** 26/10/18**Follow Up:** Review 9/11/18

Further to my letter of the 4<sup>th</sup> of September 2018, I write to confirm that Patient 35 returned for review on the 26<sup>th</sup> of October 2018 as intended. When he did so, I found his lower urinary tract symptoms to remain unchanged. His serum PSA level remained stable at 0.48ng/ml.

I demonstrated to Patient 35 intracavernosal injection of 20micrograms of Alprostadil. As Patient 35 reported that taking 10mgs of Tadalafil daily had been ineffective, I advised him to take 20mgs when required instead of taking 10mgs daily.

In any case, I have arranged a further review appointment on the 9<sup>th</sup> of November 2018.

Yours sincerely

*Dictated but not signed by*

**Mr A O'Brien FRCS**  
**Consultant Urological Surgeon**

**Date Dictated:** 29/10/18**Date Typed:** 30/10/18-NE

Patient 35

**DOB:**

Personal Information  
redacted by USI

**H+C:**

Personal Information redacted by  
USI



**Southern Health  
and Social Care Trust**

**CRAIGAVON AREA HOSPITAL  
68 LURGAN ROAD  
PORTADOWN, BT63 5QQ**

**UROLOGY DEPARTMENT**

**Telephone:** [Personal Information redacted by USI]

**E mail:** [Personal Information redacted by the USI]

**Secretary:** Mrs N. Elliott

**Patient 35**

[Personal Information redacted by the USI]

**Hospital No:**

[Personal Information redacted by USI]

**HCN:**

[Personal Information redacted by USI]

Dear Patient 35,

I was pleased to have the opportunity of reviewing you once again on the 26<sup>th</sup> of October 2018. You may recall that I had agreed to review you on Friday the 9<sup>th</sup> of November 2018 at 2pm. I do hope that it would not be inconvenient if I deferred the time of that review appointment to 3pm. In any case, I look forward to reviewing you when you do attend.

Yours sincerely

*Dictated but not signed by*

**Mr A O'Brien FRCS  
Consultant Urological Surgeon**

**Date Dictated:** 29/10/18

**Date Typed:** 30/10/18-NE



Southern Health  
and Social Care Trust

CRAIGAVON AREA HOSPITAL  
68 LURGAN ROAD  
PORTADOWN, BT63 5QQ

**UROLOGY DEPARTMENT****Telephone:** [Personal Information redacted by USI]**E mail:** [Personal Information redacted by the USI]**Secretary:** Mrs N. Elliott

DR M. MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
NEWRY  
BT34 3JD

Dear DR MURPHY

**Re: Patient Name:** [Patient 35]**D.O.B.:** [Personal Information redacted by USI]**Address:** [Personal Information redacted by USI]**Hospital No:** [Personal Information redacted by USI] **HCN:** [Personal Information redacted by USI]

|                                      |                                      |
|--------------------------------------|--------------------------------------|
| <b>Date/Time of Clinic:</b> 09/11/18 | <b>Follow Up:</b> CNA – SFA 30/11/18 |
|--------------------------------------|--------------------------------------|

Further to my letter of the 26<sup>th</sup> of October 2018, I write to advise you that [Patient 35] was unable to return for review on the 9<sup>th</sup> of November 2018 as planned. I have arranged a further review appointment for him on Friday the 30<sup>th</sup> of November 2018 when I do hope that he will be feeling better and able to attend.

Yours sincerely

*Dictated but not signed by*

**Mr A O'Brien FRCS**  
**Consultant Urological Surgeon**

|                                |                                |
|--------------------------------|--------------------------------|
| <b>Date Dictated:</b> 10/11/18 | <b>Date Typed:</b> 15/11/18-NE |
|--------------------------------|--------------------------------|



# Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL  
68 LURGAN ROAD  
PORTADOWN, BT63 5QQ

## UROLOGY DEPARTMENT

Telephone: [Redacted]

E mail: [Redacted]

Secretary: Mrs N. Elliott

DR M. MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
BT34 3JD

Dear DR MURPHY

Re: **Patient Name:** [Redacted]

**D.O.B.:** [Redacted]

**Address:** [Redacted]

**Hospital No:** [Redacted]

Patient 35

Personal Information redacted by USI

Personal Information redacted by USI

Personal Information redacted by USI

**HCN:**

Personal Information redacted by USI

**Date/Time of Clinic:** 30/11/18

**Follow Up:** Review January 2019

Further to my letter of the 10<sup>th</sup> of November 2018, I write to confirm that [Redacted] was able to return for further review on the 30<sup>th</sup> of November 2018. I was pleased to note that his serum PSA level remained very low at 0.52ng/ml on the 27<sup>th</sup> of November 2018.

Patient 35

[Redacted] also reported that the injection of 20micrograms of Alprostadil resulted in an erectile response which was better than had been the response due the injection of 12.5micrograms. [Redacted] also reported to me that he felt confident that he would be able to perform intracavernosal injection himself. I do suspect that he requires a higher dose of either 30micrograms or 40micrograms of Alprostadil. I therefore requested that you prescribe for him, Viridal Duo, 40micrograms to be used once weekly in conjunction with Tadalafil 20mgs, also to be used once weekly. I advised [Redacted] to take the Tadalafil several hours prior to intracavernosal injection prior to anticipated sexual activity.

I did emphasis to [Redacted] that it will take some time for his penile erectile function to be rehabilitated. It is therefore a minimal requirement that he performed intracavernosal injection once weekly, at least, and combined with Tadalafil 20mgs, also taken once weekly. I would have much preferred that he would have continued taking Tadalafil 10mgs daily, or indeed, 20mgs daily, as maintaining steady serum levels of Tadalafil is more effective in erectile functional rehabilitation.

[Redacted] also reported to me that he had recently been prescribed Duloxetine for his chronic pain. He also takes Oxycodone, 20mgs twice daily. I have advised him to resist the temptation to increase the dose of Oxycodone any further.

In any case, I hope to review [Redacted] in early 2019.

Yours sincerely

*Dictated but not signed by*

**Mr A O'Brien FRCS**

**Consultant Urological Surgeon**

**Date Dictated:** 30/11/18

**Date Typed:** 06/12/18-NE

**CRAIGAVON AREA HOSPITAL  
68 LURGAN ROAD  
PORTADOWN BT63 5QQ**
**UROLOGY DEPARTMENT****Telephone:**

Personal Information redacted by USI

**E-mail:**

Personal Information redacted by the USI

**Secretary:****Mrs N Elliott**

DR M. MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
BT34 3JD

Dear DR MURPHY

**Re: Patient Name:****Patient 35****D.O.B.:**

Personal Information redacted by USI

**Address:**

Personal Information redacted by USI

**Hospital No:**

Personal Information redacted by USI

**HCN:**

Personal Information redacted by USI

**Date/Time of Clinic:** 19/07/19**Follow Up:** BONE SCAN, CT & MDM

I last wrote to you in November 2018 when I was generally pleased with **Patient 35**'s progress, apart from his erectile dysfunction and my concern regarding his continued dependence upon Oxycodone. I was recently surprised and concerned to find that **Patient 35** was unexpectedly found to have an elevated serum PSA level of 6.96ng/ml in June 2019. **Patient 35** had had an excellent biochemical response to radical radiotherapy for his intermediate risk, prostatic carcinoma in 2014. His serum PSA level had been entirely normal at 0.75ng/ml in March 2019. Since the finding of an elevated serum PSA level on 5<sup>th</sup> June 2019, his serum PSA levels have increased alarmingly quickly to 27.64ng/ml by the 16<sup>th</sup> July 2019.

I found **Patient 35** to be keeping reasonably well at review on 19<sup>th</sup> July 2019, though he did report an increased degree of nocturia, having to rise two or three times each night to pass urine, in addition to having had an episode of visible haematuria. In any case, I regret that I did have to advise **Patient 35** that the increasing levels of serum PSA since June 2019 would indicate that he does have progressive prostatic carcinoma, and particularly as there has been no suspicion or evidence of any urinary infection. I have therefore requested that you prescribe for him, Bicalutamide 150mg daily and Tamoxifen 10mg daily whilst **Patient 35** has imaging repeated to stage the prostatic carcinoma. I have requested appointments for radio-isotope bone scanning and CT scanning of his chest, abdomen and pelvis, and his further management will be discussed at the Urology Multi-Disciplinary Meeting when the reports of those scans are available.

I do presume that **Patient 35** will subsequently require the addition of an LHRH agonist, and he would certainly be a candidate for the addition of Docetaxel if there was any radiological evidence of metastatic disease. In any case, he will be advised of any plans for his further assessment and management in due course.

Yours sincerely

Dictated but not signed by

**Mr A O'Brien FRCS****Consultant Urological Surgeon**

c.c. SHAUNA MCVEIGH  
UROLOGY MDM

**Date Dictated:** 20/07/19**Date Typed:** 22/07/19-CN





Southern Health  
and Social Care Trust

**CRAIGAVON AREA HOSPITAL  
68 LURGAN ROAD  
PORTADOWN BT63 5QQ**

**UROLOGY DEPARTMENT****Telephone:** [Personal Information redacted by USI]**E mail:** [Personal Information redacted by the USI]**Secretary:** Mrs N. Elliott

DR M. MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
NEWRY  
BT34 3JD

Dear DR MURPHY

**Re: Patient Name:** Patient 35  
**D.O.B.:** [Personal Information redacted by USI]  
**Address:** [Personal Information redacted by USI]  
**Hospital No:** [Personal Information redacted by USI] **HCN:** [Personal Information redacted by USI]

**Date/Time of Clinic:** 29/07/19**Follow Up:** AWAIT BONE SCAN & CT  
SCAN RESULTS

[Patient 35] attended Thorndale Unit on 29<sup>th</sup> July for flexible cystoscopy to investigation his previous episode of visible haematuria. Urinalysis prior to procedure was NAD. Flexible cystoscopy revealed oedematous inflammation with contact bleeding in the prostate and the bladder mucosa appeared quite significantly trabeculated with telangiectasia apparent around the bladder base. I have reassured [Patient 35] in relation to these findings and he is aware that Mr O'Brien will be in contact with him again with the results of bone scan and CT scans in due course.

Yours sincerely

*Dictated but not signed by*

**Jenny McMahon**  
**Urology Nurse Specialist**  
**Non-Medical Prescriber to**  
**Mr A O'Brien FRCS**  
**Consultant Urological Surgeon**

CC MR O'BRIEN  
CONSULTANT UROLOGIST  
CAH

**Date Dictated:** 29/07/19**Date Typed:** 29/07/19-CN

|                       |                                      |                       |                                      |
|-----------------------|--------------------------------------|-----------------------|--------------------------------------|
| <b>Patient ID</b>     | Personal Information redacted by USI | <b>Patient Name</b>   | Patient 35                           |
| <b>Sex</b>            | Male                                 | <b>Date Of Birth</b>  | Personal Information redacted by USI |
| <b>Time Performed</b> | 29-Jul-2019 13:30                    | <b>Time Reported</b>  | 30-Jul-2019 18:53                    |
| <b>Requested by</b>   | Aidan O'Brien                        | <b>Requested from</b> | Urology Outpatients<br>Craigavon     |
| <b>Order Number</b>   | NIRSCR0027037036                     | <b>Status</b>         | Final                                |

**Report** Final

29/07/2019 16:57 NM Bone whole body, Author: Lynch, Tom

Indication:

History of prostate cancer.

Gleeson score seven.

Rapidly rising PSA.

Description:

Unfortunately, the bone scan appearances are ominous. Extensive osteoblastic disease is demonstrated throughout the central skeleton involving the skull base, the cervical, thoracic and lumbar spine, both sides of the bony pelvis and multiple bilateral ribs.

Sternal, shoulder girdle and both proximal humeral and proximal femoral osteoblastic disease is present.

These appearances were not present on the previous bone scan from January 2013 and constitute a pattern consistent with diffuse disseminated osteoblastic metastasis.

**Clinical Info From Order** Final

Tis man has Gleason 3+4, organ confined, prostatic carcinoma managed by the combination of androgen blockade and radical radiotherapy, completed in 2014.

He has had an excellent oncological response until June 2019 since when there has been a rapid increase in serum PSA levels up to 27.64 ng/ml.

Androgen blockade has been initiated.

He may be contacted at Personal Information redacted by USI and Personal Information redacted by USI

-----  
Priority: Red Flag

Method of transport: Walking

Is the patient female and of child bearing age (11-55)?: No

Is the patient breast feeding?: No

Is the patient diabetic?: No

Does the patient have a known infection status?: No

Referral status: NHS

Referrer name: Aidan O'Brien

Referrer grade: Consultant

Referrer contact / bleep detail: Personal Information redacted by USI

|                       |                                      |                       |                                      |
|-----------------------|--------------------------------------|-----------------------|--------------------------------------|
| <b>Patient ID</b>     | Personal Information redacted by USI | <b>Patient Name</b>   | Patient 35                           |
| <b>Sex</b>            | Male                                 | <b>Date Of Birth</b>  | Personal Information redacted by USI |
| <b>Time Performed</b> | 14-Aug-2019 15:00                    | <b>Time Reported</b>  | 24-Aug-2019 17:59                    |
| <b>Requested by</b>   | Aidan O'Brien                        | <b>Requested from</b> | Urology Outpatients<br>Craigavon     |
| <b>Order Number</b>   | NIRSDH0027037061                     | <b>Status</b>         | Final                                |

## Report Final

14/08/2019 15:40 CT Chest and abdo and pelvis with contrast, Author: Finnegan, Dr Sean

Indication:

Reason for referral  
To restage prostate cancer

Clinical details

This 69 year old man had Gleason 3+4 prostatic carcinoma, presumed to be confined to his prostate gland, managed by androgen blockade and radical radiotherapy in 2014.  
He has had an excellent biochemical response since then, with low serum PSA levels until March 2019 when his serum PSA was 0.75 ng/ml.  
He was unexpected ly found to have a serum PSA of 6.96 ng/ml in June 2019.  
Serum PSA levels have since increased to 27.64 ng/ml by 16 July 2019, in the absence of any suspicion of infection.  
androgen blockade has been initiated.

Technique: CT chest, abdomen and pelvis with IV and oral contrast.

Comparison:  
CT abdomen and pelvis dated 09/07/2015.  
CT chest dated 09/01/2013.

Findings:

Chest:  
Widespread multiple bilateral small pulmonary nodules suspicious for metastases.

No pericardial or pleural effusion.  
No endobronchial lesion.  
No significant axillary, mediastinal or hilar lymphadenopathy by CT size criteria.

Abdomen - Pelvis:  
No focal liver lesion.  
No intra or extrahepatic ductal dilatation.  
Gallbladder is fluid-filled and unremarkable.  
Cortical scarring at the upper pole of the left kidney, however both kidneys otherwise unremarkable.  
Spleen, pancreas and both adrenals outline normally.  
Bowel is grossly unprepared, however no gross mucosal lesion identified.  
No significant regional or distant lymphadenopathy identified specific for prostate cancer.

Skeletal:  
Diffuse sclerotic metastases.

Conclusion:  
Diffuse pulmonary and osteoblastic metastases in keeping with metastatic disease recurrence.

|                       |                                          |                       |                                      |
|-----------------------|------------------------------------------|-----------------------|--------------------------------------|
| <b>Patient ID</b>     | Personal Information redacted by the USI | <b>Patient Name</b>   | Patient 35                           |
| <b>Sex</b>            | Male                                     | <b>Date Of Birth</b>  | Personal Information redacted by USI |
| <b>Time Performed</b> | 14-Aug-2019 15:00                        | <b>Time Reported</b>  | 24-Aug-2019 17:59                    |
| <b>Requested by</b>   | Aidan O'Brien                            | <b>Requested from</b> | Urology Outpatients<br>Craigavon     |
| <b>Order Number</b>   | NIRSDH0027037061                         | <b>Status</b>         | Final                                |

**Clinical Info From Order**

Final

This 69 year old man had Gleason 3+4 prostatic carcinoma, presumed to be confined to his prostate gland, managed by androgen blockade and radical radiotherapy in 2014.

He has had an excellent biochemical response since then, with low serum PSA levels until March 2019 when his serum PSA was 0.75 ng/ml.

He was unexpected ly found to have a serum PSA of 6.96 ng/ml in June 2019.

Serum PSA levels have since increased to 27.64 ng/ml by 16 July 2019, in the absence of any suspicion of infection.

androgen blockade has been initiated.

He may be contacted at Personal Information redacted by USI and Personal Information redacted by USI

-----  
Priority: Red Flag

Is the patient female and of child bearing age (11-55)?: No

Irradiated area between diaphragm / upper femora?: Yes

Does patient have any of the following contrast risk factors; Over 70 years of age, renal impairment, diabetes, CHF, myeloma, chemotherapy or nephrotoxic drugs?: No

Renal function information: eGFR

eGFR value? Failure to provide required information when applicable may cause a delay due to requests being returned: > 60 ml/min

eGFR date: 14 June 2018

Does the patient have a known infection status?: No

Is the patient diabetic?: No

Method of transport: Walking

Referral status: NHS

Referrer name: Aidan O'Brien

Referrer grade: Consultant

Referrer contact / bleep detail: Personal Information redacted by USI

**Cancer Centre** Belfast City Hospital Lisburn Road Belfast BT9 7AB Tel: [Personal Information redacted by the USI]

<http://belfasttrust-cancerservices.hscni.net>

**PRIVATE AND CONFIDENTIAL**

Dr. M J MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT NEWRY  
BT34 3JD

**OUT-PATIENT REVIEW**

|                     |                                        |                  |          |
|---------------------|----------------------------------------|------------------|----------|
| <b>Consultant:</b>  | Dr. F Houghton                         | <b>Dictated:</b> | 27/08/19 |
| <b>Hospital No:</b> | [Personal Information redacted by USI] | <b>Typed:</b>    | 04/09/19 |
| <b>H+C Number:</b>  | [Personal Information redacted by USI] | <b>Typist:</b>   | SW       |

Dear Dr. M J MURPHY

**RE:** Patient 35, [Personal Information redacted by USI],  
[Personal Information redacted by USI] - **DOB:** [Personal Information redacted by USI]

Reviewed Patient 35 in the nurse led telephone clinic.

Initial diagnosis in 2009 with a Gleason 7 T2 adenocarcinoma of the prostate gland. US guided biopsy in 2012 Gleason 7 was noted and a PSA of 3.9.

**TREATMENT HISTORY:**

1. Completed radical radiotherapy in December 2014.
2. CASODEX monotherapy from December '12 and stopped completely in December 2014.

I spoke to Patient 35 briefly on the phone today. He informs me that he had been feeling generally unwell and attended urology with an episode of haematuria. A PSA was checked in early June demonstrating a rise from 0.75 to 6.96. A further PSA checked late June was 14.58 and 27.64 in July. He was seen by Mr O'Brien in Craigavon and recommenced on BICALUTAMIDE 150mgs monotherapy with TAMOXIFEN cover. He also had a cystoscopy carried out. Infection was ruled out also.

Restaging scans were organised at this stage and he has recently had NM bone scan and CT CAP. Unfortunately his bone scan has demonstrated extensive osteoblastic disease throughout the central skeleton involving the skull base, cervical and thoracic and lumbar spine on both sides of the bony pelvis and multiple bilateral ribs.

Contd.

His CT scan has demonstrated widespread multiple bilateral small pulmonary nodules suspicious for metastases. The results of these scans were not discussed with Patient 35 today as he has an appointment with Mr O'Brien on Friday at mid-day and will receive the results then.

Our recommendation is that he would change from his BICALUTAMIDE to LH/RHA with effect and this will probably be discussed with Patient 35 on Friday.

We will appoint him to see the oncologist in 2 months to assess response of this. Patient 35 is having a repeat PSA tomorrow with his GP. Patient 35 has booked a holiday [Personal Information redacted by USI] for a month planning to leave on Tuesday but I imagine he will discuss this further with Mr O'Brien.

Plan -

Please appoint this gentleman to Dr Mezyski's clinic for review in 2 months as a must see to assess response of treatment. Could this appointment be made for late morning or early afternoon please.

Yours sincerely

ENDA HANNA  
ONCOLOGY NURSE SPECIALIST

**PAT-000945**

|                                                                                        |                            |
|----------------------------------------------------------------------------------------|----------------------------|
| For Trust use only:<br><b>HCN:</b> <small>Personal Information redacted by USI</small> | Referral Date: 07-Oct-2019 |
|----------------------------------------------------------------------------------------|----------------------------|

Date Sent: 07-Oct-2019

Surname:

**Patient 35****DRS MURPHY & RYAN****Practice address**

The Health Centre  
Summer Hill  
Warrenpoint  
Newry

Practice code: Z00543

Contact number(s)

Telephone: 028 4175 4100

Fax:

Practice Email:

|                                 |                                                  |                    |               |
|---------------------------------|--------------------------------------------------|--------------------|---------------|
| Referral to:                    | Community Specialist<br>Palliative Care Services | Referral Type:     | Out Patient   |
| Specialty:                      | SOUTHERN AREA<br>PALLIATIVE MDT                  | Nature of Request: | Not Specified |
| Urgency:                        | <b>ROUTINE</b>                                   |                    |               |
| Urgency Reason:                 | no priority reason given                         |                    |               |
| Electronic Attachment Present?: | No                                               |                    |               |
| HCP Name:                       |                                                  |                    |               |
| Designation:                    |                                                  |                    |               |

|                |                 |                      |                |                       |              |
|----------------|-----------------|----------------------|----------------|-----------------------|--------------|
| Practice Code: | Z00543          | Registered GP:       | Dr Mark Murphy | Registered GP Cypher: | S0728        |
| Referring GP:  | Dr Petrina Ryan | Referring GP Cypher: |                | Referred by:          | Referring GP |

|                                                    |                                                     |                 |                                                     |
|----------------------------------------------------|-----------------------------------------------------|-----------------|-----------------------------------------------------|
| HCN Number                                         | <small>Personal Information redacted by USI</small> | Title:          | Mr                                                  |
| Surname:                                           | <small>Patient 35</small>                           | Forenames:      | <small>Personal Information</small>                 |
| Previous Surname:                                  | <small>Patient 35</small>                           | Known as:       | -                                                   |
| DOB:                                               | <small>Personal Information redacted by USI</small> | Gender:         | Male                                                |
| Registered Contact Details:                        | <small>Personal Information redacted by USI</small> |                 |                                                     |
| Tel No:                                            | <small>Personal Information redacted by USI</small> | Mobile:         | <small>Personal Information redacted by USI</small> |
| Patient Email:                                     | -                                                   |                 |                                                     |
| Preferred Contact Details if different from above: |                                                     | Marital Status: | (Not Known)                                         |

**Special Needs or Requirements**

**Reason for Referral/ History of Presenting Complaint**

Description: Bone pain ++

Comment: Please see this pleasant man who has a hx of prostate cancer and more recently diagnosed with widespread bone metastases and pulmonary nodules He is due to have an oncology appt on 22nd Oct but he is in a lot of pain both shoulders and his spine He was on longtec 25 mg bd and I have increased this to 40mg bd as he was in so much pain today and added in Ibuprofen with PPI cover He is very constipated and is taking laxido and Dulcolax I would appreciate you seeing him urgently to get his symptoms under control I have requested urgent U+E and Ca++ today

**RELEVANT PAST MEDICAL HISTORY****Pre-existing conditions** (High & medium priority - all)

| <u>Description</u>                  | <u>Comment</u>                | <u>Date of onset</u> | <u>Date recorded</u> |
|-------------------------------------|-------------------------------|----------------------|----------------------|
| Malignant neoplasm of prostate      | metastatic                    | 02-Sep-2019          | 02-Sep-2019          |
| Open-angle glaucoma                 | left eye                      | 01-Jul-2016          | 01-Jul-2016          |
| Carcinoma in situ of prostate       | -                             | 07-Dec-2009          | 07-Dec-2009          |
| Congenital renal cyst, single       | -                             | 18-Nov-2008          | 18-Nov-2008          |
| [D]Postviral syndr.(asthenic) (GMS) | , Outcome=Miscellaneous Other | 30-Sep-1991          | 30-Sep-1991          |
| Lipoma                              | , Outcome=Miscellaneous Other | 05-May-1990          | 05-May-1990          |
| Depressive disorder NEC             | , Outcome=Miscellaneous Other | 30-Apr-1971          | 30-Apr-1971          |
| Anxiety states                      | , Outcome=Miscellaneous Other | 30-Apr-1971          | 30-Apr-1971          |
| Nasal turbinate hypertrophy         | , Outcome=Miscellaneous Other | 30-Jun-1968          | 30-Jun-1968          |

**Past procedures** (High and medium priority - all)

| <u>Description</u>                                  | <u>Comment</u>                                                                  | <u>Date recorded</u> |
|-----------------------------------------------------|---------------------------------------------------------------------------------|----------------------|
| Computerised tomograph scan                         | widespread multiple bilateral small pulmonary nodules suspicious fro metastases | 27-Aug-2019          |
| Diagnostic cystoscopy using flexible instrument     | contact bleeding in prostate                                                    | 29-Jul-2019          |
| Magnetic resonance imaging of lumbar spine          | -                                                                               | 21-May-2017          |
| Diagnostic colonoscopy                              | Telangiectasia/angioma                                                          | 01-Dec-2015          |
| ECG                                                 | -                                                                               | 10-Jun-2014          |
| Transurethral prostatectomy                         | -                                                                               | 14-May-2014          |
| Diagnostic colonoscopy                              | -                                                                               | 31-Jan-2014          |
| Other diagnostic ultrasound                         | urinary tract - normal                                                          | 07-Nov-2011          |
| Magnetic resonance imaging of thoracic spine normal | -                                                                               | 19-Jul-2011          |
| Partial nephrectomy                                 | FOR RENAL CYST ALSO PROSTATE BIOPSY                                             | 06-Nov-2009          |
| ECG                                                 | -                                                                               | 11-May-2009          |
| Other diagnostic ultrasound                         | & IVU - normal                                                                  | 16-Jun-2008          |
| Other diagnostic ultrasound                         | kidneys small simple cyst in upper pole region of left kidney                   | 26-Sep-2007          |
| ECG                                                 | -                                                                               | 27-Jul-2006          |
| Therapeutic open aspiration of renal cyst           | -                                                                               | 24-Oct-2005          |
| Excision of lesion of skin NEC                      | , Outcome=Miscellaneous Other:LUMBAR AREA                                       | 11-Nov-2003          |
| I-V pyelography normal                              | , Outcome=Miscellaneous Other                                                   | 08-Jan-1997          |
| U-S scan, non obstetric, diagn                      | , Outcome=Miscellaneous Other:RENAL                                             | 08-Jan-1997          |
| Lab. test result normal                             | , Outcome=Miscellaneous Other:BOWEL                                             | 16-Oct-1995          |

**Family conditions** (All priorities)

| <u>Description</u>                    | <u>Extension</u>  | <u>Modifier</u> | <u>Relation to Patient</u> | <u>Date Recorded</u> |
|---------------------------------------|-------------------|-----------------|----------------------------|----------------------|
| No FH: HYPERTENSION operator=DD (GMS) | Input             | -               | -                          | 09-Sep-1993          |
|                                       | Input operator=DD | -               | -                          | 09-Sep-1993          |



**PAT-000947**

FH: ISCHAEMIC  
HEART  
DISEASE (GMS)

**MEDICATION****Current medication** (Active Repeat medication issued within the last 12 months)

| <u>Drug name</u>                                                 | <u>Code</u>       | <u>Formulation</u> | <u>Dosage</u>            | <u>Frequency</u> | <u>Date started</u> | <u>Duration</u> |
|------------------------------------------------------------------|-------------------|--------------------|--------------------------|------------------|---------------------|-----------------|
| Bicalutamide 50mg tablets                                        | 327366007         | -                  | One To Be Taken Each Day | -                | 03-Sep-2019         | -               |
| Tamoxifen 10mg tablets                                           | 327312004         | -                  | one daily                | -                | 19-Jul-2019         | -               |
| Longtec 20mg modified-release tablets (Qdem Pharmaceuticals Ltd) | 20937911000001108 | -                  | 1 BD                     | -                | 31-Oct-2018         | -               |
| Tadalafil 20mg tablets                                           | 407858000         | -                  | AS DIR                   | -                | 24-Jul-2018         | -               |
| Travoprost 40micrograms/ml eye drops                             | 407803003         | -                  | AS DIRECTED              | -                | 30-Jan-2015         | -               |
| Solifenacin 5mg tablets                                          | 415557006         | -                  | 1 MANE                   | -                | 12-Mar-2013         | -               |

**Recent medication** (Any medication issued within last 168 days not shown above)

| <u>Drug name</u>                                                                       | <u>Code</u>       | <u>Formulation</u> | <u>Dosage</u>                                                                                 | <u>Frequency</u> | <u>Date started</u> | <u>Duration</u> |
|----------------------------------------------------------------------------------------|-------------------|--------------------|-----------------------------------------------------------------------------------------------|------------------|---------------------|-----------------|
| Ibuprofen 400mg tablets                                                                | 329653008         | -                  | One To Be Taken Three Times A Day                                                             | -                | 07-Oct-2019         | 20 Days         |
| Omeprazole 20mg gastro-resistant capsules                                              | 317291008         | -                  | One To Be Taken Each Day                                                                      | -                | 07-Oct-2019         | 28 Days         |
| Longtec 40mg modified-release tablets (Qdem Pharmaceuticals Ltd)                       | 20938111000001106 | -                  | One To Be Taken Every 12 Hours                                                                | -                | 07-Oct-2019         | 28 Days         |
| Dulcolax 5mg gastro-resistant tablets (Sanofi)                                         | 3074311000001107  | -                  | 1 or 2 nocte                                                                                  | -                | 07-Oct-2019         | 28 Days         |
| Longtec 5mg modified-release tablets (Qdem Pharmaceuticals Ltd)                        | 20937511000001101 | -                  | One To Be Taken Every 12 Hours                                                                | -                | 02-Oct-2019         | 14 Days         |
| Paracetamol 500mg tablets                                                              | 322236009         | -                  | One To Be Taken Every 4-6 Hours Up To Four Times A Day                                        | -                | 02-Oct-2019         | 25 Days         |
| Laxido Orange oral powder sachets sugar free (Galen Ltd)                               | 17420611000001107 | -                  | one daily                                                                                     | -                | 02-Oct-2019         | 28 Days         |
| Leuprorelin 3.75mg powder and solvent for suspension for injection pre-filled syringes | 19306211000001104 | -                  | 3.75mg monthly S/C during 1st week of each calendar month - commencing 1st week of October 19 | -                | 03-Sep-2019         | 28 Days         |
| Ibuprofen 5% gel                                                                       | 330202001         | -                  |                                                                                               | -                | 02-Sep-2019         | 28 Days         |

|                                                                                                     |                   |   |                                                              |                                     |             |          |
|-----------------------------------------------------------------------------------------------------|-------------------|---|--------------------------------------------------------------|-------------------------------------|-------------|----------|
|                                                                                                     |                   |   |                                                              | Apply Up To<br>Three Times<br>A Day |             |          |
| Longtec 20mg<br>modified-release<br>tablets (Qdem<br>Pharmaceuticals Ltd)                           | 20937911000001108 | - | One To Be<br>Taken Every<br>12 Hours                         | -                                   | 28-Aug-2019 | 29 Days  |
| Fluticasone<br>propionate<br>50micrograms/dose /<br>AzelaStine<br>137micrograms/dose<br>nasal spray | 21994411000001108 | - | One Spray<br>To Be Used<br>In Each<br>Nostril<br>Twice A Day | -                                   | 01-Aug-2019 | 62 Days  |
| Cetirizine 10mg<br>tablets                                                                          | 320818006         | - | One To Be<br>Taken Each<br>Day                               | -                                   | 01-Aug-2019 | 62 Days  |
| Zopiclone 3.75mg<br>tablets                                                                         | 321177003         | - | ONE AT<br>NIGHT                                              | -                                   | 01-Aug-2019 | 82 Days  |
| Bicalutamide 150mg<br>tablets                                                                       | 327368008         | - | One To Be<br>Taken Each<br>Day                               | -                                   | 19-Jul-2019 | 46 Days  |
| Ciprofloxacin 500mg<br>tablets                                                                      | 324606008         | - | One To Be<br>Taken Twice<br>A Day                            | -                                   | 24-Jun-2019 | 44 Days  |
| Shortec 5mg<br>capsules (Qdem<br>Pharmaceuticals Ltd)                                               | 23657811000001102 | - | 1 When<br>Required                                           | -                                   | 18-Apr-2019 | 103 Days |

**ALLERGIES & RISKS****Lifestyle risks****SMOKING STATUS**

| <u>Description</u>      | <u>Comment</u> | <u>Date<br/>Recorded</u> |
|-------------------------|----------------|--------------------------|
| Never smoked<br>tobacco |                | 07-Jul-<br>2016          |

**ALCOHOL INTAKE**

| <u>Description</u>                                     | <u>Comment</u>           | <u>Date<br/>Recorded</u> |
|--------------------------------------------------------|--------------------------|--------------------------|
| Alcohol<br>consumption : Social<br>drinker 10 (GMS) 10 | Prevention<br>priority=1 | 09-Sep-<br>1993          |

**BMI**

| <u>BMI</u> | <u>Height</u> | <u>Weight</u> | <u>Date<br/>Recorded</u> |
|------------|---------------|---------------|--------------------------|
| 26.81      |               |               | 2016-07-<br>29           |
| 27.77      |               |               | 2015-04-<br>10           |
| 27.13      |               |               | 2012-03-<br>20           |
| 26.35      |               |               | 2010-07-<br>14           |
| 25.62      |               |               | 2010-03-<br>22           |
| 24.58      |               |               | 2010-02-<br>09           |
| 24.32      |               |               | 2010-01-<br>12           |

**PAT-000949**

|       |            |
|-------|------------|
| 23.44 | 2009-12-04 |
| 23.73 | 2009-11-27 |
| 26.78 | 2006-08-24 |
| 25.5  | 1993-09-09 |

**Blood Pressure**

| <u>Diastolic</u> | <u>Systolic</u> | <u>Date Recorded</u> |
|------------------|-----------------|----------------------|
|------------------|-----------------|----------------------|

**SOCIAL HISTORY****OTHER PATIENT DATA**

---

|                                                              |             |
|--------------------------------------------------------------|-------------|
| <b>Signature</b> of referring doctor (or other professional) | <b>Date</b> |
|--------------------------------------------------------------|-------------|



Southern Health  
and Social Care Trust

CRAIGAVON AREA HOSPITAL  
68 LURGAN ROAD  
PORTADOWN, BT63 5QQ

**UROLOGY DEPARTMENT**

**Telephone:** [Personal Information redacted by the USI]

**E mail:** [Personal Information redacted by the USI]

**Secretary:** Mrs N. Elliott

DR M. MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
NEWRY  
BT34 3JD

Dear DR MURPHY

**Re: Patient Name:** [Patient 35]  
**D.O.B.:** [Personal Information redacted by USI]  
**Address:** [Personal Information redacted by USI]  
**Hospital No:** [Personal Information redacted by USI] **HCN:** [Personal Information redacted by USI]

|                                      |                                                        |
|--------------------------------------|--------------------------------------------------------|
| <b>Date/Time of Clinic:</b> 30/08/19 | <b>Follow Up:</b> Review 1 <sup>st</sup> November 2019 |
|--------------------------------------|--------------------------------------------------------|

I last wrote to you in July 2019 when I advised that [Patient 35] be prescribed Bicalutamide 150mgs daily in addition to Tamoxifen 10mgs daily on the assumption that his rapidly increasing serum PSA levels were indicative of progressive prostatic carcinoma. I also requested radioisotope bone scanning which was performed on the 29<sup>th</sup> of July 2019, regrettably illustrating extensive osteoblastic metastatic disease. He was indeed also found to have defuse sclerotic skeletal metastatic disease on CT scanning performed on the 14<sup>th</sup> of August 2019. Ominously, he was additionally to have widespread, multiple, bilateral, small pulmonary nodules also considered to be suspicious of metastases. As you will be aware from the letter of the 29<sup>th</sup> of July 2019 from Jenny McMahon, Urology Nurse Specialist, that there was no evidence of any urothelial malignancy when [Patient 35] had flexible cystoscopy performed that day in completion of assessment of recent haematuria.

I reviewed [Patient 35] on the 30<sup>th</sup> of August 2019, advising him of the findings of bone and CT scanning. Conversely, it was quite reassuring to find that his serum PSA level had decreased significantly to 2ng/ml by the 28<sup>th</sup> of August 2019. I availed of the opportunity of administering the LHRH antagonist, Degarelix, 240mgs that day. I also requested that the daily dose of Bicalutamide be reduced to 50mgs daily. I also requested that he be issued with a prescription for Leuprorelin 3.65mgs to be administered subcutaneously, once monthly, during the first week of each new calendar month, the first injection to be administered during the first week of October 2019.

As you may be aware, [Patient 35] and his wife had already booked a month long holiday [Personal Information redacted by USI] for all of September 2019, and I managed to convince them that it was a good idea to go on their holiday as arranged, as there was really

nothing to be achieved by not doing so. I have had the opportunity of speaking with Patient 35 by telephone on Thursday the 3<sup>rd</sup> of October 2019. It is a little disconcerting to hear him report that he has had a marked increase in the severity of generalised aches and pains, and which he believes is skeletal pain in nature. He has had the dose of Oxycodone increased to 25mgs twice daily. I have discussed with him adjuvant analgesia in the form of Paracetamol and Ibuprofen in combination with gastro protection. Therefore, I would be grateful if you would prescribe for Patient 35, Paracetamol 1g to be taken twice daily, Ibuprofen, initially 200mgs twice daily, increasing to 400mgs twice daily, if tolerated. I would also be grateful if you would prescribe for him Omeprazole 20mgs to be taken once daily. I do hope that this combination may minimise the need for a further increase in opioid analgesia.

Patient 35 does have a review appointment arranged with the Department of Clinical Oncology at the Cancer Centre at Belfast City Hospital on the 22<sup>nd</sup> of October 2019. I have asked Patient 35 to arrange an appointment with your Practice Nurse to have his serum PSA level repeated, and so that the result is available for that review.

Lastly, I would be grateful if you would issue a further prescription for Leuprorelin 3.75mgs to be administered subcutaneously during the first week of November 2019. In fact, I have agreed to review Patient 35 at my clinic at the Thorndale Unit at Craigavon Area Hospital on Friday the 1<sup>st</sup> of November 2019 at 12 noon when I would be happy to administer that next injection of Leuprorelin.

Yours sincerely

*Dictated but not signed by*

**Mr A O'Brien FRCS**  
**Consultant Urological Surgeon**

c.c. Dr Mezynski,  
Locum Consultant in Clinical Oncology  
The Cancer Centre  
Belfast City Hospital  
Lisburn Road  
BELFAST

|                                |                                |
|--------------------------------|--------------------------------|
| <b>Date Dictated:</b> 03/10/19 | <b>Date Typed:</b> 09/10/19-NE |
|--------------------------------|--------------------------------|

**CRAIGAVON AREA HOSPITAL  
68 LURGAN ROAD  
PORTADOWN, BT63 5QQ**

**UROLOGY DEPARTMENT**

**Telephone:** [Personal Information redacted by USI]

**E mail:** [Personal Information redacted by the USI]

**Secretary:** Mrs N. Elliott

Patient 35

[Personal Information redacted by  
the USI]

**Hospital No:**

[Personal Information redacted by USI]

**HCN:**

[Personal Information redacted by USI]

Dear Patient 35,

I was pleased to have the opportunity of speaking with you by telephone on Thursday the 3<sup>rd</sup> of October 2019. I write to confirm that I have written to your family doctor, Dr Murphy, requesting that he prescribe for you Paracetamol 1g twice daily and Ibuprofen 200mgs, to be taken twice daily initially, thereafter increasing to 400mg twice daily, if tolerated. I have asked him to prescribe Omeprazole 20mgs daily to minimise the risk of Paracetamol or Ibuprofen causing any gastric upset. I have also asked him to issue a further prescription for the next injection of Leuprorelin so that you may be able to collect it and bring it with you for review at the Thorndale Unit at Craigavon Area Hospital on Friday the 1<sup>st</sup> of November 2019 at 12 noon. I very much look forward to reviewing you then.

Yours sincerely

*Dictated but not signed by*

**Mr A O'Brien FRCS  
Consultant Urological Surgeon**

**Date Dictated:** 03/10/19

**Date Typed:** 09/10/19-NE



Southern Health  
and Social Care Trust

CRAIGAVON AREA HOSPITAL  
68 LURGAN ROAD  
PORTADOWN, BT63 5QQ

**UROLOGY DEPARTMENT**

**Telephone:** [Personal Information redacted by USI]

**E mail:** [Personal Information redacted by the USI]

**Secretary:** Mrs N. Elliott

Dr Mezynski,  
Locum Consultant in Clinical Oncology  
The Cancer Centre  
Belfast City Hospital  
Lisburn Road  
BELFAST

Dear Dr Mezynski,

**Re: Patient Name:** Patient 35  
**D.O.B.:** [Personal Information redacted by USI]  
**Address:** [Personal Information redacted by USI]  
**Hospital No:** [Personal Information redacted by USI] **HCN:** [Personal Information redacted by USI]

I write to you regarding this 69 year old man who had radical radiotherapy in 2014 for intermediate risk prostatic carcinoma and in combination with Bicalutamide initiated in December 2012 and completed in December 2014. Patient 35 had an entirely satisfactory oncological outcome with low serum total PSA levels up until March 2019 when his serum PSA was 0.75ng/ml. Unexpectedly, his serum PSA level had increased to 6.96ng/ml by the 5<sup>th</sup> of June 2019, and increased further and rapidly to 27.64ng/ml by the 16<sup>th</sup> of July 2019. He has been found to have extensive skeletal metastatic disease and bilateral pulmonary metastatic disease on radioisotope bone scanning and CT scanning. He has had a significant biochemical response to having Bicalutamide 150mgs daily prescribed in July 2019, his serum PSA level having decreased to 2ng/ml by the 28<sup>th</sup> of August 2019. Since then, the dose of Bicalutamide has been reduced to 50mgs daily, and he has had a second injection of a LHRH agonist.

As you will note from the enclosed letter, I have asked Patient 35 to arrange an appointment with the Practice Nurse to have his serum PSA level repeated, and so that the result is available when he attends the Department of Clinical Oncology on the 22<sup>nd</sup> of October 2019 for review. I do believe that Patient 35 may be a candidate for adjuvant chemotherapy by the addition of Docetaxel.

I have arranged a further review appointment for him on Friday the 1<sup>st</sup> of November 2019.

Yours sincerely

*Dictated but not signed by*

**Mr A O'Brien FRCS**  
**Consultant Urological Surgeon**

**Date Dictated:** 03/10/19

**Date Typed:** 09/10/19-NE

**Cancer Centre** Belfast City Hospital Lisburn Road Belfast BT9 7AB Tel: Personal Information redacted by the USIPersonal Information redacted by the USI <http://belfasttrust-cancerservices.hscni.net>**PRIVATE & CONFIDENTIAL**

Dr. M J MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
BT34 3JD

**RESULTS/UPDATE LETTER**

|                     |                                                   |                  |          |
|---------------------|---------------------------------------------------|------------------|----------|
| <b>Consultant:</b>  | Dr. F Houghton                                    | <b>Dictated:</b> | 22/10/19 |
| <b>Hospital No:</b> | <span>Personal Information redacted by USI</span> | <b>Typed:</b>    | 23/10/19 |
| <b>H+C Number:</b>  | <span>Personal Information redacted by USI</span> | <b>Typist:</b>   | AMMC     |

Dear Dr. M J MURPHY

**RE:** Patient 35, Personal Information redacted by USI, **DOB:** Personal Information redacted by USI

Diagnosis: Prostate cancer 2009.  
Pathology: adenocarcinoma, Gleason 3+4, IPSA 4.2  
BICALUTAMIDE 2012 - 2014.  
TURP 2014.  
Radical radiotherapy 2014.  
CT/IBS in 2019: bone and lung mets.  
Commenced LHRH/BICALUTAMIDE in July 2019 with response.  
Admission with pain and hypercalcemia Oct 2019.  
RT to left shoulder and T8-L2 spine Oct 2019.  
On high dose steroids.  
Last PSA 17.8 in Oct 2019.

I met this man and his wife and sister in BPS today. He has a lot of bone pain which is just settling with morphine and steroids. He has just received radiotherapy to his left shoulder and lower back. His pain may get worse initially so it is a good idea if he goes to Hospice as planned already.  
PS=3. No signs to suggest cord compression.

I discussed that his cancer is rapidly progressing. He is not fit for systemic treatment at present. I am hoping his pain gets under control and his mobility better but this may not happen.



-2-

**RE:** Patient 35, Personal Information redacted by USI, **DOB:** Personal Information redacted by USI

Plan: Continue LHRH.  
Pain control.  
Reduce Dexamethasone if possible.  
Review with PSA upon discharge.

Yours sincerely

DR J MEZYNSKI  
Locum Consultant Oncologist

**Cancer Centre** Belfast City Hospital Lisburn Road Belfast BT9 7AB Tel:

Personal Information redacted by the USI

<http://belfasttrust-cancerservices.hscni.net>**PRIVATE & CONFIDENTIAL**

Dr. M J MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
NEWRY  
BT34 3JD

**RESULTS/UPDATE LETTER**

|                     |                                      |                  |            |
|---------------------|--------------------------------------|------------------|------------|
| <b>Consultant:</b>  | Dr. F Houghton GMC4634258, FRCR      | <b>Dictated:</b> | 18/10/2019 |
| <b>Hospital No:</b> | Personal Information redacted by USI | <b>Typed:</b>    | 25/10/2019 |
| <b>H+C Number:</b>  | Personal Information redacted by USI | <b>Typist:</b>   | EB         |

Dear Dr Murphy

**RE:** Patient 35, Personal Information redacted by USI**DOB:** Personal Information redacted by USI

Diagnosis: Prostate cancer 2009.  
Pathology: adenocarcinoma, Gleason 3+4, IPsa 4.2  
BICALUTAMIDE 2012 - 2014.  
TURP 2014.  
Radical radiotherapy 2014.  
CT/IBS in 2019: bone and lung mets.  
Commenced LHRH/BICALUTAMIDE in July 2019 with response.  
Admission with pain and hypercalcaemia Oct 2019.  
RT to left shoulder and T8-L2 spine Oct 2019.  
On high dose steroids.  
Last PSA 17.8 in Oct 2019.

This gentleman attends for review. He is being referred for consideration of simple palliative radiotherapy to his lumbar spine pain. On attendance today he is clearly in a lot of pain requiring a lot of palliative care input. Imaging performed specifically to target the left shoulder and lower lumbar spine has unfortunately shown disseminated lytic disease throughout the entire vertebral column. I have treated as much as I think is safe within the lower thoracic and upper lumbar spine.

I have recommended an MRI should be performed and if there are any other areas of impending cord compression for example in the upper thoracic spine then a matched on field could be considered to that. It appears that his disease has progressed very rapidly to the castration resistant phase. His current performance status would limit or exclude further systemic options and unfortunately I suspect that this disease will become life threatening to him in the very near future. We await further word as he attends clinic next week for assessment of systemic treatment.

Yours sincerely

**Dictated but not signed by**

DR D MITCHELL FRCR  
CONSULTANT IN CLINICAL ONCOLOGY

CC Mr Haynes

Consultant Urologist  
Craigavon Hospital  
68 Lurgan Road  
PORTADOWN

Dr Mezynski  
Locum Consultant in Medical Oncology  
N.Ireland Cancer Centre  
Lisburn Road  
BELFAST

**PAT-000958****Southern Health  
and Social Care Trust**Daisy Hill Hospital, 5 Hospital Road, Newry, County Down, BT35 8DR  
Tel: 028 3083 5000

Ward Tel:

DR MJ MURPHY

THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
CO DOWN  
BT34 3JD

543

Dear Dr MURPHY

**ECR Copy**Date: 30/10/2019 12:22  
Discharge Id: 614438  
Version: 31**DISCHARGE NOTIFICATION**The patient was admitted under the care of **DR C HILLEMAND** (specialty: **GENERAL MEDICINE(C)**) into **LEVEL 4 REHABILITATION/STROKE** Ward at **DAISY HILL HOSPITAL** on **08/10/2019 00:53:00** and discharged on **30/10/2019**.

|              |                               |          |                                          |
|--------------|-------------------------------|----------|------------------------------------------|
| Forenames:   | [Redacted]                    | Address: | Personal Information redacted by the USI |
| Surname:     | Patient 35                    |          |                                          |
| D.O.B:       | [Redacted]                    |          |                                          |
| Hospital No: | [Redacted]                    |          |                                          |
| NHS No:      | [Redacted]                    |          |                                          |
| Gender:      | Male                          |          |                                          |
| Ward:        | LEVEL 4 REHABILITATION/STROKE |          |                                          |

**Presenting Complaint**

Generalised bone pain

**Patient Receiving Palliative Care?** No**Principle Discharge Diagnosis**

Hypercalcaemia secondary to metastatic disease

**Operations/Procedures/Radiology**

A CT CAP 25/10/19 confirmed: Diffuse metastatic bony lesions. Diffuse nodular lung lesions are seen bilaterally suggestive of metastatic lung deposits.

**Additional Information for GP****Past Medical/Surgical History**

Prostate Cancer (previous RXT + Casodex), TURP 2014

**Changes to Medications - Start/Stop**

See discharge prescription below for medication changes

**Clinical Narrative**

69M presented with 4-5 week h/o generalised bone pain. On admission his Ca was 3.07 on a background of prostate Ca.

A CT CAP 14/08/19 showed: Diffuse sclerotic metastases and pulmonary and osteoblastic metastases in keeping with metastatic disease recurrence.

He was treated for hypercalcaemia with IVF, bisphosphonates and analgesia. He was also transfused 2 units PRC for low Hb.

PCT were closely involved with Patient 35's admission and was commenced on Shortec PRN, Longtec Bd, Diazepam, Pregabalin, Bisacodyl, Docusate, PPI, Dexamethasone

Patient 35's pain was difficult to control with oral medication and therefore he underwent radiotherapy to shoulder and back in BCH. He has had no issues with his bowels or bladder during admission.

Bloods cultures taken on 21/10/19 for Pyrexia grew Gram +ve Cocci. He was treated with Abx for HAP and has since completed the course.

Patient 35 felt he would not be able to manage at home given his symptoms and therefore is being transferred to a Hospice today.

**Did the patient receive a blood transfusion?**

Yes

**Allergies:**

Patient Has No Known Allergies

**Details of Allergies:****Known Reactions to Allergies:****Additional Information:****Infection Status:****Follow Up Details****Arrangements for Follow Up:**No routine review  
please cc letter to Dr Houghton (Cons Oncologist BCH)  
Ongoing palliative care follow up in Hospice**Further Detailed Discharge Letter to Follow:**

No

**Awaiting Further Results:**

No

**PAT-000959****Awaited Results:****Patient Aware of Diagnosis:** Yes**Other Management Information For GP****Discharge Prescription:**

(POD = Patient's Own Drugs, PODH = Patient's Own Drugs at Home)

| Drug                                                                                             | Dose        | Frequency            | Days | Route        | GP Continue?      |
|--------------------------------------------------------------------------------------------------|-------------|----------------------|------|--------------|-------------------|
| <b>Admission drugs (unamended)</b>                                                               |             |                      |      |              |                   |
| ENOXAPARIN Pre-filled Syringe<br>(Additional Info: Amber List Medicine)                          | 40mg        | Each Night           | -    | Oral         | No (cont by hosp) |
| PARACETAMOL 500 mg Tablets<br>(Additional Info: PO or IV)                                        | 1g          | Four Times Daily     | -    | Oral         | Yes               |
| Bioxtra Mouthwash                                                                                | 10mls       | Four Times Daily     | -    | Mouthwash    | Yes               |
| BICALUTAMIDE Tablets<br>(Additional Info: Amber List Medicine)                                   | 50mg        | Each Morning         | -    | Oral         | Yes               |
| TRAVOPROST 40 micrograms in 1mL Eye Drops                                                        | 40mcg       | Each Morning         | -    | Topical      | Yes               |
| SOLIFENACIN SUCCINATE Tablets                                                                    | 5mg         | Each Morning         | -    | Oral         | Yes               |
| LIDOCAINE HYDROCHLORIDE 5 % Plasters<br>(Additional Info: Mid back. *12 hours on, 12 hours off*) | TT          | Each Morning         | -    | Topical      | Yes               |
| METOCLOPRAMIDE 10 mg Tablets                                                                     | 10mg        | Three Times Daily    | -    | Oral         | Yes               |
| TADALAFIL Tablets<br>(Additional Info: HELD DURING ADMISSION)                                    | 20mg        | Each Morning         | -    | Oral         | No                |
| DIAZEPAM Tablets                                                                                 | 5mg         | Twice Daily          | -    | Oral         | Yes               |
| DOCUSATE SODIUM 100 mg Capsules                                                                  | 200mg       | Three Times Daily    | -    | Oral         | Yes               |
| Bisacodyl Tablets                                                                                | 10mg        | Each Night           | -    | Oral         | Yes               |
| Pregabalin 50mg Capsules                                                                         | 50mg        | Twice Daily          | -    | Oral         | Yes               |
| LAXIDO SUGAR-FREE Powder                                                                         | TT          | Twice Daily          | -    | Oral         | Yes               |
| OMEPRAZOLE Capsules                                                                              | 20mg        | Each Morning         | -    | Oral         | Yes               |
| DEXAMETHASONE Soluble Tablets                                                                    | 2mg         | Each Morning         | -    | Oral         | Yes               |
| Oxycodone Hydrochloride (Longtec) 80 mg MR Tablets                                               | 150mg total | Twice Daily          | -    | Oral         | Yes               |
| Oxycodone Hydrochloride (Longtec) 40 mg MR Tablets                                               | 150mg total | Twice Daily          | -    | Oral         | Yes               |
| Oxycodone Hydrochloride (Longtec) 20 mg MR Tablets                                               | 150mg total | Twice Daily          | -    | Oral         | Yes               |
| Oxycodone Hydrochloride (Longtec) 10 mg MR Tablets                                               | 150mg total | Twice Daily          | -    | Oral         | Yes               |
| FLUCONAZOLE Capsules<br>(Additional Info: Review need on 2nd Nov)                                | 50mg        | Once Daily at....6pm | 4    | Oral         | Yes               |
| LEVOMEPRMAZINE 25 mg in 1mL Injection                                                            | 6.25mg      | 4-6 Hourly When Req. | -    | Subcutaneous | Yes               |
| BISACODYL 10 mg Suppositories                                                                    | TT          | Once Daily When Req. | -    | Per rectum   | Yes               |
| MIDAZOLAM 5 mg in 5mL Injection<br>(Additional Info: For acute anxiety and agitation)            | 2-5mg       | 2-4 Hourly When Req. | -    | Subcutaneous | Yes               |
| SHORTEC (Oxycodone) 10mg Capsules                                                                | 30-40mg     | 4-6 Hourly When Req. | -    | Oral         | Yes               |
| <b>Drugs prescribed since admission</b>                                                          |             |                      |      |              |                   |
| <b>Admission drugs (amended)</b>                                                                 |             |                      |      |              |                   |

**Stopped Medication:**

(POD = Patient's Own Drugs, PODH = Patient's Own Drugs at Home)

| Drug                             | Dose | Frequency | Days | Route |
|----------------------------------|------|-----------|------|-------|
| <b>Admission drugs (stopped)</b> |      |           |      |       |

**Authorised Forms**

|                                         |                  |
|-----------------------------------------|------------------|
| Form                                    | Authorised By    |
| Adult Clinical Details (Emergency-CMPM) | ALASTAIR DONAGHY |

**Prescribing Clinician:** ALASTAIR DONAGHY **Bleep No:** ext 62659

**Discharged by:** ALASTAIR DONAGHY **Bleep No:** ext 62659

**Cancer Centre** Belfast City Hospital Lisburn Road Belfast BT9 7AB Tel: [Personal Information redacted by the USI]<http://belfasttrust-cancerservices.hscni.net>**PRIVATE & CONFIDENTIAL**

Dr. M J MURPHY  
THE HEALTH CENTRE  
SUMMERHILL  
WARRENPOINT  
BT34 3JD

**RESULTS/UPDATE LETTER**

|                     |                                        |                  |          |
|---------------------|----------------------------------------|------------------|----------|
| <b>Consultant:</b>  | Dr. F Houghton                         | <b>Dictated:</b> | 26/11/19 |
| <b>Hospital No:</b> | [Personal Information redacted by USI] | <b>Typed:</b>    | 16/12/19 |
| <b>H+C Number:</b>  | [Personal Information redacted by USI] | <b>Typist:</b>   | AMMC     |

Dear Dr. M J MURPHY

**RE:** Patient 35, [Personal Information redacted by USI], **DOB:** [Personal Information redacted by USI]

Diagnosis: Prostate cancer 2009.  
Pathology: adenocarcinoma, Gleason 3+4, IPSA 4.2  
BICALUTAMIDE 2012 - 2014.  
TURP 2014.  
Radical radiotherapy 2014.  
CT/IBS in 2019: bone and lung mets.  
Commenced LHRH/BICALUTAMIDE in July 2019 with response.  
Admission with pain and hypercalcemia Oct 2019.  
RT to left shoulder and T8-L2 spine Oct 2019.  
On high dose steroids.  
Last PSA 95 in Nov 2019.

I met this man and his wife in BPS today. He was in hospital and hospice recently with improvement of his pain.  
He is walking with a stick now. Has abdominal cramps.  
PS=2. Abdomen SNT, bowel sounds normal.

I discussed that his cancer is active again as evidenced by raising PSA. We would stop Bicalutamide at the first instance. We should try and reduce steroids as well.

Plan: Continue LHRH.  
Stop Bicalutamide.  
Reduce Dex to 0.5mg OD.  
Review with PSA in 3 months.

Yours sincerely

DR J MEZYNSKI  
Locum Consultant Oncologist

**PAT-000961**

FOR INSTRUCTIONS TO INFORMANTS SEE OVERLEAF

**MEDICAL CERTIFICATE OF CAUSE OF DEATH**

Births and Deaths Registration (Northern Ireland) Order 1976, Article 25(2)

**FOR USE OF REGISTRAR**

ENTRY NO. ....

DISTRICT .....

To be signed by a Registered Medical Practitioner WHO HAS BEEN IN ATTENDANCE during the last illness of the deceased person and given to some person required by Statute to give information of the death to the Registrar. (SEE OVERLEAF)

Name of Deceased:

Patient 35

The Health &amp; Care Number of the Deceased:

Personal Information redacted  
by USI

Usual Residence:

Personal Information redacted by USI

Place of Death:

DAISY HILL HOSPITAL (Female surgical ward )

Date of Death:

Personal Information redacted by the USI

Date on which last seen alive and treated by me for the undermentioned conditions:

Personal Information redacted  
by the USI

Whether seen after death by,

- me
- another medical practitioner

NoYesThese particulars not to be  
entered in Death Register**CAUSE OF DEATH**Approximate interval between  
onset and death (years,  
months, weeks, days, hours)

| <b>I</b><br><b>Disease or condition</b><br><b>directly leading to</b><br><b>death*</b>                                                                   | <b>I</b><br><b>(a)     <u>Metastatic prostate Cancer</u></b><br><br><b>Due to (or as a consequence of)</b> |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|--|
| <b>Antecedent causes</b><br>Morbid conditions, if<br>any, giving rise to the<br>above cause, stating the<br>underlying condition<br>last.                | <b>(b)</b><br><br><b>Due to (or as a consequence of)</b><br><br><b>(c)</b>                                 |  |
| <b>II</b><br><b>Other significant</b><br><b>conditions</b><br>contributing to the death,<br>but not related to the<br>disease or condition<br>causing it | <b>II</b>                                                                                                  |  |

\*This does not mean the mode of dying e.g. heart failure, asthenia, etc. it means the disease, injury or complication which caused death.

**Coroner's Reference Number:** — 1 9

I hereby certify that the above-named person has died as a result of the natural illness or disease for which they have been treated by me within twenty-eight days prior to the date of death, and that the particulars and cause of death above written are true to the best of my knowledge and belief.

Signature

Date

18-December-2019 14:30

Name (Please Print)

Alice MCLEAN

Work Contact Number

2174

Work Address

Daisy Hill Hospital

GMC Registration No.

7638737

**PERSONS QUALIFIED AND LIABLE TO ACT AS INFORMANTS**

1. Any relative\* of the deceased who has knowledge of the particulars required to be registered concerning the death.
2. Person present at the death.
3. Executor or administrator of the deceased's estate.
4. ¥Occupier of the premises in which the death occurred.
5. Person finding the body.
6. Person taking charge of the body.
7. Person procuring the disposal of the body, i.e., the person employing the undertaker.

\* The term "Relative" includes a relative by marriage/ civil partnership.

¥ The term "Occupier" in relation to a public building includes the governor, matron, superintendent or other chief officer, and, in relation to a house let in separate apartments or lodgings, includes any person residing in the house who is either the person under whom the lodgings or apartments are immediately held or his agent.

**The informant must deliver this Certificate without delay to the Registrar and by personal attendance give the prescribed information concerning the deceased.  
Failure to comply with this requirement renders the informant liable to prosecution. The Registrar is an officer of the District Council and the registration may be made in any District Registration Office.  
The informant must be prepared to state accurately to the Registrar the following particulars concerning the deceased:-**

1. Full name and surname.
2. Date and place of death and the usual residence.
3. Status (single, married/civil partner, widowed/surviving civil partner or divorced/civil partnership dissolved).
4. Date and place of birth.
5. Occupation.
6. Name(s) and surname of spouse or civil partner.
7. Details of any pension (apart from a state pension) that the deceased may have held. (The pension or allowance order book or other pension etc. Document should be produced to the Registrar.)



Mortuary Summary

**Patient Name:** Patient 35 **H&C No:** Personal Information redacted by USI

**Date of Birth:** Personal Information redacted by USI

**Address:** Personal Information redacted by USI

**Date of Death:** Personal Information redacted by USI

**Place of Death:** DAISY HILL HOSPITAL (Female surgical ward )

**SBAR Details****SITUATION: Brief description of admission, diagnosis:**

Patient 35 was admitted with difficult to manage pain and hypercalcaemia on a background of metastatic prostate cancer and recent hospice discharge.

**BACKGROUND: Past Medical History, Medications**

Metastatic prostate cancer Left nephrectomy

**BACKGROUND: Describe clinical course**

Patient 35 was admitted with difficult to manage pain and hypercalcaemia on a background of metastatic prostate cancer and recent hospice discharge. It was felt presentation was likely secondary to metastatic spread of prostate cancer. He was later started on antibiotics to cover for LRTI which were then stopped when decision was made to continue with comfort care measures only. He was reviewed by palliative team during admission for symptom control and a syringe driver erected.

**BACKGROUND: Procedural details, surgery, investigations**

**Coroners Reference Number:** — 19

**Coroner Contacted By:**

**Date Coroner Contacted:**

**Date form completed** 18-December-2019 14:30

## Record of discussion with Coroner

|  |
|--|
|  |
|--|

**Doctor's Name:** Alice MCLEAN

**GMC Number:** 7638737

**Work Address:** Daisy Hill Hospital

**Work Contact:** 2174

**Implants**

**Does the deceased have any implanted cardiac device which is still implanted e.g. cardiac pacemaker, cardioverter-defibrillator (ICD), ventricular assist device? No**

**Does the deceased have a Radio-active implant which is still implanted? No**

**Does the deceased have any other hazardous device which is still implanted or not made safe e.g. Expandable Intramedullary nail - FIXION(™) nail; battery powered implant? No**



**Date of Meeting:** 10<sup>th</sup> August 2022 at 11:30am via Zoom.

**Attendees of Meeting:** Patient 35's Son, Patient 35's Wife, Mr Mark Haynes (Consultant Urologist), Margaret O'Hagan (Director of Urology Lookback Review) and Sarah Ward (Head of Service for Urology Lookback Review Team).

**Purpose of Meeting:** To offer apologies to Patient 35's Wife and Son on behalf of the Chief Executive and the Southern Health and Social Care Trust, for the below standard of urology treatment Patient 35 received. To also allow an opportunity for any questions to be raised and answered by Patient 35's wife and son in relation to the findings reported in the Structured Clinical Record Review.

### **Summary of the Meeting**

Mr Haynes (Mark), Margaret O'Hagan (Margaret) and Sarah Ward (Sarah) each introduced themselves to Patient 35's Wife and Patient 35's Son. The purpose of the meeting was explained and an apology was issued at this time on behalf of the Trust and the Chief Executive by Margaret, the opportunity for questions to be raised and advising that further meetings can be accommodated in the future was expressed.

Margaret outlined the process of this Urology Lookback Review and advised that there was an Independent Public Inquiry into Urology Services also ongoing as a parallel process. Mark explained the review process that allowed the issues in Patient 35's care to be discovered.

Patient 35's Son asked why his dad was not discussed at an MDM in 2009 when he was first diagnosed with Prostate Cancer. Mark advised he could not confirm at this time if the "Multidisciplinary Team Meetings (MDM)" had been functioning in 2009. Northern Ireland was slower to implement this process but there is a thought it was potentially around 2010 that MDM's were introduced.

**Action:** Patient 35's Son and Patient 35's Wife to be advised of the exact date that the Urology MDM's commenced in the Trust to be confirmed and.

In terms of treatment, Mark advised that in 2008 NICE (National Institute for Clinical Excellence) published guidelines and recommendations for treatment of Prostate Cancer.

In Patient 35's case, with a diagnosis of intermediate risk localised prostate cancer the recommendations were for Radical Prostatectomy or Radical Radiotherapy. There is no record of a discussion of these treatment recommendations with Patient 35 at his initial diagnosis and it appears he was placed on a surveillance pathway initially instead before commencing hormone therapy.

Patient 35's Wife advised in 2009 following this diagnosis they were advised that this was "non-aggressive cancer" and "doing nothing for a year will make no difference" and he will be reviewed in a year. Mark confirmed this was not in line with NICE guidelines and highlighted that later when Patient 35 was prescribed an unlicensed dose of hormone treatment (Bicalutamide) at 50mg for a prolonged period of time, this was also outside of NICE guidelines. Patient 35's Son asked in regards to the 2013 records of discussions about his dad's treatment options. Mark advised the notes do not record a discussion with Patient 35 but indicate a decision to "start treatment". It was recorded that a referral for radiotherapy was to be completed when Patient 35's "PSA was less than 1". Mark explained this is not standard practice.

In May 2014, the MDM discussion records recommended action to refer to the Oncology Team. This referral to Oncology was not actioned until October 2014. Patient 35's Son queried of the hormone treatment his dad was on at that time was correct. Mark advised the dose was increased to a correct dose in Oct 2013 but this would have had no effect on reducing the PSA.

Mark confirmed from the start of the Oncology Teams input in 2014 to completion of radiotherapy, there were no concerns identified with the care Patient 35 received from the Oncology team.

In 2019 a CT scan reported a significant spread of disease, noting this in both bones and lung. Mark advised that standard practice is to advise the patient of the seriousness of this finding, what treatment options are available and the non-curative intent of any treatment i.e. this disease cannot be cured and is considered palliative.

Patient 35's Wife advised this was not the case of her husband and described that she was under the impression that the addition of a hormone injection was all that was required at that time.

Both Patient 35's Son and Patient 35's Wife described their shock and devastation when they were informed within minutes of being reviewed by an oncologist in Daisy Hill Hospital in October 2009 that Patient 35 was "palliative" as his condition was never described like this before.

Patient 35's Son asked if Chemotherapy could have been an option for his dad at this point. Mark explained that Prostate Cancer care has developed extensively in the past 5 to 10 years. He explained the role of chemotherapy in conjunction with hormone therapy and the important role of the oncologist in considering this treatment option. Patient 35's Wife noted that the "injection" he received around this time made him worse. Mark outlined the MDM discussion in August 2019 recommended a change to LHRA analogue and refer to Oncology. Regarding the injection, Mark outlined the potential side effects patients may experience from this treatment. Mark also explained that it is possible that Patient 35 was so unwell at this time due to either the effect of the treatment or as a result of the progression of his cancer. Mark thought the most likely reason was that the reason Patient 35 was so unwell at this time was most likely due to the rapid progression of his cancer.

Patient 35's Son asked in the 5 years from 2009 to 2014 when his dad did not receive potentially curative treatment, how much of an impact could this have had. Mark explained he could

not give a definitive answer. However, the evidence is that the delay in receiving curative treatment would have reduced his likelihood of a positive long-term outcome (i.e. cure). Mark went on to explain that in his experience, as a practicing urologist at this time, if he were treating a patient similar to Patient 35 he would have certainly recommended surgical treatment, and outlined the potential role of salvage radiotherapy in the event that the prostate cancer returned after surgery.

In summing up the meeting Margaret commented on how the Trust was determined to improve services for urology patients and referenced that there was ongoing service improvement being progressed at the same time as the Lookback Review continues rather than waiting until the end of the Lookback Process. She referenced specific changes to the Trust MDM meetings not only for urology but also for all cancer tumour groups. She offered to share a summary of improvements if Patient 35's Wife and Patient 35's Son wish to receive a copy

**Action:** Clarify if cancer MDM summary document

Patient 35's Son expressed his gratitude for the time taken for the meeting and for apology given. He advised this meeting has helped them to understand what happened. Patient 35's Wife expressed the devastation she felt at losing Patient 35 then receiving the news that there was issues with his care.

Margaret explained she hoped that both Patient 35's Wife and Patient 35's Son could understand the approach we took to inform them of the findings as we felt it would cause too much upset and distress in a letter without offering the option to speak first. Patient 35's Wife and Patient 35's Son both agreed they were grateful of the options given to them.

## Conclusion

Mark expressed his hope that Patient 35's Wife and Patient 35's Son now had a better understanding of Mr Patient 35's care and appreciated the difficulty in hearing the issues that had been found.

Margaret also reiterated that the offer of further meetings is always open at any time and again offered a further sincere apology to Patient 35's Wife and Patient 35's Son on behalf of the Trust for the care Patient 35 received.

## Next Steps

- Sarah will draft a summary of the meeting today and send to Patient 35's Wife and Patient 35's Son for review and comment before being finalised
- When this summary is finalised it will be formally issued to Patient 35's Wife and Patient 35's Son as a record of the meeting. This will include a copy changes made to improve the effectiveness of the MDMs if desired.
- The Team will ascertain when the MDM Process officially commenced in Northern Ireland and feedback to Patient 35's Wife and Patient 35's Son

|                                   | Date     | Clinical Notes                                                                                                                                                                      |
|-----------------------------------|----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| →                                 |          |                                                                                                                                                                                     |
| Age                               | 13.10.08 | TELEPHONE CONSULTATION                                                                                                                                                              |
| URINE Protein<br>Sugar<br>Acetone |          | LUTS                                                                                                                                                                                |
| WEIGHT<br>kg.                     |          | <ul style="list-style-type: none"> <li>• POSTMICTURITIONAL DRIBBLING</li> <li>• NOCTURIA X 1-3</li> </ul>                                                                           |
| →                                 |          | PERSISTENT LEFT LOIN PAIN                                                                                                                                                           |
| Age                               |          | PLAN                                                                                                                                                                                |
| URINE Protein<br>Sugar<br>Acetone |          | * CT CHEST, ABDOMEN + PELVIS                                                                                                                                                        |
| WEIGHT<br>kg.                     |          | * REVIEW 24.10.08                                                                                                                                                                   |
| →                                 |          | <div style="background-color: black; width: 100%; height: 100%; text-align: center; color: white; font-size: 0.8em;">           Personal Information redacted by USI         </div> |
| Age                               |          |                                                                                                                                                                                     |
| URINE Protein<br>Sugar<br>Acetone | 24.10.08 | CT ON 24.10.08                                                                                                                                                                      |
| WEIGHT<br>kg.                     |          | <ul style="list-style-type: none"> <li>• EXOPHYTIC, SMOOTHLY ROUNDED,</li> <li>? CYSTIC LESION ARISING FROM POSTERIOR CORTEX OF LEFT KIDNEY</li> </ul>                              |
| →                                 |          | <ul style="list-style-type: none"> <li>• DENSITY 42 HU</li> <li>• MINIMAL ENHANCEMENT TO 45 HU</li> </ul>                                                                           |
| Age                               |          |                                                                                                                                                                                     |
| URINE Protein<br>Sugar<br>Acetone |          |                                                                                                                                                                                     |
| WEIGHT<br>kg.                     |          | LEFT LOIN PAIN IS WELL LOCALISED TO AREA OF LESION, IS CONSTANT, DATES BACK TO PRIOR TO ASPIRATION OF CYST IN 2005                                                                  |

# IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label  
or Enter in  
Block Letters  
Full Name  
Date of Birth  
Unit No.  
Ward/Dept.  
Address  
Consultant

## NOTES

When used for In-patient follow-up ignore left-hand column

| Out-Patient<br>Use Only           | Date | Clinical Notes                                             |
|-----------------------------------|------|------------------------------------------------------------|
| →                                 |      | AND COULD VERY WELL BE DUE<br>TO IT.                       |
| Age                               |      |                                                            |
| URINE Protein<br>Sugar<br>Acetone |      | TAKES COCODAMOL PRN                                        |
| WEIGHT<br>kg.                     |      | ? CAUSE OF FATIGUE                                         |
| →                                 |      | SIGNIFICANT OBSTRUCTIVE AND<br>IRRITATIVE LESIONS          |
| Age                               |      |                                                            |
| URINE Protein<br>Sugar<br>Acetone |      | Q: MODERATELY ENLARGED PROSTATE<br>- CLINICALLY BENIGN     |
| WEIGHT<br>kg.                     |      | P<br>FLON                                                  |
| →                                 |      | • U/E: CREATININE 93<br>• GLUCOSE = 5.3<br>• PSA = 3.47 ↓  |
| Age                               |      |                                                            |
| URINE Protein<br>Sugar<br>Acetone |      | • MSSU = NAT                                               |
| WEIGHT<br>kg.                     |      | • P. GIMSULOSIN 400 MGS DAILY<br>AND<br>PARACETAMOL 1 G BD |



|                                   |  | Date     | Clinical Notes          |
|-----------------------------------|--|----------|-------------------------|
| →                                 |  | 19/7/19. | AO'BRIEN                |
| Age                               |  |          | Urology                 |
| URINE Protein<br>Sugar<br>Acetone |  |          | LUNGS                   |
| WEIGHT<br>kg.                     |  |          | • NOCTURIA x 2-3        |
|                                   |  |          | • RECENT HEMATURIA      |
| →                                 |  |          | PLAN                    |
| Age                               |  |          | RX BICARUTAMIDE 150 MGS |
| URINE Protein<br>Sugar<br>Acetone |  |          | AND                     |
| WEIGHT<br>kg.                     |  |          | TAMOXIFEN 10 MGS        |
|                                   |  |          | • BONE SCAN             |
|                                   |  |          | • CT - CAP              |
| →                                 |  |          | • REVIEW                |
| Age                               |  |          |                         |
| URINE Protein<br>Sugar<br>Acetone |  |          |                         |
| WEIGHT<br>kg.                     |  |          |                         |
| →                                 |  |          |                         |
| Age                               |  |          |                         |
| URINE Protein<br>Sugar<br>Acetone |  |          |                         |
| WEIGHT<br>kg.                     |  |          |                         |
|                                   |  |          |                         |
|                                   |  |          |                         |
|                                   |  |          |                         |

Personal Information redacted by the USI

# IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label  
or Enter in  
Block Letters  
Full Name  
Date of Birth  
Unit No.  
Ward/Dept.  
Address  
Consultant

Personal Information  
redacted by USI  
HCN  
Patient 35  
Personal Information  
redacted by USI

Personal Information  
redacted by USI  
HCN

## NOTES

When used for In-patient follow-up ignore left-hand column

| Out-Patient<br>Use Only           | Date    | Clinical Notes                                       |
|-----------------------------------|---------|------------------------------------------------------|
| →                                 | 30/8/19 | MR. A. O'BRIEN<br>UROLOGY OPD<br>CAH                 |
| Age                               |         |                                                      |
| URINE Protein<br>Sugar<br>Acetone |         |                                                      |
| WEIGHT<br>kg.                     |         | PSA ↓ 2.0 ON 28 AUG 19                               |
| →                                 |         | FIRMAGON (DEGAREUX) 240 MGS<br>ADMINISTERED          |
| Age                               |         | PLAN                                                 |
| URINE Protein<br>Sugar<br>Acetone |         | • REDUCE DOSE OF BICALUTAMIDE<br>TO 50 MGS DAILY     |
| WEIGHT<br>kg.                     |         | • R/ LEUPROREUN 3.75 MGS<br>FIRST WEEK OF<br>OCTOBER |
| →                                 |         | • REFER TO (ONCOLOGY)                                |
| Age                               |         | • REVIEW NOVEMBER 2019                               |
| URINE Protein<br>Sugar<br>Acetone |         |                                                      |
| WEIGHT<br>kg.                     |         |                                                      |

Personal Information redacted by USI

7 February 2017

A

**FILE REFERENCE: 4**

B

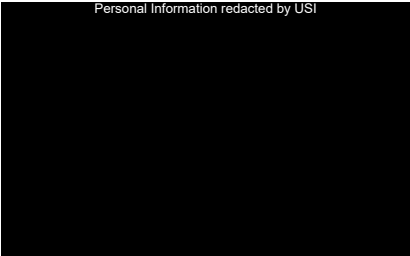
**AIDAN O'BRIEN  
(JOHN WILKINSON)**

C

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Audio Transcription Prepared by:

Personal Information redacted by USI



D

E

F

G

H

A JOHN WILKINSON: Hello, how are you?  
 A MR O'BRIEN: Hello John, I am Aidan O'Brien and this is my son Michael.  
 A JOHN WILKINSON: Good to meet you and good to meet you too. Did Jennifer ask you for  
coffee or tea or anything?  
 A Mr O'Brien: She did but we are fine.  
 B (Inaudible)  
 B JOHN WILKINSON: Personal Information redacted by USI ?  
 B MICHAEL O'BRIEN: Personal Information redacted by USI  
just yet.  
 C JOHN WILKINSON: You don't know (name unclear) do you?  
 C MICHAEL O'BRIEN: I know of him but I don't know him. He would be a few generations  
ahead of me  
 C JOHN WILKINSON: He went to school with me (inaudible). He played a bit of rugby with  
me and wonder do you know, I only know these people because my son's in this business – is  
 D it Personal Information redacted by USI He is a local guy from Personal Information redacted by USI has been involved in bits and pieces that I  
have been involved in, I do not mean personally.  
 D MICHAEL O'BRIEN: Witnesses and so on  
 D JOHN WILKINSON: Yes witnesses and stuff.  
 E JOHN WILKINSON: I am pleased to meet and I am not pleased to meet you if you can  
 understand what I am saying. It has been a very traumatic time for you and your family.  
 I am well aware of that.  
 F MR O'BRIEN: First of all, actually how are you?  
 F JOHN WILKINSON: Poorly. I thought I was over this. It just keeps coming back you know.  
 So I am hot and bothered. Sorry, you have to excuse --  
 F MR O'BRIEN: It's some kind of Personal Information redacted by the USI or something that you've had?  
 G JOHN WILKINSON: It must be because I have had this since the beginning of December.  
 You know. But last week it really did wipe me out because I'm helping a couple of  
 G schools of Belfast that you will have heard of in the news and I had to leave at 1 o'clock on  
 Monday and come home. I couldn't --  
 G MR O'BRIEN: Function.  
 H JOHN WILKINSON: You know. But sure.  
 H MR O'BRIEN: But you are bit better than you were when I last spoke to you?  
 H JOHN WILKINSON: I am indeed but that's what happens. Illness is a wonderful thing.  
 H MICHAEL O'BRIEN: Take some time out and properly recover.

A JOHN WILKINSON: That's what my wife -- my wife hid the keys on me last week because I was off on the Monday and the Tuesday. I promised Roberta that I would -- she was at something that she couldn't avoid being at, and I promised her that I would present certificates to people over in Trust here. So I got out of my bed and came across but Personal Information redacted by she hid my car keys and the only way I could escape was to find the spare set of car keys in order to get out. You know. So I was not flavour of the month.

B MICHAEL O'BRIEN: That's the lesson I learned when I get sick. Instead of soldiering on for two weeks and carrying it out, take a couple of days and you'd be much better for it.

JOHN WILKINSON: Take the time out. I know. I know.

MICHAEL O'BRIEN: (Inaudible) watch television.

C JOHN WILKINSON: I have got documentation. As you know I'm the appointed NED In this situation. I have got the documentation that you would have received. So I am fairly well up to speed with where things are sitting presently. My role, as you would know, is to facilitate, to expedite, to carry to the investigating panel, or whoever, your concerns and represent you to them directly and to keep pushing to efficiently and effectively get this seen to. So that is -- you would have received that information, would you not, about what my role --

D my role --

MR O'BRIEN: Yes.

MICHAEL O'BRIEN: That's the guideline and so on.

E JOHN WILKINSON: That's guideline but paraphrasing it, as far as I can see, that's what my role is. So I am here at your disposal.

MICHAEL O'BRIEN: Okay.

JOHN WILKINSON: You can abuse me as much as you want.

F MICHAEL O'BRIEN: We thought about how we would approach that. We have typed out some of the points.

JOHN WILKINSON: Good.

MICHAEL O'BRIEN: So I will give you a copy of that first all.

JOHN WILKINSON: That's fine.

G MICHAEL O'BRIEN: It is really just broadly considered in three stages really.

JOHN WILKINSON: Okay.

MICHAEL O'BRIEN: So.

JOHN WILKINSON: Yes. We are moved into the formal investigation process.

H MICHAEL O'BRIEN: It has but it's just that it seemed to be -- it is unclear at this point what effect that letter of March 23 had. I don't know whether you have seen that letter from 23 March 2016. We have a copy of it somewhere. It will be best maybe if you explain

how that letter came about, dad.

A JOHN WILKINSON: 23 March. No.

MR O'BRIEN: No.

JOHN WILKINSON: 22 December, 30 December, no.

MICHAEL O'BRIEN: Okay.

B JOHN WILKINSON: That must have been one of the initial things.

MICHAEL O'BRIEN: One of the things that when there was the meeting of 30 December, I didn't go to that meeting, my mother attended with dad, but this was raised as it was suggested that there had been a previous attempt to deal with this matter informally.

JOHN WILKINSON: Yes.

C MICHAEL O'BRIEN: You will see that in the letter from Dr Wright, which is dated about the 12th or something of January.

MR O'BRIEN: Mmm.

MICHAEL O'BRIEN: I suppose we're not sure what the impact of this letter has been on the

D Trust's decision making so far because in the meeting of 30 December and in the letter that follows it would seem to be framed that this was an informal approach to resolve the issues, didn't yield results and now we've had to escalate it. If you can see that first letter.

MR O'BRIEN: Mmm.

JOHN WILKINSON: This is this one?

E MICHAEL O'BRIEN: And then there was the letter of --

MR O'BRIEN: Yeah, 6 January from Dr Wright.

JOHN WILKINSON: Hold on.

MR O'BRIEN: You've got it.

F JOHN WILKINSON: Just wait until I see. Yes, I have.

MICHAEL O'BRIEN: The letter it's referenced do you see in that.

JOHN WILKINSON: Yes.

MICHAEL O'BRIEN: Prelude to it all.

JOHN WILKINSON: That's right.

G MICHAEL O'BRIEN: And one of the major -- we do include what it is that we are concerned about there. It's not a -- that letter is not an informal approach under the guidelines. You will know how the informal approach ~~brooch~~ works under the MHPS, that it involves bringing about a local action plan and taking the time to go through, what's the problem

H and what are the issues that are giving rise to this difficulty.

JOHN WILKINSON: Yes.

MICHAEL O'BRIEN: And considering ways to resolve it.

A JOHN WILKINSON: Yes.

A MICHAEL O'BRIEN: None of that happened.

JOHN WILKINSON: Okay. I am just scribbling for my --

MR O'BRIEN: You scribble away.

B MICHAEL O'BRIEN: Issues were raised and there were more issues in that letter than had gone forward to the investigation. There's another issue around a review back log. That isn't part of the investigation if you see part 2.

JOHN WILKINSON: Yes.

C MICHAEL O'BRIEN: And that was being dealt with as well. But untriaged referrals, which were those -- a point. The point 3 patient --

C JOHN WILKINSON: Patient centre letters?

MICHAEL O'BRIEN: -- letters, so that's part of the investigation and over the page notes at the home.

JOHN WILKINSON: Yes.

D MICHAEL O'BRIEN: So we are unclear as to how this feeds into the investigation that's ongoing now.

JOHN WILKINSON: Okay.

E MICHAEL O'BRIEN: In the first place, this must have arisen out of something, this letter. We have included a number of questions about what was -- was there a complaint made that led to this letter being issued? Was there an investigation completed prior to that letter, because you'll see that there is a note taken of a number of untriaged letters and a review of the review back log. So that's not something that you're just going to get off a list. Something like that, somebody has gone and looked into that.

F JOHN WILKINSON: Yes.

MICHAEL O'BRIEN: Was there a decision-making process with a clinical manager with a medical director and the director of human resources, that's what happen under the MHPS, to undertake an informal approach. Was that decision taken?

G JOHN WILKINSON: Right, okay.

MICHAEL O'BRIEN: Because this certainly is not an informal approach. Why was this approach taken whatever it is? Why did they do it? Why did they not try to address it by bringing up a plan to deal with it?

H JOHN WILKINSON: You have detailed these questions here on the second part of that first page, isn't that right?

MR O'BRIEN: Yes.

JOHN WILKINSON: Yes. But that's good.

A MICHAEL O'BRIEN: Basically, we raised what the concerns are about it and then there are a number of questions that follow it.

JOHN WILKINSON: Yes.

MICHAEL O'BRIEN: Another issue about the letter and --

B JOHN WILKINSON: Just for me, because I have not got a medical background obviously, so I just want to make sure that I am getting this correctly.

This letter, which was dated 23 March, and I am putting it in my colloquial terms, this will set it out much more clearly, this letter has signalled four issues now, four issues, and really what you're saying is in order to get level of detail someone has either made a complaint or the board have undertaken an investigation of its own accord without signalling this to yourself. And if this is the case, then is it -- was it implemented under an informal investigation or was it implemented under a formal investigation or (inaudible) any case, what case?

C

~~MICHAEL O'BRIEN~~ JOHN WILKINSON: And what is it? Yes. And then I am coming at it from probably a similar point of view as you are, in the sense that I see how guidelines work, and I have done employment cases and there's a lot of unusual activity it seems me over the last nine months with regard to this in the way it has been handled. Because after 23 March there is nine months of radio silence.

D

MR O'BRIEN: Absolute.

E JOHN WILKINSON: Yes.

MICHAEL O'BRIEN: Nothing else comes up. I don't know if you know then but dad was on leave from November.

JOHN WILKINSON: Yes, I do know.

F MICHAEL O'BRIEN: Due to come back in January.

MR O'BRIEN: Well, that was my decision but it was premature.

JOHN WILKINSON: You are going to occupational health?

MR O'BRIEN: On Thursday.

JOHN WILKINSON: Yes, good.

G MICHAEL O'BRIEN: And then called into a meeting.

JOHN WILKINSON: And then immediately --

MICHAEL O'BRIEN: That was it. On 30 December there was a meeting. But we'll come to that.

H JOHN WILKINSON: Okay. No, that gives me -- I understand that. I am at pains to represent you properly. That's why I am rehearsing it again so that I get it (inaudible). Is that all right?



MICHAEL O'BRIEN: Absolutely.

MR O'BRIEN: Can I just say that in addition to the radio silence the lack of any kind of plan, even any kind of query as to how these issues raised in the letter of 23 March have arisen, what is the cause of them, how can we alleviate them, how can we draw up a plan to resolve them to bring them to an end, anything of that nature. I would like to add in the clinical context, which I do appreciate we are not here to do, but the clinical context is that I am running as fast as I can to do as much work as is possible, particularly in the field of operating. At that stage I had approximately 280-odd patients awaiting on my waiting list for in-patient admission for surgery, dating back to February 2014. And using every available operating session that comes up. In fact, actually I haven't missed one available operating session that could be availed of. Even when I leave I came in to do this. In addition to doing additional lists or review clinics to address the back log, particularly of cancer patients and so forth.

And I have been asked since the meeting of 30 December you know, did you response to this? My response to was to try to do as much as possible to address the clinical priorities of the day in every day that transpired since then. And if I had been relieved some of that pressure and expectation in some kind of planned manner to address these issues, they could have been addressed but none of that happened.

JOHN WILKINSON: Okay.

MR O'BRIEN: And whilst I entirely appreciate from a procedural point of view that your remit is in a very restrictive manner restricted to the formal investigative process as it initiated on 30 December, it seems me that it is inappropriate to begin there rather than 23 March and look at a nine-month period during which I was struggling health-wise as well. I mean, I should have been off having my surgery in the spring time and I put it off for as long as possible until I simply was fearful that I wouldn't be able to pass urine anymore and was having at times agonising pain in doing so.

So it is a major bone of contention on my part that when I was handed this letter and I asked in these words, what I am to do? And the response was a silent shrug of the shoulder. And that letter told me nothing other than what I knew already, do you know, which were already concerns to me. The greater concern to me but wasn't even on the letter, which is the enormous numbers of people who are suffering poor clinical outcomes because of the length of time that they are waiting to be operated on.

So that is the clinical context in which is placed our concerns about the entire process to date beginning in March and the lack of any informal process whatsoever.

JOHN WILKINSON: To address the issues --

~~MICHAEL~~ MR O'BRIEN: Absolutely.

A JOHN WILKINSON: -- (inaudible) identified. I think that sort of information I have read.

MICHAEL O'BRIEN: There was a letter.

JOHN WILKINSON: There was a letter, wasn't there, that detailed that type of information because what struck me was you said there was a shrug of the shoulders.

B MR O'BRIEN: That's right.

JOHN WILKINSON: -- in the letter it said --

MICHAEL O'BRIEN: That was in the minutes of the meeting.

JOHN WILKINSON: -- the eyes were rolled or something.

MR O'BRIEN: I never claimed that. I am going to correct that as a factual error.

C JOHN WILKINSON: I am just saying I recognise the sentiments if you understand that.

MICHAEL O'BRIEN: If you were coming at this even from a non-clinical background and you were presented, say, from a Trust perspective in March that there a problem with letters not being triage, there is a review back log and there is a question of whether all records of being kept of consultations and so on, would the first question you'd ask not be, why is this happening? That is what I find unbelievable. There is no enquiry. What is the problem here? Are you finding some difficulty with it? This letter doesn't include that.

D If you are thinking about a suggestion that somebody isn't doing all that they are meant to do, which is what fundamentally it comes down to, there is a question -- it really can be one of two things. Either the person is overworked and they can't get round to doing all the things they are meant to do, or else they are taking their foot off the peddle so to speak.

E And this letter it starts off by saying:

F "We are fully aware and appreciate all the hard work, dedication, time spent during the course of your week."

Because it is known that he is working 60/70 hours a week.

JOHN WILKINSON: Yes.

G MICHAEL O'BRIEN: You know, 50 per cent more that he is contracted to do. So they know it's not because he's not relaxing. You know, this -- these problems they are not something that you can just resolve in an afternoon or a day. It will (inaudible) take time off (inaudible).

JOHN WILKINSON: Can I take you back just a little bit because I understand what you are saying and as I read -- I can't give opinion or views.

H MICHAEL O'BRIEN: I understand that.

JOHN WILKINSON: But it's very difficult to restrain oneself. Suffice to say that you will be

A given, this is what I need to clarify with you, you will be given an opportunity to describe the mitigating -- I am not following up a prepared speech here. This is just the way I am, but you will be given an opportunity to describe in detail the mitigating circumstances which may have led to the situation in which you have found yourself. Now, recognising that that is the case, what is it that you want from me now in particular? To make

B representations -- do you understand what I am saying?

MR O'BRIEN: Yes, I do.

MICHAEL O'BRIEN: The representation that we make fundamentally is that in March they should have taken an informal process. They should have undertaken that with an action plan to resolve the issue. Having failed to do so, why aren't they doing it now? You

C know, I made that point to Mr Weir on our last meeting. He is tasked to investigate it and that's his role as well. But we will be at every point making that issue, that point because if there was a missed opportunity to deal with it in a collaborative fashion when you are dealing with somebody who you recognise from the get-go is working so hard. That's

D the -- I find it incongruous that you have something that is not even a warning and then not followed up. ~~Can~~, can be escalated to a full formal investigation under these processes.

MR O'BRIEN: Could I just also say that if you look at this logically, if this was in the eyes or in the views of some people an informal attempt, then --

JOHN WILKINSON: Sorry, if this was an informal attempt?

E MR O'BRIEN: Yes. Grave as the issues are it was considered appropriate to attempt to raise it, we'll say informally, and not formally. I can only come to the conclusion that it was believed, particularly by an oversight group and maybe particularly by the medical director by December of this year, that it had to become formal because some kind of informal

F attempt or process had failed but there was no informal process.

JOHN WILKINSON: Yes. Okay.

MR O'BRIEN: I think that's a very important issue.

MICHAEL O'BRIEN: You can come to that view whenever you read that correspondence on

G 6 January, or as I understand happened on 30 December it was mentioned we tried to (inaudible) this informally before and we were unsuccessful, so now we're taking it to the next stage.

JOHN WILKINSON: But at no stage were you told that it was -- there was an informal --

MR O'BRIEN: No, nothing.

H MICHAEL O'BRIEN: No. And this is (inaudible), and I've seen hundreds of warnings and so on in my time.

MR O'BRIEN: In fact, I was called to meet with Mr ~~Mackelell~~ and with Martina Corrigan,

A who was standing in for Heather Trouton, who is assist the co-signatory, and Eamon said, I just wanted to meet you because we had a number of concerns, four of them, and he named off three of them. He couldn't remember the fourth. He said you know we thought it would be nicer to meet you just to face to face rather than sending you a letter. So he opened the envelope to find out which what the fourth one and he give it to me. And I

B read it and I asked, what I am to do? What do you want me to do? And the answer was and that was it. That's the informal process.

MICHAEL O'BRIEN: It is also relevant that --

JOHN WILKINSON: Can I interrupt you because that's very important that you're saying -- you are saying that was the informal process?

C MR O'BRIEN: Is it?

MICHAEL O'BRIEN: Well, it's not though.

JOHN WILKINSON: That's what I'm saying. You're saying it would seem that that was the informal process but nowhere was it described to you, because I would know from my

D business and in schools if I had meeting with someone and there's an issue, I would say to them, look, we are now meeting under the informal --

MR O'BRIEN: No, no. Nothing like that.

MICHAEL O'BRIEN: Exactly.

JOHN WILKINSON: So there nothing?

E MR O'BRIEN: Nothing like that.

JOHN WILKINSON: Intimated to you about that?

MR O'BRIEN: Nothing. Nothing.

MICHAEL O'BRIEN: So it's not an informal process.

F JOHN WILKINSON: Okay.

MICHAEL O'BRIEN: It isn't. Our concern is that it has been treated as one.

JOHN WILKINSON: Okay. It's been treated as one and then escalated a formal process.

MR O'BRIEN: Yes.

JOHN WILKINSON: Your position would be that before it reached this formal process it

G should have gone through an informal process.

MR O'BRIEN: Of course.

MICHAEL O'BRIEN: (Inaudible) supposed to.

JOHN WILKINSON: Bearing in mind some of the statements, like we "we fully appreciate

H all the hard work" et cetera.

MR O'BRIEN: Yes.

JOHN WILKINSON: Isn't that what you're saying?

MICHAEL O'BRIEN: That's exactly.

JOHN WILKINSON: Okay.

MICHAEL O'BRIEN: There is also another issue with regard to this meeting and that is that, whilst we don't want to personalise the issue, Mr Macklee should not have been involved at all because my father had had a formal grievance against Mr Macklee. Now that grievance was stayed effectively.

MR O'BRIEN: I suspended it because Personal information redacted by the USI and with the -- on condition that I could initiate it again at any time in the future, which I haven't done. And, you know, one can only speculate as to whether this letter would have been followed up with some kind of informal attempt to resolve the issues had it been someone other than Eamon Macklee, but, in a sense, that's secondary to the fact that there was no informal process.

JOHN WILKINSON: Okay. But so you're -- I've got the first scenario. The second scenario is that there was a case sitting with regards -- as it were, suspended by you against Mr Macklee and he was -- is he your direct line manager?

MR O'BRIEN: Not my first line manager. The lead clinician is Mr Young.

JOHN WILKINSON: Sorry, I do know him. That's a problem for you?

MR O'BRIEN: No, it's not at all. No.

JOHN WILKINSON: Irrelevant information redacted by the USI

[REDACTED]  
[REDACTED]  
[REDACTED] So as long as there is no problem for you.

MR O'BRIEN: No. None whatsoever.

JOHN WILKINSON: Okay. Right. So there was -- if we look at it then, he was a couple of --

MR O'BRIEN: People about that, yes, associate medical director, yes.

JOHN WILKINSON: All right.

MR O'BRIEN: At that time. He's no longer.

JOHN WILKINSON: Right. Okay

MICHAEL O'BRIEN: But it had also been agreed at that time of the -- around that time the grievances were being issued that he would have no dealings with him again.

MR O'BRIEN: Yes. I sought and obtained an assurance from Dr Rankin and from Eamon Macklee himself, particularly from Dr Rankin, that I would have no more dealings or meetings with him because I was on the point of breakdown as a consequence of his treatment over a period of years. But anyhow, as I said to you --

A JOHN WILKINSON: Was this agreement before this letter was issued?

MR O'BRIEN: Absolutely. Years before, yes.

MICHAEL O'BRIEN: And it had never been broken before.

MR O'BRIEN: No.

JOHN WILKINSON: Fine. That's okay.

B MICHAEL O'BRIEN: That would be -- it would seem inappropriate that he would be involved at all.

JOHN WILKINSON: Yes.

C MICHAEL O'BRIEN: That point is in the first page. So there are a number of questions that arose out of it. Was MHPS actually involved in the decision to issue this letter? I am not sure on that at all.

JOHN WILKINSON: Okay.

D MICHAEL O'BRIEN: If a decision was taken under MHPS it would have had to have involved the medical director, wouldn't it? (Inaudible) ~~B~~ because it would go to an oversight committee in the same way.

~~JOHN WILKINSON:~~ MICHAEL O'BRIEN But you had a meeting with the medical director about a week --

E MR O'BRIEN: Yes, just one week later, on 1 April 2016, on entirely unrelated issues. Two issues one was trying to improve the radiological input into our urology<sup>ical</sup> MDM. So that's completely unrelated to any of this. And the other one was that he was advising me to try to reduce my workload, which is an irony. My own view of this matter, and I am speculating, I don't believe that Dr Wright knew of the letter of 23 March at that time.

F And I suspect, it is just a suspicion, that he has been misadvised perhaps or misinformed as to there being an informal process when there definitely was no informal process.

JOHN WILKINSON: Okay.

MICHAEL O'BRIEN: You see the reason why that's interesting is because under the guidelines -- I'll find it in a second. At page 8 I think it is. Paragraph 15 does say that:

G "If an informal approach can address the problem whether a formal investigation is needed. This is a difficult decision. It should not be taken alone but in consultation with the medical director and the director of HR, taking advice from NCAS where necessary."

So it seemed that if it this was under MHPS it would probably have involved the medical director, so we doubt that it was at all.

H JOHN WILKINSON: Okay.

MICHAEL O'BRIEN: But that's the March 23 letter. We don't really how that fit into it all.

We would look like to know the answer to that.

A JOHN WILKINSON: You would like to know how that letter informed the future direction.  
MR O'BRIEN: Yes.  
MICHAEL O'BRIEN: Is the reason why we have a formal investigation now (inaudible)  
assumption that this was an informal process (inaudible). We've already made the point,  
you would love to have been able to deal with informally.

B MR O'BRIEN: Absolutely.  
MICHAEL O'BRIEN: And will continue --  
MR O'BRIEN: I would have absolutely. I mean, if it had been -- if I had sat down around a  
table like with the people involved to address these issues over a period of three months or  
six months or something of that nature December never have happened but that was never

C afforded me that opportunity.  
JOHN WILKINSON: Yes. Okay. Okay.  
MICHAEL O'BRIEN: I don't think there is anything else to say in the letter then of 23 March  
unless it occurs to you.

D JOHN WILKINSON: Just give me a second. I have got a -- I think I've got a grasp of the role  
that the letter plays and the impact of it. The impact that it has or has not had on the  
movement into the formal investigation.  
MICHAEL O'BRIEN: Yes.  
JOHN WILKINSON: Procedure.

E MICHAEL O'BRIEN: It is just that the way that letter on 6 January was framed it just does  
seem that that was that they believe:  
"As discussed you will recall that with we had previously attempted to address some  
of the issues regarding these administrative practices informally. However, this has been

F unsuccessful."  
You see in the normal course of things that appears to me to be a statement that we  
attempted to do this using informal processes. That has failed now we escalate it.  
JOHN WILKINSON: You have no letter which mentions informal --  
MICHAEL O'BRIEN: Not at all.

G JOHN WILKINSON: -- or formal an at early stage?  
MR O'BRIEN: And nothing following up from that at all.  
JOHN WILKINSON: Okay. Okay. I should have a copy of that 23rd. As I said say to you, I  
don't have it here.

H MICHAEL O'BRIEN: We can get it.  
MR O'BRIEN: I think this is my only copy of it.  
JOHN WILKINSON: You just hold on to it. You hold onto that.

MR O'BRIEN: But certainly human resource do have a copy of the letter. That I can tell you.

JOHN WILKINSON: I can source that. You go on ahead. Don't worry about me.

MICHAEL O'BRIEN: Moving on to the origin of the investigation itself. I suppose the confusion continues in a sense. That we are not really sure why the investigation -- what the origin of this current investigation is because it is also mentioned that it arises out of an SAI and the serious adverse incident appeared to be into a referral that was made by a radiologist. You explain that because I'll get that wrong.

MR O'BRIEN: Yes. The SAI, which I hope I have here, so the SAI basically concerns a lady who had been referred in October 2014 with, on the face of it, in the referral letter asked for an assessment of this lady with a history of bowel and breast cancer, and who -- and in whom an MRI scan has shown her to have a large simple right renal cyst and she's having right flank~~ed~~ pain basically.

For reasons that, I don't know, we can go into if you wish, but that's more the mitigating circumstances and the contextual, all of that, basically this lady was not -- she was referred as a routine referral. In my response to the draft report of the SAI investigative panel, if I had triaged it I would have kept it as a routine referral. She wasn't seen until January 2016 when she was seen by a colleague in January 2016. He realised that the referral referred to the wrong lesion on the same kidney. So this lady had a three lesions: a large simple cyst on the upper pole, a smaller simple cyst on the lower pole and in the front of the kidney a complex cyst with the potential that it could be malignant.

So she was seen in January 2016. When she was seen in January 2016 that was appreciated~~\_-~~ ~~the~~ radiologist had somehow mistakenly and inappropriately reported and didn't make reference to that cyst. And following her initial consultation she had another CT scan done when she was found to have enlarged left axillary nodes. When they were~~-~~ ~~biopsy-ed~~,biopsed it was found that she had metastatic disease from her right breast carcinoma. So she underwent removal surgically of these nodes followed by chemotherapy and radiotherapy.

That deferred her renal surgery, which was of lesser importance until October 31 or 30 October and when she had that lesion removed from her right kidney it proved to a malignant lesion. My understanding is that that is when the SAI was initiated.

MICHAEL O'BRIEN: We think that's the case. But in the short form, basically, your involvement in it -- there are a number of different specialities involved in it -- but your involvement in the SAI was that the referral was made to. That it was ~~untriaged~~ un-  
triaged~~\_-~~

MR O'BRIEN: The referral wasn't made to me. The referral was received by the Trust during



A my week ~~asef~~ urologist of the week and I didn't have time to triage it. If I had triaged it, I would have kept it as routine anyhow. But there was a whole catalogue of failings of the part of radiology and other clinicians who were looking after her to refer her but basically -- I mean, I can afford you with a copy of my report and all of that there.

B But I think that what we are concerned about is the relationship between the investigation of the serious adverse incident and this formal investigation.

MICHAEL O'BRIEN: Insofar as it relates to the concerns that are the subject of the investigation, it only relates to triage. That's the issue that arises out of the SAI.

JOHN WILKINSON: Is that the -- really the only time really that you were involved in that case? Is that what you were saying? That during that triage period you --

C MR O'BRIEN: I didn't triage the letter.

JOHN WILKINSON: You didn't triage the letter.

MR O'BRIEN: I've never met the patient.

JOHN WILKINSON: No. And that was due to pressure of work and so forth.

D MR O'BRIEN: Of course, yes.

JOHN WILKINSON: Then subsequent to that letter being received by the Trust, the lady came through another avenue.

E MR O'BRIEN: No. They are just dealt with in chronological order and there was effectively a 60 something week interval for a routine referral to be seen. So she was seen for the first time by one of my colleagues in January 2016. He decided to restage her. That raised the enlarged lymph nodes which was entirely a consequence of her breast carcinoma, which is really you know a dominant issue in terms of her long-term survival and so forth, and that -- she had her renal surgery deferred until the last Friday of October. That is either F 30 October or 31 October. So she had this lesion removed. The removal of it, the overwhelming probability is its removal has been curative.

G I am unclear as to why the SAI was initiated. Was it initiated because of radiological mistakes in reportage or was it initiated by urology? I don't know who initiated it. But it is interesting that before the SAI is even complete, and in effect it hasn't been completed yet because it was the second week of January that I received the final draft report for my comments -- every clinician would have been equally so. Before it has even reached that stage it is brought to the attention of the medical director, who then becomes aware, it seems to me, of these issues raised in the letter of 23 March and all of a sudden there's a H formal investigation.

JOHN WILKINSON: Okay.

MICHAEL O'BRIEN: The only involvement my dad has in the SAI is that the urologist of the

A week, which is on a rota basis of all the consultants in the department, they do the triage of all of referrals. It is not specific to them. They just do them. Then once they are triaged, they can be go to anyone just in chronological order. It was referred to dad as a routine referral and then, because he didn't triage it, it was treated as a routine referral. I suppose the only involvement would have been, was this a missed opportunity to catch something that had been missed elsewhere?

B But why we are raising that is the suggestion is that this investigation flows from SAI.

JOHN WILKINSON: Yes.

C MICHAEL O'BRIEN: Now, the SAI, dad's involvement in it, is quite minimum in that sense because he didn't have an involvement.

MR O'BRIEN: I didn't have an involvement at all.

D MICHAEL O'BRIEN: It suggests he should have had an involvement in it but in so far as that involvement is there it is to do with triage. Now you will know that in December the investigation that has commenced is much more expansive than that. So it is unclear how that investigation with its scope commences. Why is not simply an investigation into triage? Why is it an investigation into all administrative practices. Maybe it is the March letter. It could well be but we don't know what's the nature of the complaint.

JOHN WILKINSON: Okay.

E ~~JOHN WILKINSON:~~ [MICHAEL O'BRIEN](#) There's a couple of issues around that.

JOHN WILKINSON: The nature of which complaint?

~~MR~~ [MICHAEL](#) O'BRIEN: The complaint that leads to the investigation of the 30 December, whatever it is. We don't know the nature of it at all. How does it come from SAI that does not report until 13 January?

F JOHN WILKINSON: Yes.

MICHAEL O'BRIEN: Because the SAI doesn't have any report until 13 January.

MR O'BRIEN: That's right, yes.

G MICHAEL O'BRIEN: And that's only a preliminary report awaiting the comments of the practitioners involved. So it's far from finalised.

MR O'BRIEN: Yes.

JOHN WILKINSON: Yes. Have you got date there when that was supposed to be issued?

H MR O'BRIEN: I have got the letter from Esther ~~GKishkerry~~ [Gishkori](#) -That is here. So I received 13 January.

MICHAEL O'BRIEN: It is dated the 13th. This is when he gets the report for his comments.

MR O'BRIEN: Yes.

A MICHAEL O'BRIEN: How does that work, you know?

JOHN WILKINSON: Yeah, okay.

MICHAEL O'BRIEN: Was there --

B MR O'BRIEN: Why was the medical director, or anyone else, advised of the outcome of an SAI before the outcome is even finalised? These people wouldn't have been involved I presume in ~~the~~ well, they were not. The authors of the report are one of my colleagues, one radiologist, Christine Rankin, whom I don't know, an acting booking manager and Connie Connolly, lead nurse acute governance. So four people who are on the ground and I do not know how -- interesting.

C JOHN WILKINSON: Okay.

MICHAEL O'BRIEN: Regarding, if you say what is your position that we want to present, part of our position is that it is helpful if we start to understand what is really happening here. I supposed in that sense our position is, we would look more information (inaudible).

D JOHN WILKINSON: I don't know how I can comment on this. It seems to me -- first of all, there are two majors issues here that I can see. First of all, there is the terms of reference of the investigation, which you haven't probably got yet. I don't even know if they have been decided yet. Honestly don't know.

E MICHAEL O'BRIEN: I don't know. We haven't --

JOHN WILKINSON: So there's that. And it is not so much those terms of reference that you're looking for clarification on, which you will in due course I expect receive, but it's prior to that and the kicking in, if you excuse the phrase, of the investigation itself based on a SAI report which had not been finalised nor agreed, but which nevertheless seems to

F have instigated the investigation process.

MICHAEL O'BRIEN: Yes.

JOHN WILKINSON: Isn't that really what you're --

G MR O'BRIEN: I would add another layer to that in the other direction. When I read the final draft report of SAI I also had the impression that the linkage between the SAI, not yet complete, and the issues that are now being formally investigated have -- I think they have significantly impacted upon the final draft report of the SAI because all of the other missed ~~the~~ opportunities on the parts of a number of radiologist, going back to December 2012 in relation to this lady, and clinicians dealing with her bowel and breast cancer have all been

H minimised to human error and the reason for her delay is because I didn't triage her letter, which if I had done I would have kept as routine anyhow.

JOHN WILKINSON: Right, okay, I understand.

A MICHAEL O'BRIEN: So is there an osmosis (inaudible).  
 A MR O'BRIEN: So it seems to bi-directional.  
 JOHN WILKINSON: I understand what you are saying. I understand clearly. So now I haven't read this here obviously but I have -- I am happy with where I am on this but is this mentioned -- is this mentioned here?  
 B MR O'BRIEN: The SAI, yes.  
 JOHN WILKINSON: Yes, it is all mentioned here.  
 MICHAEL O'BRIEN: What we mention is -- we'll go through again just what the concerns were first.  
 JOHN WILKINSON: Okay.  
 C MICHAEL O'BRIEN: The issue of concern had been reported before the completion of the report itself.  
 JOHN WILKINSON: Okay.  
 MICHAEL O'BRIEN: Before given an opportunity to comment on it. So it would seem to be  
 D premature to launch a formal investigation arising out of an SAI that hasn't completed. Secondly, it's the fact that it only relates to triage. So if an investigation is triggered from a SAI, an SAI that refers to triage, why is the investigation considering other administrative matters. And then, ~~the~~ well, it is of the third issue. It is regarding the feed in of the 23 March letter.  
 E JOHN WILKINSON: No, that's fine.  
 MICHAEL O'BRIEN: So the questions, and they're all fairly direct, but it is all on those issues. So the questions that we are asking: what is the complaint, who made it, when is it made, in what form, what are the nature of the concerns that were made in that complaint?  
 F JOHN WILKINSON: Okay.  
 MICHAEL O'BRIEN: So it is really, how did we get here effectively?  
 JOHN WILKINSON: Yes.  
 MICHAEL O'BRIEN: I am interesting also in, if you see the -- going back to that letter of 6 January, once again we do have a presentation of some data regarding the issues.  
 G There's a number of untriaged letters.  
 JOHN WILKINSON: Yes.  
 MICHAEL O'BRIEN: 318. There's a note that there are 60 undated clinics. Approximately 600 patients. We don't know where those figures come from but was there an  
 H investigation that preceded 30 December that fed into this?  
 JOHN WILKINSON: Okay.  
 MICHAEL O'BRIEN: And who did it if that is the case.

A JOHN WILKINSON: I think that you have mentioned that earlier, the other point. I think you know.

MICHAEL O'BRIEN: (Inaudible) March and (inaudible) figures again. (Inaudible) coming up to 30 December.

B JOHN WILKINSON: Yes. The other issue then is, at the point of 30 December we would like to know whether there was consideration given to the informal approach. There would have been -- an oversight committee met, I believe it was the day before.

MR O'BRIEN: I don't know.

C MICHAEL O'BRIEN: We don't know exactly but the days that led up to 30 December the oversight committee met and they would have to consider which way to go. It would be interesting to know whether they did consider an informal approach and, if they did, why was it deemed inappropriate? Did the March 23 letter have an impact upon that? And also flowing from that, what was the actual rationale for the immediate exclusion?

JOHN WILKINSON: Okay. Yes.

D MICHAEL O'BRIEN: Because what we have is, again that letter of 6 January, it simply says:

"This is a precautionary measure and is to protect you from any further concerns being raised, to protect the interests of patients and to assist the investigative process which is (reading to the words)."

E Reading out the headlines of why an exclusion can be put in place, but, as you know from these processes, exclusion is supposed to be an exceptional measure.

It is unclear -- it was never made clear, what is it about your practice that you thought that would actually (inaudible) and what alternatives were considered to exclusion? Could we have had some sort of oversight in the meantime because that was by far and away the

F most damaging aspect of the last six week-

MR O'BRIEN: Yes.

MICHAEL O'BRIEN: I mean, it was devastating.

JOHN WILKINSON: Look I can (inaudible) convince me of that. I understand that.

G MR O'BRIEN: It's the most awful experience I have ever had in my life and I am including in that, you know, loss of parents and bereavement and so forth. Nothing compared to it. It is the most ...

JOHN WILKINSON: From a professional point of view, I can understand that entirely.

Entirely. Yes.

H MICHAEL O'BRIEN: It is just --

MR O'BRIEN: It's like been eviscerated.

JOHN WILKINSON: Yes. Yes.

A MR O'BRIEN: Terrible. Anyhow.

A MICHAEL O'BRIEN: Those are the questions really about the origins of the investigation.

JOHN WILKINSON: Okay. Yes.

MICHAEL O'BRIEN: The final area relates to the conduct of the investigation. Now, the Trust guidelines do say that the investigation must be completed within four weeks.

B JOHN WILKINSON: Yes.

B MICHAEL O'BRIEN: I don't know if you have the Trust guidelines.

JOHN WILKINSON: I have it here.

MICHAEL O'BRIEN: That's clear.

JOHN WILKINSON: Yes. You're not talking about -- are you talking about a scoping

C exercise that was done originally or are talking about --

MR O'BRIEN: No, the investigation must be completed within the four-week period of immediate exclusion.

MICHAEL O'BRIEN: There's no mention of scoping exercise.

D MR O'BRIEN: When I raised that in that correspondence that I sent to Dr Wright he replied that the guidelines create an expectation that the investigation would be complete within four weeks. It doesn't. The guidelines create a requirement.

JOHN WILKINSON: Yes, that's at the back of that. There is an appendix.

MICHAEL O'BRIEN: Appendix 2. It does say:

E "The case investigator must complete the investigation within four weeks and submit to the case manager with a deferral of five days."

That's from the appointment.

JOHN WILKINSON: Yes.

F MICHAEL O'BRIEN: They are supposed to be appointed at the point of the oversight committee meeting.

JOHN WILKINSON: Yes.

MICHAEL O'BRIEN: We are now -- the trust can rely on breach of contract. I have said that

G to Siobhan Hynds and Colin Weir on a week or two ago and it's acknowledged and this is just the way it is because all these cases tend to take longer than the four weeks. I don't understand how the Trust can knowingly be aware of an obligation to complete an investigation within four weeks and then proceed beyond it and almost without any regard to the impact of what they are doing from a contractual point of view.

H You know, as I said as well at the last meeting, so far as guidelines and so on are concerned, you do often get guidelines that say we will aim to have something done within.

A JOHN WILKINSON: A period of time.

A MICHAEL O'BRIEN: Or we will aim to do it as expeditiously as possible. I see that in an employee handbook. It is rare enough thing for the guidelines and contractual terms to say "it must be". But this arises out of a very heavily negotiated framework that was from the departments, the BMA, and they have concluded that the investigation must be completed

B within four weeks and it's a contractual term.

JOHN WILKINSON: For me, where is that (inaudible) bottom? The case investigator must complete the investigation within four weeks and submit the case (inaudible). Yes.

MICHAEL O'BRIEN: That's their procedure. It's very strange. When I raised that point, I mean, Colin Weir and Siobhan Hynds are (inaudible) people.

C JOHN WILKINSON: I have raised this point.

MICHAEL O'BRIEN: And they are trying to do their best, I have no doubt, but they don't seem to --

JOHN WILKINSON: I have raised the point. That's all I can say. I saw an advice as to the

D timescales that were in and around this sort of case. Knowing that, in my own business again, there is a timescale but it is not as rigorous as this. It would be "with agreement of". You know, consultation would have to take place in order to move out but it would give you that liberty to do so.

MICHAEL O'BRIEN: There be a wriggle room, a " save in exceptional circumstances".

E JOHN WILKINSON: That would be, yes.

MICHAEL O'BRIEN: Doesn't exist here.

JOHN WILKINSON: Okay.

MICHAEL O'BRIEN: I don't know. I think that we actually have to make clear that we don't

F accept that the Trust can do that because from your point of view you have to make clear that we can't accept it because we are not accepting that they can (inaudible).

JOHN WILKINSON: Have you mentioned that you are dissatisfied with the way in with the investigation has been conducted and that it should be --

G MR O'BRIEN: Did you have a copy of my letter --

MICHAEL O'BRIEN: Trust guidelines are mandatory.

JOHN WILKINSON: Must, must.

MICHAEL O'BRIEN: Must be completed in four weeks.

JOHN WILKINSON: That's fine. That's okay. That's fine.

H MICHAEL O'BRIEN: So we're not -- we don't accept that they can just do that.

MR O'BRIEN: Do you have a copy my letter that I wrote to Dr Wright in view of the fact that a non-executive director had not yet been appointed?

A JOHN WILKINSON: I do, yes. I did.

MR O'BRIEN: In which I said "it must be completed". That was into the third of the four weeks.

JOHN WILKINSON: Yes.

B MR O'BRIEN: When I myself contacted the case investigator to learn that he was having a first meeting with the representative from human resources on the penultimate day of the four-week period, Thursday 26 January, and that there was not even planned a meeting with me at all until sometime after that date.

JOHN WILKINSON: Yes, okay. Yes. The conduct of the investigation is concerning.

C MICHAEL O'BRIEN: And it is breach of contract so far as I can see. We mention that point at --

JOHN WILKINSON: You have it there.

MICHAEL O'BRIEN: That the case investigator and the HR people weren't supposed to meet until the 26th because of that letter they did move that forward and we eventually met

D them on the 24th, isn't that right?.

MR O'BRIEN: Yes.

MICHAEL O'BRIEN: So it was moved forward a couple of days and they did have their case conference on Thursday the 26th. We were advised that (inaudible) listed on the 27th.

E But it just shows you that it was that final week and the investigation is still in its infancy. And not wanting to drag you into it here, but you weren't even appointed.

JOHN WILKINSON: Then you can't.

MICHAEL O'BRIEN: (Inaudible).

JOHN WILKINSON: That's okay.

F MICHAEL O'BRIEN: (Inaudible) appointed for half the permitted time.

JOHN WILKINSON: Yes, absolutely.

MICHAEL O'BRIEN: The other issue that is somewhat that is somewhat (inaudible) is that you know that part of these investigations is a requirement of confidentiality and you will know that people have been told that dad is off on sick leave in an attempt to protect that

G privacy and the investigation is supposed to be handled in that way.

JOHN WILKINSON: I haven't been told that. Just to clarify that.

MICHAEL O'BRIEN: But that's the way it was dealt and that's smart. But even in general terms there's supposed to be confidentiality around the investigation. One point that's now

H concerning, we were told on 24 January that there is -- I can't remember the exact term that was used, but I think it was said "a team of investigators" involved in this case now.

JOHN WILKINSON: Right.



A MICHAEL O'BRIEN: It's so expansive that there's a multitude of people involved in this and that Colin Weir would effectively be validating the information that they present to him. We don't know the identity of these people. I raised that with Siobhan Hynds on the 24th that we would like to know who they are.

B MR O'BRIEN: One of the things that concerns me, as you may or may not I am being reviewed by occupational health on Thursday.

JOHN WILKINSON: Next Thursday.

C MR O'BRIEN: This Thursday, two days' time, at 2.30, and then I'm ~~hope~~-meeting with Siobhan Hynds and Dr Khan, the case manager, immediately afterwards, so I am travelling from Personal Information redacted by USI down to Daisy Hill to meet with Dr Khan because that is where he is based. One of the concerns I do have is -- I am meeting with him to be advised of the conditions of my return to work when I return to work.

D JOHN WILKINSON: Okay.

E MR O'BRIEN: I have already been advised by him informally by telephone, you know, that I am returning to my former role, that there are not going to be any restrictions on my clinical practice but there is going to be monitoring of some ~~time~~-kind. I do not know what that it is. But one of the things that does concern me, and I did undertake and I still undertake I have no desire whatsoever to impede or obstruct or interfere with any

F investigative process that is ongoing, even it should long since have been completed, but I do not know if I meet Joe Bloggs in the course of my work, are they investigating me or do I continue with the pretence that I have just returned from sick leave only. It would be helpful to know who is involved, like, for example, are there any other clinicians involved. That would be very helpful. Is there a nursing staff involved or is it purely administrative people involved?

G JOHN WILKINSON: Obviously I don't know the answer to that but you would like to know.

H MICHAEL O'BRIEN: We would like to know but also it is concerning with the number of people involved in it, how do they keep that confidentiality and privacy involved? The fundamental thing is this investigation is not -- it is probably not suitable for MHPS. It is outside the scope of MHPS what they are doing. They're taking an expansive look into all areas of administrative practice. They self-evidently can't do under the framework because they've already had to go beyond the timeframe in giving us an idea of when that will end. They have to have a multitude of people involved doing it. So it is just -- it is a question of the confidentiality around that reputational damage.

JOHN WILKINSON: Can I ask the question then with this regard to the investigation? (Inaudible) I know what you are saying. At no stage since the investigation proper has

A started have you been told when -- first of all, have you been told when the investigation has started officially and have you been given a closing date?

MICHAEL O'BRIEN: Not at all.

MR O'BRIEN: Not at all.

JOHN WILKINSON: Neither of those two?

B MICHAEL O'BRIEN: None of those two.

MR O'BRIEN: The only reference that has been made to the investigation was when we met on 24 January they were still scoping. Is that right?

MICHAEL O'BRIEN: I don't even know where -- what's scoping?

JOHN WILKINSON: That's the word I'm using (inaudible).

C MICHAEL O'BRIEN: It has been said, right, but there's no scoping stage in the procedures. That is simply because they are starting an investigation and they don't know what they are going to be investigating yet because the whole thing is cart before horse. To me that's the investigation anyway. It's all part of an investigation, whether they're investigating what the terms of their investigation will be or whether they are investigating them but we don't

D know if there's an official start date for an investigation. We know that it should have started with the appointment of the case investigator. We don't -- we certainly do not know of an end date. We've just been told that it is going to take longer than the four weeks allowed and we will hope to do as soon as possible.

E JOHN WILKINSON: Yes, but that wasn't with your agreement.

MICHAEL O'BRIEN: No, it's just in a letter. We haven't responded to that letter yet. I don't know whether -- I am considering whether we should respond in writing, saying we don't accept this but we are saying it to you now. We may well put it in writing (inaudible).

F JOHN WILKINSON: You need to tell me if I need to raise this with them or not.

MICHAEL O'BRIEN: I think it needs to be raised. It does need to be raised. One of the problems we have here is that we would like to be able to deal with this in a non-confrontational way.

JOHN WILKINSON: Indeed, yes.

G MICHAEL O'BRIEN: But in the confrontational way is the only way we have, then that's the only show (inaudible).

MR O'BRIEN: It is just when I look at -- I'm a clinician. I'm not as au fait with procedure and propriety as Michael is and the legal aspects of that, nor from your experience either. I

H look back on a situation whereby -- I mean, I could give you the concluding sentence of this formal investigation. We would not be here at all if I had not been overworked as a consequence of my concerns regarding numerous patients. I bitterly regret that, you

A know -- I am here 25 years and I have 25 years' experience of being left holding the can for patient outcomes, the Trust not taking its responsibilities. I could into that in detail but I won't.

JOHN WILKINSON: I know.

B MR O'BRIEN: I look back to 23 March and this could all have been resolved over an agreed period of time if I had been alleviated of those other expectations and pressures. I am just going to give you one snippet. On 7 November I emailed my colleagues and the head of service, the administrative head of our service, Martina Corrigan, with a list. I took a list of ten people from my waiting list whom I considered were those people who most needed to be dealt with. Where they dealt with? Not at all.

C The reason I was pushing the boat out to come back on 3 January was because that failure to respond to that reaffirmed my belief that the fortunes of all these patients are entirely dependent upon me. Not on a department collectively, never mind a Trust in its management looking at these issues.

D If I were to just share with you the response to a complaint -- a letter of the complaint that I responded to on 16 October. This is of a man who was admitted in March of last year a stone obstructing a ureter. I partially fragmented it. I left in a stent. He was put on the waiting list to come back in, maybe in about four weeks' time or thereabouts, to have the stent removed and the stone fragmentation completed. The guy is not electively readmitted at all until he is admitted with an extended spectrum ~~betalactamine-beta-~~ lactamase resistant infection and bacteraemia, spending weeks in hospital and so forth.

Anyhow, in my response to that I said you know:

F "With a total of 232 patients awaiting in-patient admission, 136 of them categorise as urgent, it has been impossible to facilitate all patients enquiring about and seeking readmission irrespective of the gravity of the indication. However, recently circulated data has revealed that four of my consultant colleagues have had totals of 29 patients on their waiting list, 77, 59 and 41 awaiting in-patient admission. Indeed, the total number of patients on those four colleagues awaiting urgent admission was 131 on 13 October, less than the number of patients awaiting urgent admission on my waiting list. It is my view that these figures portray such a disparity in the fortunes of patients on different waiting lists as to render that disparity indefensible."

G Now, mind you, I just add rhetorically, I've had no response to this letter from H Mrs ~~GKishkeorry~~ Gishkori to whom it was addressed or whatever.

JOHN WILKINSON: Right. Okay.

MR O'BRIEN: Who is on my oversight committee. There is no reply to this. In fact, actually

A the reply that goes out to the patient is completely sanitised and there is no reference to  
any of these things.

JOHN WILKINSON: Right, okay.

B MR O'BRIEN: I have 25 years' experience of this. I do believe, and I just share this  
informally with you, I believe that there are several layers of management in this Trust and  
I don't think they speak to one another. I think there is a sort of a vertical absence or a  
dysfunction.

C Personally, I don't believe that the medical director was aware of the letter of  
23 March. I do suspect that he has been misinformed or led to believe that the 23 March  
was part of an informal basis, which was non-existent, which did not succeed and therefore  
warranting some kind of formal investigative process, which then -- in the course of which  
the cart was put before the horse and before they started to scope and scoop they had  
excluded me. It's --

D JOHN WILKINSON: The SAI fits into this.

MR O'BRIEN: And the SAI fits into it somewhere.

JOHN WILKINSON: Yes, I understand.

MR O'BRIEN: That's just my view.

E JOHN WILKINSON: I am just, because I am new to the Trust. Relatively new. A year at the  
end of this month. It has been quite a learning experience, never mind the language. And  
I came in to see if I could help, assist, whatever word you want to use. So whenever you  
say that the Trust, and this is not me being defensive in any, but it is getting an  
understanding. I understand what you are saying with regard to the numbers of patients  
that you are looking after and then the apparent disparity in the people alongside you.

F MR O'BRIEN: Absolutely.

JOHN WILKINSON: Why was that allowed to happen? Whose responsibility is it to oversee  
that type of thing? How often is there a review taken of the workloads of individuals and  
so forth. So it would seem to me that those --

G MR O'BRIEN: And who's that undertaken by even if was undertaken and do those people  
undertake it, if it were undertaken, speak to the people who are then making decisions with  
regard to oversight committees and immediate exclusions? I don't think so.

H JOHN WILKINSON: Again I have to be careful what I say obviously, but whenever I read  
this initially my immediate response would have been, it would seem to me that there may  
be an opportunity for Mr O'Brien to highlight mitigating circumstances which may or may  
have lead to a situation. That's why I said early on, you will get a chance, which I  
hope -- you will afford that opportunity to yourselves you know. But I can understand and

A thanks for this. This is enormously helpful because it will put into some sort of sense (inaudible).

MR O'BRIEN: Can I say one other thing from a clinical point of view, and I have, maybe, sort of like, rhetorically put it this way. But if you look at 23 March letter, or indeed if you look at the issues that were presented to us when we met with Colin Weir and Siobhan on

B 24 January with four issues, including the private practice one.

MICHAEL O'BRIEN: We haven't mentioned that one.

MR O'BRIEN: Yes. I do say actually there's ~~is~~ one issue that never appears on that A4 paper or indeed on an opposite page which would be a balance sheet. That is that relative to any of these considerations, the cohort of patients who day in day out are suffering poor

C clinical outcomes are those patients awaiting in-patient admission, or actually, even more specifically, in-patient readmission. I have said also, I could keep the Trust going, a team of them going, with SAIs if they want.

JOHN WILKINSON: Yes, I know. I understand.

D MR O'BRIEN: So ...

MICHAEL O'BRIEN: The final point, the investigation expanded to include an issue about whether private patients for a particular procedure were being seen more quickly than NHS patients.

JOHN WILKINSON: Yes, I read that.

E MR O'BRIEN: Nine patients.

MICHAEL O'BRIEN: Nine patients, yes. Now, I don't understand how that arises out of administrative practice -- an investigation into administrative practice. I don't see how that can arise out of it at all. I'd be familiar with the idea that if you undertake an investigation

F into particular subject, your note keeping, you might end up with a number of concerns some of which you did not know whenever you started that investigation. But this doesn't arise out of that at all. This is a comparison between NHS work and private work. It's remarkable that was included.

G Now, Mr Weir did say that he didn't think there was anything in that particular issue, so that may fall away, but it does raise a question about the way in which this investigation is being conducted.

JOHN WILKINSON: Okay.

MICHAEL O'BRIEN: But that is the final question on that point. You know, I know you said

H you've been here a year now, I don't know if you have done this before, overseeing these investigations before.

JOHN WILKINSON: No, but I have carefully briefed.

A MICHAEL O'BRIEN: I was wondering what the scope is in bringing people together in trying to resolve the matter.

JOHN WILKINSON: In terms of a mediation-type process is that you mean>

B MICHAEL O'BRIEN: Yes. I don't know what the scope is for that. It seems to be unfortunate, although I understand why it is the case, but it seems to be unfortunate that there's a kind of disconnection between different people in the process. My dad will have a meeting with the investigator. Then that will go into a case manager. He will have case conference (inaudible) room.

C JOHN WILKINSON: Totally sympathetic to that I have so say from my position sitting here for your guys. You know, why can't -- but then I am not a company man I have to say -- why can't you sit down with other people and just say, look, let's see where we are with this. So let me -- I will put that to them again and see where that gets us to.

D MICHAEL O'BRIEN: This will be something that we will put in the presentation if we have to go down that road eventually. When there was a job planning done in 2011, which is when the job planning was reduced from 15 sessions to 12, isn't that right. Dad had completed an issue -- a commentary on the new job plan and raised a number of concerns, focusing entirely on the amount of time devoted to administrative work, saying I don't have enough time to do all of my administration. We can give you that at any time. He was saying I have to do triaging, I have do this and I have to do that and I don't have enough time. That's 2011.

E There are number of comments along the road where people have been unable to complete triaging. There was meeting we found in March 2015.

F MR O'BRIEN: I convened a meeting actually because I was lead clinician of the cancer services. We just wanted to clarify exactly what kind of triaging we would do of the red flag referrals and we -- some of us were doing ticking a box. You know, yes, it stays red flag. Others were doing what is called advanced triage, including myself, which means you look at it and you say to yourself, now, this person needs a CT scan and then a flexible cystoscopy, or whatever. So I will ring the person up, some others would write to the person, and say -- and organise a CT scan and then feed back to the office of cancer services. You know, this person will have a CT scan done next week, arrange an appointment the following week.

G MICHAEL O'BRIEN: It's quite thorough.

H MR O'BRIEN: It's quite thorough. It's called advanced triage, which other specialities don't do. But I have the minutes of that meeting here, where I couldn't get the agreement of my colleagues to do that because (a) it was too time consuming and there simply was not

enough time to do when you are urologist of the week.

A JOHN WILKINSON: All right.

MICHAEL O'BRIEN: So you've got that --

MR O'BRIEN: However, you get about four times that number of non-red flag referrals and all of a sudden the reason why Patient 10 and the patient in the SAI waited 64 weeks to be seen for a routine referral, which I have would kept routine, is because I didn't do advanced triage and look into it and discover at that time that the radiologist had messed up the reporting.

B

MICHAEL O'BRIEN: So the concerns had been -- there have been issues around getting this triaging done during the urologist of the week system because it was very onerous on all of them.

C

The issue about whether there has been enough time allocated to administrative practice, I can actually remember you talking about it. I wasn't involved. I can remember you talking about that at the time of the planning. That was five years ago. Dad also gets appraisal every year or every two years.

D

MR O'BRIEN: It's every year, yes.

MICHAEL O'BRIEN: And, for example, in his most recent appraisal it included that "I only triage the red flag referrals." It's there.

JOHN WILKINSON: Yes, okay.

E

MICHAEL O'BRIEN: So with all of that in mind and bearing in mind that perhaps it could have dealt with informally in March, it has not been, I would like to explore the potential to deal with this in a way it should have been dealt with in March by getting an action plan to deal with the problems. But I don't know what the scope is (inaudible).

F

JOHN WILKINSON: I'll find that out.

MICHAEL O'BRIEN: And I am just not clear on how they intend to get round the contract to investigate it beyond the four weeks.

JOHN WILKINSON: You mentioned something earlier on that you had expressed concerns over the new job plan and with regards to the ability to actually do administrative duties.

G

When was that --

MR O'BRIEN: That was in 2011. I have it here. That is it there.

MICHAEL O'BRIEN: (Inaudible).

MR O'BRIEN: Yes, it is both because then there was facilitation. I can give you this.

H

JOHN WILKINSON: No, we'll have copies. I just need it. I just -- I have noted it here.

MR O'BRIEN: So we have raised several important issues.

JOHN WILKINSON: What I will be doing from here on is, I will be having a meeting with,

in the first instance, ~~Vivian~~-Vivienne Toal.

A

MICHAEL O'BRIEN: What's the role?

JOHN WILKINSON: This is her office.

MR O'BRIEN: She's the head of human resources.

JOHN WILKINSON: She has oversight. She is one of them who is involved in that

B

oversight. I will raise -- she'll get a copy of this, if that's okay by you guys.

MR O'BRIEN: Do you want me to give you a copy?

JOHN WILKINSON: No, no, I'll file --

MICHAEL O'BRIEN: We have an extra one.

JOHN WILKINSON: You have an extra one? That would be good. But in relation to that

C

there are other issues that I will raise from the notes from the conversation which will either highlight points that you have made here or, for example, in addition, request that the oversight panel look again at the possibility and potential for a mediation process.

Now, there may be other -- but I'll write you a letter as (inaudible) to tell you know that

D

here is the background. Sorry, here is what I am actually intimating. In other words,

you'll get the facts as I present them to ~~Vivian~~-Vivienne alongside a copy of this. And then

there will be a letter subsequent to that after these people have had a chance to review

what you are saying. I can't give you --

MR O'BRIEN: Of course, not.

E

MICHAEL O'BRIEN: We understand.

JOHN WILKINSON: I just don't know.

MR O'BRIEN: Can I just say one last thing, which I often express my greatest fear and

F

concern about. I have all of the data which I am compiling over a period of five years

quantifying all the additional work that I have done and the roles that I have led,

particularly in terms of lead clinician and chair of MDM, bringing that whole -- the

Southern Trust through the peer review process. But I was also lead clinician of the entire

urological cancer services for the province, taking the province right through the peer

review process. And my gravest concern is that all of the mitigating context of the day

G

will count for nowt. I set that alongside the 23 March where there are issues which I

would have loved to have had the opportunity of resolving if I had been alleviated of some

of those pressures. That's my concern.

JOHN WILKINSON: I think -- you will not let me put words into your mouth, but for me I

H

think what you are saying is that, irrespective of the outcome this, there could be

reputational damage which you would be concerned about. Is that what you are saying?

MR O'BRIEN: Reputational damage or there could be a disciplinary outcome. The Trust



have had the privilege of initiating and carrying out an investigation into me.

A JOHN WILKINSON: Yes.

MR O'BRIEN: I don't have the privilege of initiating an investigation into their failures, which in my view are stark and in terms of patient outcomes have consequences that are a multiple of anything that could emanate from mine. And I have -- all of my overwork has been in an attempt to reduce those and yet will all of that overwork and that effort count for nought? That's my concern.

B MICHAEL O'BRIEN: You can look at in terms of the job planning. Have you seen the job plans?

JOHN WILKINSON: I have --

C MICHAEL O'BRIEN: Have you seen the sessions?

JOHN WILKINSON: Yes, I have I seen the sessions.

MICHAEL O'BRIEN: You can have quite a few hours a week to do administrative work. Maybe about four.

D MR O'BRIEN: Four.

MICHAEL O'BRIEN: If you do an extra clinic in 2016, an extra operating session, you are increasing the amount of administrative work you have to do and you are cutting into the time that you have to do it. Fundamentally, in order to keep on top of the workload elsewhere, you are making it even more easy difficult to deal with these issues raised in March.

E MR O'BRIEN: As I said to Dr Wright, there are only 24 hours in a day. I have tried to increase them but it doesn't work. I have done it without sleep. I have done it without food. To give you an idea, like when I would chair MDM, I would operate all day on a Wednesday, operating ending at -- starting at 9 ending at 8 o'clock in the evening. I would usually do my administrative work arising from that by email and so forth. See the last one or two patients in recovery. Usually be in the changing room at 9 o'clock. Drive home. Arrive there at quarter to 10. Have something to eat and then sit down and preview 40 cancer cases to be discussed at the meeting that I would chair the following case, ending at 2/3 o'clock in the morning for years. Unallocated, unrecognised.

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G JOHN WILKINSON: Can I just -- and this is not being prejudice(inaudible) in anyway -- I am aware of the significant -- this is not -- please, don't take this as being, ah listen to your man talking, I am aware of the significance of your contribution to this hospital in particular but across the province and wider. So don't underestimate the efforts that you have put in. That is recognised by people. I know that.

H MR O'BRIEN: Okay. That's very good to know.

JOHN WILKINSON: It's not good to know. (Inaudible). Again, I don't throw out

compliments to people (inaudible)-

MR O'BRIEN: (Inaudible).

MICHAEL O'BRIEN: It is also recognised in the March letter. That is what I would always come back to.

JOHN WILKINSON: Yes, I know.

MICHAEL O'BRIEN: It is recognised in that letter. The Trust knew. Faced with these concerns, know what the man does, so why not deal with the problem. Realistically it would have involved taking a few weeks off to deal with it.

MR O'BRIEN: That is what I said to Colin Weir. If I had known that that letter and the radio silence afterwards and the lack of informal process could have ended up on 30 December, the most devastating day of my life, I would have taken all of my annual leave and done the thing.

JOHN WILKINSON: Yes, I know. I know. Let's see how far we can get with this.

MR O'BRIEN: It has been very good to meet you. You're a nice person.

JOHN WILKINSON: Talk to my wife, she would tell you different. When she hides the keys on me.

A

22 March 2017

B

**FILE REFERENCE: 7**

**AIDAN O'BRIEN**  
**JOHN WILKINSON**  
**MICHAEL O'BRIEN**

C

Audio Transcription Prepared by:

Personal Information redacted by USI

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MR O'BRIEN: It's getting worse, isn't it.

MR WILKINSON: It's terrible.

MICHAEL O'BRIEN: I suppose it's visiting time as well. That makes it all ...

B

MR O'BRIEN: That would make it worse indeed.

MR WILKINSON: It's funny, I was walking to one of my past pupils. You would know her dad. I was talking to [Personal Information] there. I would know [Personal] very well.

MR O'BRIEN: [Personal Information] ?

C

MR WILKINSON: [Personal Information], yes. I was in the canteen and [Personal] was there. She was telling me that one of the jobs she has here at the moment is to [Personal Information redacted by USI]. Just doing some papers [Personal Information redacted by USI]. So I was giving her first-hand experience of what I felt about [Personal Information redacted by USI].

MICHAEL O'BRIEN: That's not the daughter I met though? There's a daughter who went into law?

D

MR O'BRIEN: This is [Personal Information redacted by USI] daughter.

MICHAEL O'BRIEN: Didn't he have a daughter who went into the law? No? Don't think so. What did she do?

MR WILKINSON: [Personal Information redacted by USI].

E

MICHAEL O'BRIEN: Is that the only daughter he has?

MR O'BRIEN: Yes. He only has one son and one daughter.

MICHAEL O'BRIEN: It must be somebody else then who came down to the house, your house, one time and asked about it all.

F

MR O'BRIEN: No, that must be somebody else. Who was that?

MICHAEL O'BRIEN: Don't ask me (inaudible). I thought that was his daughter.

MR WILKINSON: Were you able to explain that?

MICHAEL O'BRIEN: I can remember because, you know, ~~in the email (inaudible)~~ [Personal Information] and I both explained that, my wife was [Personal Information] at the time. (Inaudible) I think I prefer to do the [Personal Information redacted by USI] (inaudible).

G

MR O'BRIEN: ~~(Inaudible)~~ Whose daughter who that actually was?

MICHAEL O'BRIEN: [Personal Information] was it? No, no.

MR O'BRIEN: No, that's [Personal Information redacted by USI] daughter.

H

MICHAEL O'BRIEN: [Personal Information redacted by USI] Knew it was somebody in the hospital.

MR O'BRIEN: Of course. We have just been talking around the houses, Michael. Not talking about (inaudible).

A MICHAEL O'BRIEN: (Inaudible).  
 MR O'BRIEN: You go ahead.  
 MICHAEL O'BRIEN: It seems like you have -- it just seems like we just have to wait until it comes now. It doesn't seem there's anything (inaudible).  
 MR O'BRIEN: You got a copy of the terms of reference?

B MR WILKINSON: No, I didn't get it. No, I haven't.  
 MR O'BRIEN: It was actually copied to you.  
 MR WILKINSON: I haven't got it.  
 MR O'BRIEN: There you are.  
 MR WILKINSON: Was that included on the list?

C MR O'BRIEN: Yeah, I saw -- I think it says you at the bottom. Yes  
 MICHAEL O'BRIEN: No, it just says board members.  
 MR O'BRIEN: Oh, board members.  
 MICHAEL O'BRIEN: It doesn't say that you were CCed into it.

D MR O'BRIEN: I see. I misinterpreted it.  
 MR WILKINSON: Okay.  
 MICHAEL O'BRIEN: There's not much (inaudible).  
 MR WILKINSON: Can I have a look?

E MICHAEL O'BRIEN: ~~Forwarded to (inaudible)~~ It is for the 5<sup>th</sup> ground which is more to do with management than it is with --  
 MR WILKINSON: To be honest with you, I think that was put in because of my representation.  
 MR O'BRIEN: Well, we were just discussing that with my wife earlier on before you arrived and thought that perhaps that is the case indeed.

F MR WILKINSON: So I think the whole openness and transparency of all of this needs to be clear. So that was the reason why (inaudible).  
 MICHAEL O'BRIEN: You've got -- the final thing is a list of --

G MR O'BRIEN: Michael, I've brought ~~some~~ something separately. Those were your original.  
 MICHAEL O'BRIEN: So they replied to this (inaudible) those concerns we had the last time we met.  
 MR O'BRIEN: (Inaudible). That's it.  
 MICHAEL O'BRIEN: (Inaudible).

H MR O'BRIEN: You saw that. The letter from Dr Khan.  
 MR WILKINSON: No, sorry, I was thinking of -- the last time we met you gave me --  
 MR O'BRIEN: A list of things.

MR WILKINSON: -- of 47 other --

MR O'BRIEN: I haven't any response to that at all.

MR WILKINSON: I would expect to have that by the end of the week or early the following week as far as I can gather. I think the reason for the delay on that was because different questions were owned by different people. And it is gathering that together. That would be a -- the quicker you get the response the better ~~(inaudible)~~ that is really what I am trying to say here.

MICHAEL O'BRIEN: Yes, you know when we read through Dr Khan's response to our questions and there are some questions that -- I mean, it's not done out in a way that answers the questions as such. It is just that they deal with each headline topic and then they speak about it a little bit.

Do you think that we're entitled to know because it says that was n't as a result of a complaint, that -- which came from acute services directorate managers had identified concerns. Do you think we are entitled to know whether there was an investigation before the March 2016 letter and who completed it and, you know, how they come to these numbers on triage patients and, you know, what was the decision-making process behind deciding to go through having a letter sent out as opposed to anything else? You know, was that there a meeting?

MR WILKINSON: I am not being obtuse on this. What I think you are entitled to know is immaterial I think.

MICHAEL O'BRIEN: Under the -- not in a personal point of view but in terms of -- because ~~(inaudible)~~ it's not clear in the processes that I can see, where that line of what we are entitled to know is.

MR WILKINSON: What I can think you can do, and I think I was saying this to you, Aidan, on phone, you should make direct representation to the case manager.

MR O'BRIEN: Yes.

MICHAEL O'BRIEN: Okay.

MR WILKINSON: About those particular the gaps.

MICHAEL O'BRIEN: The gaps.

MR WILKINSON: I don't think -- I am not managing the case. He is. And therefore those questions need to be, in my opinion, addressed directly to him. I checked out whether that is the way to do things and that is the way to do things s

MR O'BRIEN: That can be done. That is very good.

MICHAEL O'BRIEN: That's good to know. That's helpful.

MR O'BRIEN: I was saying that to you, Michael, that it is one of the things that John had said

to me on phone last evening or whatever, Sunday evening or whatever.

A MR WILKINSON: Sorry, I have to make this observation. I have never seen a doctor write like that in my life before.

MICHAEL O'BRIEN: On this document.

MR WILKINSON: No.

B MICHAEL O'BRIEN: Doctors, generally speaking (inaudible) medical notes and records (inaudible). It's painful.

MR O'BRIEN: Without going into the rather comical aspects of it, but the reason my writing is like this is because my writing was so bad when I was at grammar school that my teachers couldn't correct any of my work because they couldn't read it.

C It was happy or unhappy, both, stroke of genius. One Monday morning when the English teacher asked me up to the front of the class to read out the essay at that he had corrected over the weekend but he hadn't corrected it because he couldn't read it. But more importantly I couldn't read it either. I was sent to the school principal. He gave me one

D month to sort it out and make my writing legible or else leave. He gave me a month because there were roughly 30 days in a month and there were only 26 letters in the alphabet and I had one day per letter. So I started printing. And what you are looking at is, all of these years later, that is the printing with squiggles and, there you are, that's the explanation for it.

E MR WILKINSON: Mine would be similar because I used to write -- my writing was so small the teacher said I can't read this.

MICHAEL O'BRIEN: I do it in print.

MR O'BRIEN: One of the things that we wondered about actually, is did you actually have a

F copy of the minutes or any communication from the oversight group that occurred prior to Christmas?

MR WILKINSON: No. I have no copy of anything like that.

MR O'BRIEN: No.

MICHAEL O'BRIEN: Or any documentation around that time?

G MR WILKINSON: No. I have nothing like that. The case manager --

MR O'BRIEN: Will have it of course.

MR WILKINSON: -- I would expect he will have that. That would be my understanding.

MR O'BRIEN: Yes.

H MICHAEL O'BRIEN: Well, I mean, we can raise these. I think it is important before any defence is made (inaudible) to get this information. I think it is --

MR WILKINSON: At this stage --

A MICHAEL O'BRIEN: -- (inaudible) because it seems to me quite unfortunate the way things are going to go. I have looked at this witness list and these hearings. I think it is going to be quite brutal for all of the people involved, a lot of people involved, because I don't think --

B MR WILKINSON: As a lay person, and knowing the circumstances, and, yes, there are going to be a lot of issues which will arise out of this.

MICHAEL O'BRIEN: I think people are going to find it personally very uncomfortable. Yourself included obviously. All of them.

MR WILKINSON: Everyone.

C MR O'BRIEN: I have got somewhat used to the discomfiture of it. Somewhat used to working in isolation from my consultant colleagues because my other colleagues, nursing colleagues, know nothing about it. And that is very, very different.

D MICHAEL O'BRIEN: (Inaudible) it is just going to have be at the end of this process someone who thinks about how people work on. It does seem to me because, you see, this part I think what they are investigating, and I think that the hospital and the Trust might have -- they certainly do have to look at all of the untriaged patients and all of the undictated notes and to see whether there has been any patients that have come to any harm, potential harm, as a consequence of it. I can understand that aspect of what the Trust are doing.

E But with regards to how we got here and what the problems are, it doesn't seem to me, again as a lay person as well looking at this, it doesn't seem to me that it would be beyond people to be able to see what the problems were are.

F MR O'BRIEN: That's part of the injustice of it, is that this process went from March 2016 through to 30 December, you know, without anyone, no one at all, asked me why.

MR WILKINSON: Yes. Again --

~~MR WILKINSON: --~~

MR O'BRIEN: But that's not your --

G MR WILKINSON: I don't want to sound that I don't care, because I do care, but at the same time from your end of things, I know if I was in your father's position I would be looking for mitigating circumstances that led to this situation. And in my business we have performance review. We have got performance review. And if I assume you have gone through different reviews, and I think you did say to me that there were occasions that you have mentioned. So, as you said earlier, there is going to be embarrassing moments for a lot of people involved in all of this. And the Trust is going to have to take it on the chin, but, unfortunately, individuals are going to be.

H



A MICHAEL O'BRIEN: That is what I am saying. I find it unfortunate that rather going through a process where you are going to have a hearing where people are going to have to, in a sense, give evidence -- they'll be here as witnesses (inaudible) the hearing. and they will speak and they will say things and they will have questions asked of them and be defensive and people will say things against others to try and cover their own backs.

B Because people do that. That's natural instinct. Rather than having people sit down as professionals, all involved in this area, looking at all of the documentation, and being able to understand, which would call for a bit of self-~~reflecting~~ reflection for everybody involved, what happened and how do we move on.

C MR WILKINSON: I did say to your father, I think in one of my e-mails, I had asked, I think the words I used, even at this late stage is there a possibility for mediation. And that was denied.

D MICHAEL O'BRIEN: That's okay. That's what they want. That's what it is going be.

MR WILKINSON: There again, is there an opportunity for you to put that again to the case manager?

E MR O'BRIEN: We haven't done that. I haven't been in any communication with him, though I haven't yet replied to this letter that you have seen, which I find to be somewhat concerning, but without losing contact with the point that you have just been making. You see, this is one of the things that go to the core of it. How is it that some kind of mediated resolution, or whatever words that are appropriate to describe it, that Michael and you are just referring to, is inappropriate. However, it was felt that to give a letter to someone in March it was an appropriate. And you do nothing in the meantime. And then the same issues precipitate all of this.

F MICHAEL O'BRIEN: It is not even a recurrence of the issues because the SAI is based upon an untriaged referral that happened before the March letter. You know, it was one of the untriaged referrals contained within the March letter.

G MR WILKINSON: I was thinking and looking ahead to all of this. How long is this going to last? Because if I was in your position, getting some of the questions to your -- getting some of the answers to the questions that you guys have raised, it's not going to be done in half an hour. Do you know what I mean?

H MR O'BRIEN: But, John, we'll never get truthful answers to all of the questions that we have raised.

MICHAEL O'BRIEN: I will eventually. It just depends on how far --

MR WILKINSON: How far -- absolutely.

MICHAEL O'BRIEN: That we will eventually.

A MR O'BRIEN: Like, for example, just to give you an example, I was replying to the note of the meeting that Michael and I had with Colin Weir and Siobhan Hynds on ~~23~~ 24 January, when we asked the question, where did the complaint come about, the nine private Turp patients? From the scoping exercise we were told. This was flagged up from the scoping exercise.

B MR WILKINSON: Right.

MR O'BRIEN: Even though the scoping exercise is an exercise scoping out the extent of the other three concerns, which are triage, which didn't affect a private patient at all because he was never triaged, and dictation of letters, which, you know, that's an NHS practice, and retention of charts at home, which once again, is not an issue.

C MICHAEL O'BRIEN: It is an NHS. When you scope out a history of NHS practice and somehow end up with another issue that is unrelated to NHS practice.

D MR O'BRIEN: I have a strong suspicion that that is an issue raised, I believe it fervently, that has been an issue raised by another, who I believe may have quite an adverse view of any private practice by anyone and it is completely unrelated to the scoping exercise. Now we will ask who initially raised that as often as we like. The only answer we will ever get is Mr Scope.

E MICHAEL O'BRIEN: To the things like that maybe, but I think with regards to what happened in March, meetings, that information will come out eventually because there will be a paper trail.

MR WILKINSON: There will be. But I think to source that --

F MICHAEL O'BRIEN: Go to the case manager. That's okay. That's useful to know and we will do that as well. As part of what you doing, I know that you have been making representations for us and it is has been helpful, but your role is it between the investigation and the board? Is it to ~~---~~

MR WILKINSON: It is between the investigation and the board. My role is quite indistinct I have to say. I could have been contacted prior to the exclusion.

G MICHAEL O'BRIEN: Probably should have been.

MR WILKINSON: I could have been, do you know what I mean. At that stage -- you could have said to, look, John, we're not happy with this. Is there another way of doing this? That could have been an avenue that could have been explored but then I was not appointed until after the exclusion. Is that right? So there's an issue there.

H The other thing is to make sure that within the bounds of -- these are my words -- within the bounds of the investigation that there is a momentum kept going and if you are not happy with that momentum I can make that known to the case manager. And

say, look, guys, what is holding this up? What is going on here?

A MICHAEL O'BRIEN: I am not altogether clear on what took them -- this came last week, dad?

MR O'BRIEN: Yeah.

MICHAEL O'BRIEN: Three months.

B MR WILKINSON: You see, I am not even, in terms of my role, and I know it is quite invidious for you guys, you're somewhat surprised that I haven't seen that. That was not copied to me. I have no knowledge of that whatsoever.

MR O'BRIEN: I will scan it.

MR WILKINSON: I suppose the question is, should I have?

C MICHAEL O'BRIEN: You see, what we are talking about is whenever you have any investigation starts, you are supposed to have the terms of reference really -- (inaudible).

MR WILKINSON: At the very start.

MR O'BRIEN: Yes, that is what NCAS says.

D MR WILKINSON: Absolutely.

MR O'BRIEN: And that they can be expanded but --

MICHAEL O'BRIEN: You bear in mind -- let me finish this point. From March 2016 untriaged out-patients, there's unrecorded outcomes from clinics and patient notes at home. That's the additional one that's gone now because it was dealt with. So those three issues were. In the letter that Dr Wright first handed to you, which was dated -- sorry, the letter from 6 January, which followed up from the 30 December meeting, untriaged referrals, back log of undictated clinics, notes at home.

MR WILKINSON: Right, okay.

F MICHAEL O'BRIEN: So that is the 6 January. This is 16 March. What are they doing? Bearing in mind that you have a procedure that I am sure that the board and the Trust spent a lot of time drafting that says that this shall all be completed in four weeks.

MR WILKINSON: Now they will argue -- I don't know, I am not representing them, I am just saying, I know, and I will ask them about this, they will argue that bearing in mind the scope, the size of the investigation, all things --

G MR O'BRIEN: It doesn't matter what their argument is because they actually have Trust guidelines, which are tighter than the MHPS ones framework, and it says that the investigation must be completed within four weeks of the appointment of the case investigator.

H Personally, I mean, I have never really shared with you a lot of my suspicions, I believe they have been scoping for a year. I didn't know that. But I now do believe it.

A Obviously there was a scoping exercise done in order to provide the data that was included in the letter of March 23.

B The date of the incident of the SAI is 6 January 2016. That is the date when it was appreciated, you know, that this lady actually had been referred on for assessment of a simple cyst which she had, but in fact she should have been seen earlier because of another solid lesion in her kidney. All of that was put off because in the reassessment of that it was discovered that she had metastatic disease from her breast cancer, unrelated to her (inaudible) cancer. So she needed surgery. She needed chemotherapy and radiotherapy. And that took the bulk of a year until she had her renal surgery on 30 October, when it is claimed that the SAI began. I don't believe it began then. I think it began in January.

C The things that concern me moving forward is not only the prejudice that is expressed in the letter from Dr Khan. The kind of thing is I want to make it absolutely --

(Phone rings)

MR O'BRIEN: -- I want to point out to you that concerns were identified. I understand --

D "It is important that I state at the outside that I was not involved in the conversations or discussions that took place at that time. I understand that concerns were identified by managers."

So I understand that there were ~~(inaudible)~~ identified by managers within the directorate. And:

E "The purpose of the letter was to set out to you those concerns on an informal basis in order to enable you to put in place measures to rectify the concerns."

Like what is enabling in the letter I have absolutely no idea. There is not a single enabling word in the letter. And then --

F MR WILKINSON: I am quite confused.

MR O'BRIEN: To say that it was expected. Now, I don't know who did the expectation.

Now, if it is an expression of his own view of expectation, my own view is that that is so prejudicial on his part he couldn't be the case manager.

G MICHAEL O'BRIEN: Yeah I don't know -- (Inaudible).

MR O'BRIEN: This is the kind of thing we are up against. But we will reply to that and I will share --

MR WILKINSON: But if you are of that opinion you need to -- I think you need to reflect on that opinion and come to a view, is it in your interest to pursue that or not.

H MR O'BRIEN: Yes.

MICHAEL O'BRIEN: No, I think another thing -- what you would do is you would seek --

MR O'BRIEN: I know exactly what you are saying because then you could be in a worse

situation.

A MR WILKINSON: Yes.

MICHAEL O'BRIEN: You could seek clarity on ~~(inaudible)~~ Whose perspective?

MR O'BRIEN: That is what I will doing.

MR WILKINSON: That's fine.

B MR O'BRIEN: I am just sharing that with you. I wouldn't be expressing but I would be seeking clarification.

MR WILKINSON: Yes.

C MICHAEL O'BRIEN: ~~(inaudible)~~ I do agree, I'd find it a massive coincidence, an unbelievable coincidence if the fact that there was a March letter that didn't arise out of that SAI. Didn't arise out of it. That referral came in to you in October 2014. The patient eventually was seen by urology in January 2016. Eventually, because of the waiting time under routine. So was seen by a consultant in urology at that time, who would have looked at it and once they did a more detailed look at what was going on, ~~what (inaudible)~~ would have noticed, maybe this could have been referred with a greater degree of urgency if had been looked at in the more detail way back when.

I know the Trust procedures around adverse incidents, whenever it becomes aware of any potential problem they are supposed to initiate that process. I think within a number of days. So they don't wait nine months until there is an operation in October. They don't.

E So I would find it a massive coincidence if in March you have a letter where the top item is untriaged referrals two months after this patient, who had become the subject of a SAI, is before urology and that those two are unrelated. That would be to me a startling coincidence because it is not like these issues are raised with you a lot. When is the last time you have got a letter about any concern in your practice?

F MR O'BRIEN: No idea.

MICHAEL O'BRIEN: You know what I mean. But we come back to what we were saying about the timing. The status of the MHPS and the status of the guidelines I think there needs to be some clarity around them. For my money -- you're an education al background?

G MR WILKINSON: Yes.

H MICHAEL O'BRIEN: If the Department of Education issued a circular for the expectations with regard to how you handle students, whatever it would be. Something like that. Off the top of my head. And an individual school puts in place a policy and guidelines for dealing with teachers who may have breached that department circular, it is the school's policy that gets applied because it's the school's policy that reflects the relationship

between the school, the employer, and the teacher, the employee.

So it is not some framework that came out of -- not actually Northern Ireland, but came out of the Department of Health and Social Services in England, would have been an UK wide framework. It is how each individual trust puts that into practice with its own -- these are massive organisations. The Southern Health and Social Care Trust would have, I am sure 10-20 thousand ~~(inaudible)~~ employees.

MR O'BRIEN: (Inaudible).

MR WILKINSON: 14.

MICHAEL O'BRIEN: It is not a small group. Though it is not like this is an amateur or a thing. This is a big employer. And I would imagine that those guidelines were arrived at following I would say there would outside advice in the drafting of that, and that is what it says, investigation (inaudible) and it is obligatory.

MR WILKINSON: All I would say to you on that one would be, applying it to education, unless I followed due process, excuse the language, but I would be stuffed if I didn't follow due process.

But that will be making sure that due process was not followed and that's the argument that you would have to make sure was acceptable or correct or valid, whatever word you want to use on that one. It would seem to me -- I think it is in appendix 1 that the four weeks is mentioned if my memory is right.

MICHAEL O'BRIEN: Yes, that is where it is.

MR WILKINSON: But somewhere in the text there may be a reference to this process which says something like, and you have heard this line, in exceptional circumstances. Now, that is the line that would be peddled towards --

MICHAEL O'BRIEN: In the guidelines?

MR O'BRIEN: In the Trust guidelines. I don't think in the Trust guidelines.

MR WILKINSON: I need to have a look.

MR O'BRIEN: We will have a look. We have them.

MR WILKINSON: Just for your own.

MR O'BRIEN: But irrespective --

MICHAEL O'BRIEN: It says it in the MHPS. It certainly does (inaudible).

MR WILKINSON: It is not in Trust guidelines?

MR O'BRIEN: We will have a look at it. But irrespective of what is in it and whether we are right or wrong, I think the point that we are wondering about, and I have wondered about, I want to ask you, I have not asked you. Yeah, it seems to me that if you have a national framework, and an awful lot of national frameworks include an expectation that individual

A organisations will establish their own guidelines and structure to incorporate it, which actually is overarching. For example, in Dr Khan's letter he says "under the Maintaining Higher Professional Standards framework". He really actually should be saying under the Trust guidelines and handling concerns about doctors and dentists.

MR WILKINSON: Yes.

B MICHAEL O'BRIEN: My view on that would be is that I think that if there is a framework that contains a balancing of competing rights in a process, I think that the Trust would be free to constrict themselves more than the framework does. They are free to do that. But they come into difficulty if they give themselves more room than the framework.

MR WILKINSON: They come into difficulty there, yes.

C MICHAEL O'BRIEN: But they are free to constrict themselves and that appears to be what they have done. Now, the guidelines would take precedence. So in a sense what you would do is you say, you operate off the guidelines. If there was, for whatever reason -- if, for whatever reason, the guidelines contain some provision that allowed the Trust more  
D leeway than the framework really ought to have given them, you could make a complaint about that. What you would be saying is that you are not following your guidelines because your guidelines failed to follow the framework. So it is a (inaudible) double lock in a sense.

MR WILKINSON: Yes.

E MICHAEL O'BRIEN: But I don't know -- see how the Trust can -- and maybe you are right, and we will read over that to see if there's an earlier reference in the guidelines to exceptional circumstances, and there may well be. Maybe I missed that.

F MR WILKINSON: To answer your question more directly in terms of education and to use one that I would be aware of, we will get handed down circulars about discipline in schools. If you interpret those disciplines and apply them to your school and something happens within your school, it will not be the circular similar that will determine what happens. It will be your school and governors' interpretation of that. So, yes, that's correct.

G MICHAEL O'BRIEN: That is the way I would understand it to work.

MR O'BRIEN: Because otherwise there is no raison d'etre or purpose to any organisation having its own guidelines interpreting certainly a national or other.

H MR WILKINSON: I think the way forward on that would be again to -- once you have done your homework on it, who am I to say this, once you have done your homework and you are sure, then to make approaches to the case manager.

MR O'BRIEN: ~~(Inaudible)~~ I have a note of that. Is that what you want him to do?

A MICHAEL O'BRIEN: (Inaudible). It is interesting. You know, and there is also another point. If it is the case --

MR WILKINSON: (Inaudible) But Michael through out all of this, there are process issues throughout the whole run.

B MICHAEL O'BRIEN: I was also thinking there are examples. In my profession we work to very strict timings, time limits, that have the effect of whether your case can be heard or not. Whether a court has jurisdiction to hear it. There are many examples of timelines that may something like three months for a case to be filed or a document to be issued, or three years or a one year, whatever it may be. And there are examples of where you can -- in

C certain circumstances there are certain time limits that can be extended by application and you can ask for an extension of time. You can argue for an extension of time.

D But this is the other point about this extension of time in this case that is concerning me. Once you extend time, that does not give you a free for all. You have to argue what is the length of your extension of time. How do you justify it. So that is not to say, it is four weeks unless it is exceptional and then in that case there is no time pressure at all. Do you know what I mean? When you extend it beyond the four weeks you have to argue that your extended time is in itself reasonable.

E MR WILKINSON: Is six months reasonable? Now, that's a figure that is coming off the top of my head.

F MICHAEL O'BRIEN: No, six months would seem to be properly realistic. We have a witness list that says March for one witness up until 6 April. And then we have three further beyond that -- beyond 6 April that haven't had a date confirmed yet. So it seems to me, before you get through those witnesses, you are looking somewhere probably mid to late April. And then you are going to have meeting with you, which would probably be late April or early May. You would have a report after that in mid-May. Then you will have your response to it late May. And then you will be making decisions in June. There's your six months at least.

G MR O'BRIEN: And meanwhile, halfway through that six-month period, and this is what I find from a clinical point of view disgusting, this faux primary concern that the Trust has about patient safety. And has one thing been done? Not at all.

MICHAEL O'BRIEN: Sitting up in an office

MR O'BRIEN: Sitting up in an office.

H MICHAEL O'BRIEN: Those documents.

MR WILKINSON: The documents are?

MR O'BRIEN: The charts, yes.



A MR WILKINSON: Okay.

A MICHAEL O'BRIEN: So far as you can tell.

MR O'BRIEN: Yes, absolutely. Well, my secretary has told me that they haven't even been -- the clinical outcomes haven't been returned to them or anything.

MICHAEL O'BRIEN: You were coming back from work after your operation.

B MR ~~O'BRIEN~~WILKINSON: Mmm?

MICHAEL O'BRIEN: When they found out you were coming back to work after your operation, they just decided to (inaudible).

MR O'BRIEN: That's right.

C MICHAEL O'BRIEN: They found out that week. You were coming to come back the following -- on 30 May -- sorry, 30 December you had indicated you might be coming back on 2 or 3 January, isn't that right?

MR O'BRIEN: No, I had planned it. I had operating --

MICHAEL O'BRIEN: 2 January.

D MR O'BRIEN: 3 January.

MICHAEL O'BRIEN: I think it was (inaudible)

MR O'BRIEN: Actually I got the call on Wednesday 28 December from Dr Wright's PA asking if -- he wanted to meet me at 11 o'clock on Tuesday 3 January. I said I couldn't meet him because I am operating and she said okay. Could he meet you on Friday? I said

E I am on sick leave. He is on annual leave but he will come in. I said, sure, just get him to phone me.

MR WILKINSON: You didn't know what was --

MR O'BRIEN: Well, I didn't realise or appreciate anything at all. And then I got a call back.

F She said I will find out if he wants to phone you. She rang me back to say, no, it has to be a face to face meeting and I thought mmm. What is that about?

MR WILKINSON: Yes, I know.

MR O'BRIEN: And I went home and said to my wife, you know, and she said find out what the agenda is. Then I got the short agenda, which is not filed, with the comment at the

G back you may bring a colleague, or whatever, for support and I thought, oh aye.

MR WILKINSON: Yes, I know.

MICHAEL O'BRIEN: You wouldn't have been told that ~~(inaudible)~~ had you not gotten the agenda.

H MR O'BRIEN: I wouldn't even been told that, yes.

MICHAEL O'BRIEN: You know there's a point to this. I have sat over the last number of weeks and wondered, at what point do you start to -- how is it best to raise these

A procedural issues? Do you just wait? If I was looking at this as a lawyer what I would be doing is I would be sitting and waiting.

MR WILKINSON: So would I.

MICHAEL O'BRIEN: And I would be rubbing my hands with the multi-million pound-claim that I would have at the end of it. But I don't want that because that involves something terrible happening.

MR O'BRIEN: If I get a million pounds I will be gone. But --

MR WILKINSON: If you were looking at it from a legal perspective you would wait. Definitely. You would wait.

MICHAEL O'BRIEN: Yes. (Inaudible) and consulted with me. And you know what else I would do? I wouldn't just wait. I would put in a few pieces of correspondence which would add extra rope to the noose for the employer to hang themselves on. Because you will have raised (~~inaudible~~)some of these problems and you wouldn't do it in an aggressive way. You would do it in a very nice way. Look, I have just got a little concern about this and this, and then they just ignore it. And it's all wrecked.

MR WILKINSON: It's all there.

MR O'BRIEN: You know so, John --

MICHAEL O'BRIEN: I don't want that. But the problem with that is that you are 64 in a couple of months' time and that process that I am talking about, where you go next, is another year and that is how your career is. But if it was someone who came in to me today, and I got a phone call from a solicitor and they sent me this as a brief, that is what I would do. But I don't want to do that.

MR WILKINSON: You see, I have to agree with you. I can see where that (inaudible).

MR O'BRIEN: Part and parcel of that journey, possibly ending up in that destination, and I hadn't thought of it in terms of that kind of destination --

MICHAEL O'BRIEN: That is what I do for you (inaudible).

MR O'BRIEN: Because one of the things I was going to ask you about is that to date I have had a number of meetings, the one of 30 December, and the note of that meeting inserted things into the note that were not said by us.

MICHAEL O'BRIEN: I was there in that meeting too.

MR O'BRIEN: No, the 30 December one.

MR WILKINSON: Did you make a reply to that one and say --

MR O'BRIEN: Yes. Now, I haven't even received an acknowledgement of that.

MR WILKINSON: I did raise that. I raised that with ~~Vivian~~ Vivienne Toal and she said we need to get something done on that one.

MR O'BRIEN: Yes.

MR WILKINSON: So that actually was raised. I know I raised it.

MR O'BRIEN: When you raised it -- because I sent it by post. I just want to make sure that it was received.

MR WILKINSON: I don't think that ~~Vivian~~ Vivienne had seen that letter before. I do not think she had seen it. But what she did do she said, John, I would need to make sure that that letter was replied to.

MICHAEL O'BRIEN: I have a recollection, now you say this, that Siobhan Hynds had seen it and (inaudible) she knew you'd got the corrections to the minutes. Remember the meeting with Dr Khan. (inaudible) Dr Khan. Did she not know that we -- she had received that? No?

MR O'BRIEN: I can't recall now.

MR WILKINSON: But ~~Vivian~~ Vivienne, I have no dealings with Siobhan, so I don't even know her (inaudible).

MR O'BRIEN: Can I --

MICHAEL O'BRIEN: No, it is just, because we have had two meetings since then.

MR O'BRIEN: Expressing my concern in a global manner, I don't have a faith anymore. I wouldn't have had a reason to even ask the question whether I do or not. But I don't have a faith or a confidence in the recording of proceedings anymore. And the one example above all I want to give you is that when Michael and I met with Colin and Siobhan Hynds on 24 January -- and the one example that I want to just raise is what I have referred to as "the big elephant in the room"

MR WILKINSON: Yes.

MR O'BRIEN: The big elephant of why did I end up in this situation? Well, it is overwork on several fronts but the biggest reason for the overwork was all of the additional in-patient operating that I had done under pressure and expectations from patients and under concerns that I would have had for their clinical outcomes. I have shared that with you before. And, you know, Siobhan did ask me and she did record who would you have raised these concerns with before? And I said above all, you know, I have raised -- I have raised my concerns with everybody at every level over 20 years without change. But the important thing is, and I am telling you something now, I am raising it with the both of you right now.

MR WILKINSON: Yes.

MR O'BRIEN: And it will never be heard of again. That was not even included in the note.

MR WILKINSON: ahh Right. Okay.

MR O'BRIEN: Right.

A MICHAEL O'BRIEN: That whole area of conversation.

MR O'BRIEN: That whole area -- that everything to do with the biggest cause of concern that this Trust should have about the outcome of its urological patients are the experience and the outcomes that people have as a consequence of delay in admission and particularly readmission. Do they know about it? I don't think they do.

B MICHAEL O'BRIEN: But it wasn't in the minutes

MR O'BRIEN: But it wasn't in the minutes.

MICHAEL O'BRIEN: There was example, for example in that meeting --

MR WILKINSON: Were you given an opportunity to amend those minutes?

C MR O'BRIEN: Yes, I actually have them prepared. As I said, it is my final paragraph:

"The note omitted any reference to the issue of the large number of patients awaiting admission for surgery and more particularly those patients are waiting readmission for surgery."

D MICHAEL O'BRIEN: We have done that now.

MR O'BRIEN: So we have done that. But the reason I was asking you, we have already sent our amendments of the meeting of 30 December. I have not even received an acknowledgment yet.

E MR WILKINSON: I am surprised that that hasn't -- I can check. I can chase that again.

MICHAEL O'BRIEN: We can also include that (inaudible).

MR O'BRIEN: I am concerned. The reason I am referring to this, Michael, I haven't even had opportunity -- when I see a list of witnesses.

MR WILKINSON: Yes. Go ahead.

F MR O'BRIEN: Right, who are going to be interviewed by a case investigator with Siobhan Hynds taking notes, or it doesn't matter, my experience to date is that every meeting that I have had, and the most recent that I had where I didn't even realise a note would be produced, was a return to work meeting, and I was quite taken aback by what was included in it, what was omitted from it. You know it is --

G MICHAEL O'BRIEN: You didn't even think that it was being minuted (Inaudible).

MR O'BRIEN: I didn't even think it would be minuted. I have said that the next and any meetings that I do have, you are an exception to this, any meetings that I do have in this investigation I will be producing the note.

H MR WILKINSON: Yes. Yes.

MR O'BRIEN: You see, it is an unfair advantage which has been abused and I have evidence of its abuse. That is the convenor very often actually doesn't tell you what they are

A meeting you for, as on 30 December, and hands you the paper of accusation, you are  
stunned. And then doesn't even produce a reliable -- like, for example, you know one  
thing that my wife and I took profoundly in an offensive way was the insertion that  
Mrs O'Brien said, "And this is how we are repaid for all of the work". And my daughter is  
B in her final months of Personal Information  
redacted by USI and she said and repaid was put in quotes which is  
a journalistic technique for this actually happened. It was absolutely appalling. If you  
could get paid it would be wonderful without ever wondering about getting repaid. That  
is -- but that is biased. That is prejudice.

MR WILKINSON: Yes.

MICHAEL O'BRIEN: That is note taking.

C MR O'BRIEN: Mmm?

MICHAEL O'BRIEN: That is note taking. I have so many things where I deal with note  
taking.

D MR WILKINSON: You should get an opportunity, and I think you are taking it, to amend the  
note. Whether or not they accept it is immaterial. It should be in some way included as an  
appendix or an addendum.

E MICHAEL O'BRIEN: Yes, you are right about that. It doesn't matter whether they accept it  
or not. One of the key things about -- about particularly records of conversation or  
comment that you make, because at this stage the comments they make aren't important.  
You know, they aren't. They would be the comments that you make or a failure to record  
some other comments that you have made, is that if you don't accept their note of what  
you've said and you have at this stage this is what I actually said, then they can't rely on  
their note what you said.

F MR WILKINSON: That's the advantage of making sure you respond.

G MICHAEL O'BRIEN: In fact, even if it was the case that you had said something differently  
in December than you did in your amended notes that you provided in January, or  
whatever time it was, what does it really matter, because it's what you said in January is  
probably -- it's the comment that's based on reflection anyway. You know. (inaudible) in  
a sense you know. So I just --

MR O'BRIEN: John, one point that you mentioned there that I hadn't thought of before. Why  
do you think that you could have been appointed before?

MR WILKINSON: No, I didn't know. No, it's not that I thought I could have been.

H MR O'BRIEN: Yes.

MR WILKINSON: I think my training -- the new NEDs were all trained sometime in January.  
I have it here somewhere. And then it was shortly after that, maybe two or three weeks, I

A got a call from Roberta saying, John, I want you to be the NED on, I hate that word-  
~~(inaudible)~~by the way, I want you to be --

MR O'BRIEN: On this case.

MR WILKINSON: On this particular case. So it wasn't that -- I didn't know anything about  
 B the case at that stage. I just said, okay, I can do that. I'll do that. So I don't know. In  
 terms of, did I think I could have been -- in fact I don't think I could have been because I  
 wasn't trained.

MR O'BRIEN: Leaving aside that, do you think that any NED could have been about  
 appointed?

MR WILKINSON: Could have been appointed prior to the time that I was? There were still  
 C some non-executives there who had been trained.

MR O'BRIEN: Let's say you were all trained. That is the point I am making. You know.

MICHAEL O'BRIEN: This was in the process you're asking?

MR O'BRIEN: Yes.

D MR WILKINSON: ~~(inaudible)~~but there were only three --

MICHAEL O'BRIEN: The appointment should have been made at the point of the oversight  
 group.

MR WILKINSON: That probably -- that could have been the key.

MR O'BRIEN: What's that?

E MICHAEL O'BRIEN: At the time the oversight committee, prior to the meeting on  
 30 December, they should have appointed the case investigator, the case manager and the  
 non-executive director. And they pointed out in that meeting on 30 December, I can't  
 remember how the note goes, but they said that the investigator they knew who that was.

F They mentioned Colin Weir. They knew that Dr Khan was going to be the case manager.  
 And there is a non-executive director and they simply said we haven't quite got that sorted  
 yet.

MR WILKINSON: Yes.

G MICHAEL O'BRIEN: But at that point they really should have had a non-executive director.  
 It could well be that they did not have people to do it at the time but the reality is the  
 process --

MR O'BRIEN: They hadn't asked Roberta at that stage.

MICHAEL O'BRIEN: The process suggests that they should have done. That's my  
 H (inaudible).

MR WILKINSON: Yeah. I would say, without a great deal of knowledge, but I would have  
 thought there would have been at least one of four ~~(inaudible)~~ available. Sorry, there

would have been four (inaudible)-available and one of those people could have done it. I would have thought. Because there were three new ones that came in at my time and we didn't -- that was January sometime.

MR O'BRIEN: I thought actually the point I was wondering, I just wondered, did that infer that you had a view as to whether or not the decision to make -- to have a formal investigation could have been separated in time from the issue of immediate exclusion? I still do not know why I was excluded. I haven't been given one reason for exclusion. In fact that was most apparent when Michael and I sat with Colin Weir and Siobhan Hynds asking us -- asking them repeatedly what are the concerns that we would have to address if I were to return to work. Well, we don't have any. We just invite you to give --

MICHAEL O'BRIEN: Precautionary. They took a precautionary step without realising that it's supposed to only ever be taken in exceptional --

MR O'BRIEN: In exceptional circumstances.

MICHAEL O'BRIEN: So they just basically didn't apply that part of the process. They just didn't do that. I think that's the reality.

MR O'BRIEN: Causing me all of that.

MR WILKINSON: Yes, yes.

MICHAEL O'BRIEN: I don't think that they applied that part of the process. They just said, obviously, we are going to have a formal investigation so we'll suspend him -- we will exclude him and then we will come back and see where we go from there.

MR WILKINSON: But in all of these things it is, you know, the legal -- you know, the due process should have been applied right from the very beginning. If you're going to go down a certain route you have to make sure that the Is are dotted and the Ts are crossed because you can slip up in the process. I find that in my world. The number of the principals who don't do that is amazing. You just have to follow the process.

MICHAEL O'BRIEN: So you know, we'll come back to it. If I was dealing with a lawyer, I told you what I would do but I'm not. What I would like to do is to raise these things so that people can react appropriately at the time. And we can raise it with the case manager. I don't know whether it should be raised with anybody beyond the case manager because there is a case manager -- because there's a case being managed within the operations of the Trust which is governed by a board.

MR WILKINSON: By the Board.

MICHAEL O'BRIEN: That should (inaudible).

MR WILKINSON: Although, having said that, they are quite independent. Like, none of the Trust -- none of the board members -- am I serious in saying this? I would know that none

of the NEDs would know anything about this. I know that.

A MICHAEL O'BRIEN: I think that is probably correct because if ever there was any hearing held by the case manager and you ever wanted to appeal that decision it would probably be heard by the board, so they would probably be kept at arm's length at this stage.

MR WILKINSON: Yes.

B MICHAEL O'BRIEN: What we are saying is, there is a process being undertaken by employees of the Trust and we are very unhappy with several aspects of how that has taken place to date and how it continues to proceed. And do we just plead with them internally or do we -- do you raise a grievance?

C MR O'BRIEN: I don't know any of these things (Inaudible)-

MICHAEL O'BRIEN: Do you raise a grievance?

MR WILKINSON: Yes, you could. Yes.

MR O'BRIEN: From my point of view --

MICHAEL O'BRIEN:: I've done that before in cases too.

D MR O'BRIEN: You see, one of the things that I do not know, I would love to know, for certain. I personally do believe that Richard Wright knew nothing about March 23 letter and was only appraised --

MICHAEL O'BRIEN: At the time in March.

MR O'BRIEN: -- in March.

E MR WILKINSON: Was he long here at that stage?

MR O'BRIEN: He was. Yes. I had a meeting with him on Friday 1 April about a completely unrelated issue during which time he said, Aidan, you should be working less hard, you know. In fact, because I was giving -- I emailed a legal opinion at 3 o'clock in the morning on behalf of the Trust you know, or something like that there. Anyhow we talked about other matters. I don't think he knew a thing about in March, April, May --

F MICHAEL O'BRIEN: He wouldn't (inaudible).

MR O'BRIEN: -- June, July, August, September, October. I think October is the earliest.

G Probably November or December. And I was off at that time. Now, but Richard Wright is not on the witness list. Now, if I was case investigator looking into all of this from March, I mean, you would need to be interviewed.

MR WILKINSON: Can you, for example -- let's take that (inaudible). Sorry for interrupting.

H Can you make representation to the case manager and say, you are interviewing these guys, should you not be interviewing Dr Wright?

MR O'BRIEN: I am sure we can.

MICHAEL O'BRIEN: We could probably do it. One of the other interesting aspects about



A this is that if you are doing a comparative analysis of different people's practice, some people you would want to interview are all the peers in the group, wouldn't you.

MR WILKINSON: You would.

MR O'BRIEN: They might all be. They might all be the list and when the list is --

B MICHAEL O'BRIEN: You've got Michael Young who is really the line manager. (Inaudible) the other peers (inaudible) I don't know.

MR WILKINSON: To what extent is Esther involved here?

MR O'BRIEN: She's on the oversight group.

MR WILKINSON: Is she on the oversight?

MR O'BRIEN: Yes.

C MR WILKINSON: Initially, yes. Sorry.

MR O'BRIEN: I gather.

MR WILKINSON: Was she involved -- I am just wondering, I don't know the detail of that aspect of it.

D MR O'BRIEN: Nor do I. It is important for you to appreciate that nor do I (inaudible). I think the management is dysfunctional. I think it is -- there is no -- there is no wiring going on behind different levels. If you look at this logically, and thinking of them as reasonable people, because most of the time most people are reasonable most of the time and try to do their best, the only plausible explanation in all probability for the sheer

E lacuna that there is between issues that were subsequently considered to be so grave and so vast as to warrant a formal investigation and immediate exclusion, to be addressed by an enabling letter with expectations attached to a guy completely overworked beyond his suffering prostatism, and all of that there, so that's all possibly done just with a letter. We

F thought we would give you the letter rather sending it to. And nine months later you have this enormous nuclear bomb set off is that the people who set off the nuclear bomb because of their concerns about the issues knew nothing about March. Is that not reasonable?

G MR WILKINSON: Yes, yes.

MICHAEL O'BRIEN: Or certainly weren't involved in the March letter.

MR WILKINSON: Is there something, coming to chase on this for me, is there -- because your question at the very beginning was, John, what are you doing? What is your role?

MICHAEL O'BRIEN: (Inaudible).

H MR WILKINSON: But -- I know. As I said to you, as far as I would be concerned there, there was an exclusion. That's done and dusted as it were in terms of my involvement with that but there could have been an opportunity there if the appointment had been made

because that is what it says. To keep the pace going and if there is something.

A MR O'BRIEN: I think, John, if you could do the following. I would very much appreciate it because I don't particularly want to be -- I thought about either writing, emailing or literally phoning Dr Wright's PA to ask, did you actually get my proposed amendments?

MR WILKINSON: I will chase that.

B MR O'BRIEN: Would you do that for me?

MR WILKINSON: I had that in here.

MR O'BRIEN: Okay, and let me know the answer to that.

MR WILKINSON: Yes, okay.

C MR O'BRIEN: I will share with you, I'll send to you, a copy of the amendments to the first meeting that we had -- well, the only meeting that we had with the case investigator at the time. Are there any other things that we want him to do?

MICHAEL O'BRIEN: I don't know.

MR WILKINSON: It's curious (inaudible).

D MICHAEL O'BRIEN: It is. It must be a strange position for you.

MR WILKINSON: It is I have to say. It is really. Yes.

MICHAEL O'BRIEN: I don't know. Is part of what you would be doing is at the end of this process you would be reporting back to the board to see -- so that they could learn from any of your observations of how it's gone?

E MR WILKINSON: No, no. As far as I can see, like Roberta has said to me, John, keep an eye on the learning that needs to take place in terms of my particular role and how it is exercised, but, excuse the language, I am damned if I can understand and can get sufficient guidance in order to carry out my role to the best of my ability.

F MICHAEL O'BRIEN: You see, one the things that procedure says if dad was frustrated or unhappy with any aspect of the procedure he'd contact you.

MR WILKINSON: Yes.

MICHAEL O'BRIEN: But it's not clear what you are supposed to do with that (inaudible).

MR WILKINSON: Or even in terms -- you could be dissatisfied with -- if it is straight

G forward I can deal with it but if there's a medical thing and --

MICHAEL O'BRIEN: I don't think any of this is medical. It's all procedure.

MR WILKINSON: Procedural is easy. But I think you are in a position -- I know you are in a position where you can go straight -- you can go straight to the case manager. Because

H this mediating thing, me sitting in the middle of direct contact, doesn't enable communication because you're better dealing with the case manager than you are -- and I don't mean that in any --

A MR O'BRIEN: Okay. Now that I know -- because I thought that the case manager sat like St Peter out there in a celestial bench, judgment bench, and waited for the proceedings to be presented to him by the case -- and we weren't to actually contaminate the process by approaching him in the meantime.

MR WILKINSON: I have asked this question.

B MICHAEL O'BRIEN: I thought that too.

MR WILKINSON: I have asked this question twice. Twice. And I will stand over the answer, which was no. There can be direct contact.

MR O'BRIEN: That's very, very useful to know that.

MICHAEL O'BRIEN: We will write a letter and we will CC -- give you a copy of it too.

C MR O'BRIEN: Because to be fair to Dr Khan --

MR WILKINSON: And don't be afraid to quote me because I am happy with that. I know where I stand.

MICHAEL O'BRIEN: We'll preface it by saying that we were informed by (inaudible) --

D MR WILKINSON: Yes, me.

MICHAEL O'BRIEN: -- that we could contact you directly with some of these concerns.

MR O'BRIEN: To be --

MICHAEL O'BRIEN: I suppose that contextualises it.

MR O'BRIEN: -- to be fair to Dr Khan, Dr Khan is being also provided with information

E which itself might be contaminated by whoever, concerning that period from March to December. It is my own view that Dr Wright -- I have a suspicion that Dr Wright might have been presented with things that, you know, that heavily influenced him.

The one thing I'll never understand about all of this is, is how any reasonable people,

F and I believe Dr Wright is certainly a reasonable person, Esther, and whoever else was the third person, Francis Rice -- you know, I know Francis very well. I know all of these people. How on earth after all of these years they came to the decision of 30 December without in some way making contact with me and saying, Aidan, what has happened?

MR WILKINSON: Yes. Yes.

G MICHAEL O'BRIEN: I think that's probably right.

MR WILKINSON: That's that what like -- if that was done at that early stage --

MICHAEL O'BRIEN: It could have been.

MR WILKINSON: It could have been.

H MR O'BRIEN: Roberta said, and her verdict will always ring true to me, her verdict was -- she said to me, Aidan, there was an easier way to do this.

MR WILKINSON: I know.

A MR O'BRIEN: And when I think of all of those people's outcomes not progressed at all.  
 A MICHAEL O'BRIEN: Maybe it is case manager to have a look at it. I think I will mention to him about looking at other ways to resolve this directly. You see, one of my problems with -- when you (inaudible).  
 MR O'BRIEN: I am watching the clock for John's sake.  
 B MICHAEL O'BRIEN: This is the final point I make. When you have large organisations like this with processes and procedures quite often once the wheels start to turn it's like juggernaut and it's very -- - you'll have heard me say that before. It is very hard to stop. It's going to go where it is going to go. You can try and nudge it every now and then but it is going to come to its conclusion and then you are going to have to compete with  
 C whatever is there.  
 But if it is the case that people can exercise independent judgment, it is probably going to be the case manager, Dr Khan, because he is the one whose judgment is ultimately being exercised. He will be the one who has to exercise judgment at some  
 D point.  
 MR O'BRIEN: Mmm.  
 MR WILKINSON: But will the case investigator not make recommendations?  
 MICHAEL O'BRIEN: The case investigator makes recommendations on the investigation I suppose. The case manager has to decide what to do with that information (inaudible).  
 E MR WILKINSON: Yes. Okay.  
 MICHAEL O'BRIEN: So I don't know. We haven't met Dr Chada.  
 MR O'BRIEN: Haven't even been contacted.  
 MICHAEL O'BRIEN: That's very strange. Dr Chada has been in place now for nearly a  
 F month.  
 MR WILKINSON: Yes.  
 MICHAEL O'BRIEN: Haven't met her. That's bizarre. Colin Weir, whenever he was appointed officially -- it took him a long time to get officially appointed as the investigator. I think it was a couple of weeks went past before he was officially appointed.  
 G He was a bit unsure what was happening. But when he did, one of the first things he did was to meet you.  
 MR O'BRIEN: No, it wasn't. Just to be clear.  
 MICHAEL O'BRIEN: One of the first things I said.  
 H MR O'BRIEN: No, no. Hold on. I had to ring him. I was getting alarmed. I had to make contact with Colin, wondering if it was the right thing or the wrong thing to do, to be contacting the case investigator. On the Monday, on the first day of the third week,

wondering what is happening.

A MICHAEL O'BRIEN: But he didn't know. He wasn't sure if he was.

MR O'BRIEN: No, he was sure that he was. He had been appointed by then. He was also very concerned about a four-week period that was coming to an end on 27 January and he had not been told who he was being assisted by from human resources. So he went to the bother of finding out himself, finding it was girl called Siobhan Hyde or something he told me. And that the two of them were meeting for the first time on Thursday 26 January, one day before the four-week period, and that they had no plans to meet me before then. This is -- you talk about procedure. It is appalling.

C MICHAEL O'BRIEN: Of course Dr Khan didn't write that letter.

MR O'BRIEN: No, Dr Khan didn't write this letter. He signed it. But if you send a letter --

MR WILKINSON: (Inaudible).

MICHAEL O'BRIEN: (Inaudible).

MR O'BRIEN: Mmm?

D MICHAEL O'BRIEN: It was either somebody in human resource or I wouldn't put it past somebody in the DLS who wrote that letter. I guarantee you.

MR WILKINSON: DLS?

MICHAEL O'BRIEN: Probably somebody in human resources wrote that letter.

E MR O'BRIEN: Maybe it was ~~Vivian~~ Vivienne that wrote this letter.

MICHAEL O'BRIEN: (Inaudible) No way in hell did Dr Khan write that letter, I guarantee you. He might have (inaudible).

MR WILKINSON: Yes.

MR O'BRIEN: Did you read this letter?

F MR WILKINSON: Yes, I did.

MICHAEL O'BRIEN: You see things like that comment (inaudible) "you as an experienced consultant (inaudible)", I don't think a doctor writes that letter.

MR WILKINSON: No. You would know from phraseology and the way things are written.

G MICHAEL O'BRIEN: No, that is not his. But, then again, may be some people do have a different writing voice than they do a speaking voice but I don't believe it.

MR O'BRIEN: (Inaudible) if it is someone from human resources --

MR WILKINSON: But if he signs.

MICHAEL O'BRIEN: It is his.

H MR WILKINSON: If he signs it, it is his.

MR O'BRIEN: His letter. Yes, he takes responsibility for it.

MICHAEL O'BRIEN: He does. I am not saying that. That's just telling you (inaudible).

A MR O'BRIEN: So, John, what I am going to do, the one thing I value -- I mean you have been very, very helpful and at a time psychologically very important when I was more traumatised than I am most of the time now. So I really appreciate all of that. What I still do appreciate is -- I think this is very, very important that I, and Michael beside me, that we have a third party repository for our concerns.

B MR WILKINSON: Yes. Okay.

MR O'BRIEN: Even if you or we do have no idea what you are supposed to do with them.

MICHAEL O'BRIEN: I think that is right.

MR O'BRIEN: I think that's a very important thing. So what I am going to do, because, for example, I don't think we would have sent you a copy of the amendments to the first meeting with Dr Wright.

C MR WILKINSON: No, I haven't got them.

MR O'BRIEN: I will do that and I'll send you a copy of this as well. So I will include you in any correspondence that we have in the future because I find that of reassurance.

D MICHAEL O'BRIEN: That there's somebody independent within the organisation.

MR O'BRIEN: At board level.

MR WILKINSON: I can assure you that that is the case.

MICHAEL O'BRIEN: No, it's just to make sure that you are getting all of the informationse.

MR WILKINSON: Right, okay.

E MICHAEL O'BRIEN: I think that is right and I think actually to an extent it probably keeps them on their toes a little bit. Probably. I don't think that Colin Weir -- you know, Colin Weir was taken off this. Colin Weir seemed to me a very nice man. He wouldn't been a particularly bad draw as an investigator. That was not necessarily a good thing.

F MR WILKINSON: I know.

MICHAEL O'BRIEN: But, at the same time, all of that happened and that fifth ground all happened because of the meeting we had --

MR WILKINSON: Absolutely

G MICHAEL O'BRIEN: -- in late January, early February. Whenever ~~t~~That was -- that all happened because of that.

MR O'BRIEN: But do you not -- you talk about procedure and propriety. For an organisation this size with its human resources department talking about my administrative practices, to have appointed a case investigator without realising that he was actually my clinical director and that he was going to be one of the people interviewed, what did you do about these issues, is appalling.

H MR WILKINSON: I used to have a clerk of sessions in my church. He was (inaudible). And

A if someone made a comment which required an opinion or a yes or a no answer, he would have replied, you guys are good at this by the way. "Is that so, Mr Wilkinson", so he didn't -- "is that so" because you are expecting an answer from the person because you've asked them a question and do get an answer but it's not a yes or a no. Is that is so, Mr O'Brien. Guys, I have to rush on.

B MICHAEL O'BRIEN: No, thank you.

MR WILKINSON: I really want to reassure you, I am completely -- no one will sway me one way or the other but I will be supportive in terms of, look, this has to be pushed on. If is something that you need me to do and you want me to do, and you have given me a couple of things there, I will do them but that's -- and I will attend here at whatever time you want me to. A bit like yourself.

C MR O'BRIEN: I think that, you know, the pushing on bit, we are not inviting you now to not ask them to push on so they can sink further into their time scales sink hole, because it is already ridiculous. I think -- I really do value the independence aspect of it, to be able to share all these things with you, because I think the board is going to have a lot of learning to do and I think the Trust is -- the executive --

D MICHAEL O'BRIEN: I just wish that people could learn.

MR O'BRIEN: Mmm?

MICHAEL O'BRIEN: Learn from mistakes before they happen whenever they are obvious.

E MR WILKINSON: Yes, but that's --

MICHAEL O'BRIEN: There are certain things that the Trust are going to do here. They are going to do this. And it is going to be damaging.

MR WILKINSON: It is, yes.

F MR O'BRIEN: It is.

MICHAEL O'BRIEN: A blind person could see it.

MR WILKINSON: That was the reason why I said, look, is there not another opportunity here for round the table discussions in order to expedite this.

G MICHAEL O'BRIEN: (Inaudible) They will have to have a hearing with you speaking, Michael Young and Martina Corrigan. How do you all go back to work the following week?

MR WILKINSON: I know.

H MICHAEL O'BRIEN: You know where mediation is really useful. People talk about things are too serious for mediation. It is not about seriousness. Mediation isn't easier than the hearing. The hearing is easy. This is actually the easiest thing to do. It has consequence.

MR WILKINSON: It is clean.

A MICHAEL O'BRIEN: But it is easier to do. Mediation is harder to do and where it is really useful is whenever you are dealing with people who fundamentally have to maintain a relationship at the end of it.

B So, if you are dealing with a family fall-out, Personal information redacted by USI, that's when it is useful because they have to get on with it at the end of it. Children they have to see at the weekends (inaudible).

C If it is, you know, a commercial relationship where there is some fall-out in the middle of a building project but who is paying when and what work is supposed to be done by, which is timeline, you go have and have a quick dispute resolution. It might be difficult. You might lose out. But the point is that you maintain the commercial relationship because that's everybody needs.

Hearings are great whenever everybody is walking away and you don't need to see each other again.

D MR WILKINSON: We had a dispute and resolution services within education. My first one of those I was just brought in. It as to do with special educational needs. It was hard. Hard.

MICHAEL O'BRIEN: It is hard. It is not won't be easy at all.

MR WILKINSON: Hard work.

E MICHAEL O'BRIEN: But it's worth it if you genuinely want to learn. If you want to come out of this with a list of, here's what went wrong and here is what we do, if that is what you genuinely want to achieve by the end of this investigation, then I think it would be better -- the outcome would be better by having the key players looking at all of the data, looking at all of the information, saying, look, what went wrong. And that calls for self-reflection that's not easy. It will call for you to recognise certain things that happened that shouldn't have mentioned. On everybody.

MR WILKINSON: Yes.

~~MR WILKINSON~~ MICHAEL O'BRIEN: So it's not easy.

MR WILKINSON: Do you need to put that in your letter?

G MICHAEL O'BRIEN: I guess I do. Okay.

MR O'BRIEN: John, thank you once again.

MR WILKINSON: Good to see you. Remember what your mother said to you. I'll not forget that. All right.

H MR O'BRIEN: I'm not sure. 'Don't work too hard I'm not sure it's worth it' (inaudible).

MR WILKINSON: Absolutely. Cheerio, guys.