

Aimee Crilly

From: Hunter, Catherine Personal Information redacted by the USI
Sent: 12 November 2015 09:18
To: Gishkori, Esther
Cc: Haynes, Mark; O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Young, Michael; Suresh, Ram; Hall, Sam; Korda, Marian; Reddy, Ekambar; Farnan, Turlough; McNaboe, Ted; McCaul, David; Leyden, Peter
Subject: 3 South Concerns
Attachments: Ward 3 South Concerns 2015.docx
Importance: High

Esther,

I refer to my recent e-mail correspondence with Heather Trouton, a copy of which I attach.

I have also raised my concerns with Mr Hayes and at his request, I have copied this e-mail to all the consultants attached to the ward.

While I appreciate the need to keep 36 beds open on the ward, I am gravely concerned with the lack of staff and skills mix at present. While I am very grateful for the help given to me in recent days by Heather and Trudy Reid in getting us staff to cover unfilled shifts, I feel this is only a short-term measure and a medium to longer term solution needs to be developed and I would be keen to discuss this with you and my clinical sisters.

Currently, the standard of care being given to patients is being compromised and I would consider the ward to be clinically unsafe at times. I am also responsible for the welfare of my staff and feedback from them indicates an environment of desperation with many of them coming to see me in tears and unsure how long they can continue to work in such conditions.

In such circumstances, I am obliged by my NMC Code of Conduct to escalate my concerns to senior management and I would request an urgent meeting with you to discuss a plan of action to address the situation.

Catherine Hunter
Ward Manager
3 South

Ward 3 South – Craigavon Area Hospital

I have now been in the position of Ward Manager for 8 weeks and have assessed the operation of the ward during that time.

Overall View:- My overall assessment is that the ward is clinically unsafe due to severe staff shortages owing to high sickness levels and vacant posts.

Main Issues

- 1) Staff Shortages – At present, due to sick leave and vacant posts, the ward is operating with a deficit of approximately 1/3 of its full staffing compliment prior to requesting cover from the bank/agency. My experience is that the bank/agency is not always reliable, with only about 50% of the hours covered.

Band	Current Deficit	Deficit after Sickness
Band 7	0	0
Band 6	7.5	7.5
Band 5	209.25	366.25
Band 2/3	184.875	214.875
Total	401.625	588.625

366.25 hours deficit of Band 5 nurses equates to almost 3 full 24 hour periods without cover, prior to going to the Bank/Agency,

214.875 hours deficit of Band 2/3 nurses equates to just over 4 full 24 hour periods without cover, prior to going to Bank/Agency.

If we only get 50% of this time covered, there is still a significant shortfall in staffing which is compromising patient safety and staff morale.

Even when booked, bank/agency staff are not always reliable. For example, I have been made aware of an incident that took place on Friday night (6/11/15), when the bank night-time auxiliary did not turn up for work and despite the staff requesting cover from the bed manager, no additional staff were provided. A patient fell twice on the ward as there were not sufficient staff members available to help him. Appropriate forms have been filled in and this incident will now have to be investigated. This is an example of patient safety being compromised and it is one of many issues that have been highlighted to me in recent weeks.

At present, as ward manager, I am having to regularly look after a quota of patients to ensure the safety of all patients on the ward, as a result of staff shortages and patient dependency. As a result of this, I have been unable to discharge a large percentage of my managerial responsibilities and have not been able to meet with

my Band 6 nurses to discuss action plans/strategies for the ward. I find this extremely frustrating as I have identified ways to improve the performance of the ward but am currently unable to implement these. I am aware that RQIA carried out an inspection earlier this year and whilst many of the cosmetic features of the ward have been improved, the problems they identified with staff have not and I feel have probably worsened due to staffing shortages leading to poor morale.

- 2) Staff Morale – During my 8 weeks in post, I have constantly had to reassure staff who come to my office in tears, due to the pressure and demands upon them caused by the staff shortages. I believe it will only be a matter of time before sickness levels increase further due to stress putting even more pressure on those staff remaining. Members of staff are also indicating their desire to move on and look for posts elsewhere.
- 3) Skills Mix – I have identified a significant shortage of the necessary skills required for running a specialised ward for ENT & Urology. This position is exacerbated by the high level of bank/agency nurses working on the ward. Many of the permanent members of staff do not have the knowledge or confidence to deal with laryngectomy patients and many ENT conditions. As a result, patient safety is being compromised. There are a number of very inexperienced members of staff who are having to be left in charge of the ward, when they do not have the necessary skills to take on this level of responsibility. However, given the staffing position, there has been no alternative to this available.
- 4) Nursing Care Records – I am discovering that these records are not being fully maintained despite the nursing staff knowing that this is a requirement. However, the feedback I am getting and my own observation is that they do not get the time to fully discharge this duty even when many of them are working over their contracted hours. All their time is being spent trying to maintain patient safety.
- 5) Cancellation of Staff Training – Given the staff shortages, I have had to cancel staff training as it would have compromised patient care to release them. Given the need for training, this is frustrating and counter-productive.
- 6) Staffing of ENT Clinical Room during the day – I have been advised by my Head of Services, that within my staffing allocation, 1 member of staff should be available to be released from 'the floor' to assist in the ENT clinical room. I am regularly unable to fulfil this requirement due to lack of staff on the floor.
- 7) Pharmacy Cover on ward – as you are aware we do not have an allocated pharmacist on the ward. Recently, it came to my attention that a large amount of non-stocked

drugs were stored in an unmarked, locked cupboard on the ward. I immediately alerted the pharmacy department to this and they came to the ward immediately to remove the substantial amount of drugs that had been accumulated. This would not happen with an allocated pharmacist on the ward.

Proposed Solutions

- 1) **Staff Shortages** - This is something outside my control. I understand that it is impossible to predict sick leave and that the Trust is currently undertaking a recruitment drive to fill vacant positions. However, I believe that my ward is currently in crisis and if immediate action is not taken to address the current position, we will haemorrhage further staff, exacerbating the current dire position. I firmly believe that our bed capacity must reflect the staffing levels available to provide an acceptable standard of nursing care to maintain patient safety. It is my judgement that the staff I currently have work extremely hard but at current levels cannot maintain safety for 36 patients. I would recommend that in the absence of an immediate improvement in staff numbers that serious consideration is given to reducing the ward capacity.
- 2) **Staff Morale** – this is directly linked to staff shortages, lack of training and the intense pressure they are working under. I am supporting them as much as I can by taking an allocation of patients, when required, which is becoming a regular occurrence (this is not sustainable as I am unable to adequately carry out my management duties) and 2 staff meetings will be arranged within the next week to allow staff the opportunity to address issues they have identified and to provide reassurance and praise to them. I would also like to commence staff appraisals so that performance can be assessed but also that each individual's needs can be identified and a plan put in place to further develop their skills and careers. I believe this in turn will show a commitment to each staff member and lead to increased motivation and willingness to take on further responsibility. As a result, the ward will benefit greatly.
- 3) **Skills Mix/Staff Training** – It is essential that staff training recommences as soon as possible as there is an immediate need to upskill the nurses on the ward to ensure that acceptable levels of patient care are provided at all times. As mentioned above, I would like to appraise all staff to identify skills gaps and training needs and put a plan in place as a matter of urgency. However, this will be dependent on having adequate staffing levels to cover the ward at all times. Trained staff will also feel empowered to take on greater responsibility which will take some of the pressure off ward management, enabling them to manage and plan for the ward more effectively.

- 4) Nursing Care Records – This is an area I will address with all staff to impress upon them the absolute need for accurate nursing care records to be maintained. However, this is directly linked to the staffing levels and the need to maintain patient safety at all times.
- 5) Staffing of the ENT Clinical Room – this is an area directly linked to the staffing levels on the ward and at present it is impossible to staff this room. This compromises patient safety and Mr Hall has expressed great concern about the current position.
- 6) Pharmacy Cover – I understand that this situation is currently being addressed and I would ask that it is dealt with as a matter of urgency.

In conclusion, when I started work on the ward, I was made aware of a number of issues that needed addressed. However, I was not provided with an induction which would have been very beneficial given the significant issues identified in the RQIA report. I have assessed the ward over the past 8 weeks and have identified solutions to many of these issues. However, I am greatly frustrated at the lack of time I have to put plans in place given the need to take allocations of patients. It is impossible to manage the ward effectively when having to take on clinical duties on a regular basis and many audits have not been carried out on time or at all. I am highlighting this as I do not want it to be seen as a lack of my management ability but it is impossible to do 2 jobs at once.

As already stated, I currently believe that my ward is clinically unsafe and this is due to chronic staff shortages, which is something outside of my control. I have verbally highlighted this on a number of occasions over the past few weeks to my line managers but the position is now worsening and I feel this needs to be highlighted in writing and that immediate action is now required to address the shortcomings. Having had the opportunity to review the RQIA Framework document provided to me by Trudy Reid, I am greatly concerned that my ward would not meet many of the requirements.

I am willing to work with anyone and anyhow to improve the performance of the ward and I fully believe I have the skills to do this. However, staffing is the one area outside of my control and as a result I need the support of my line managers to urgently address the position.

I would request a meeting this morning, so that the issues highlighted can be discussed as staffing levels this week are particularly low with little bank cover currently in place.

Catherine Hunter

Ward Manager

3 South

From: Haynes, Mark [Personal Information redacted by the USI]
Sent: 13 November 2015 07:07
To: Hunter, Catherine; Gishkori, Esther; Trouton, Heather
Cc: O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Young, Michael; Suresh, Ram; Hall, Sam; Korda, Marian; Reddy, Ekambar; Farnan, Turlough; McNaboe, Ted; McCaul, David; Leyden, Peter
Subject: RE: 3 South Concerns

Thanks for the update Cathy

This is extremely concerning and in particular if patients incidents have occurred due to staffing issues already we need to act now and not wait for a more significant incident to occur.

My experience of Bank / agency staffing is that while they may fill a vacant gap, they often do not perform the full role as we would see performed by a regular member of staff. The result is that the regular members of staff come under increased pressure during their shift. In addition to the Bank and agency staff you also highlighted to me that some members of our nursing team are very newly qualified and this has meant that at times the ward staffing (at staff nurse level) has been made up of bank / agency staff, a newly qualified nurse and one more experienced nurse, increasing the pressure on the regular members of staff significantly. I recently operated on the relative of a colleague and the informal feedback from this family regarding the ward was that the staff are excellent but under significant pressure and not able to attend to patients as would be expected.

Where the ward is understaffed for the 31 beds continuing with 36 beds open and relying on Bank / agency staff is not safe as you highlight. In prioritising care, emergency admissions come first and so we should not be admitting elective patients while the current situation exists.

Mark

From: Hunter, Catherine
Sent: 12 November 2015 09:18
To: Gishkori, Esther
Cc: Haynes, Mark; O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Young, Michael; Suresh, Ram; Hall, Sam; Korda, Marian; Reddy, Ekambar; Farnan, Turlough; McNaboe, Ted; McCaul, David; Leyden, Peter
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Esther,

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I have also raised my concerns with Mr Hayes and at his request, I have copied this e-mail to all the consultants attached to the ward.

While I appreciate the need to keep 36 beds open on the ward, I am gravely concerned with the lack of staff and skills mix at present. While I am very grateful for the help given to me in recent days by Heather and Trudy Reid in getting us staff to cover unfilled shifts, I feel this is only a short-term measure and a medium to longer term solution needs to be developed and I would be keen to discuss this with you and my clinical sisters.

Currently, the standard of care being given to patients is being compromised and I would consider the ward to be clinically unsafe at times. I am also responsible for the welfare of my staff and feedback from them indicates an environment of desperation with many of them coming to see me in tears and unsure how long they can continue to work in such conditions.

In such circumstances, I am obliged by my NMC Code of Conduct to escalate my concerns to senior management and I would request an urgent meeting with you to discuss a plan of action to address the situation.

Catherine Hunter
Ward Manager
3 South

Angela Kerr

From: Hunter, Catherine Personal Information redacted by USI
Sent: 02 July 2016 02:41
To: Haynes, Mark; O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Suresh, Ram; Hall, Sam; Korda, Marian; Farnan, Turlough; McNaboe, Ted; McCaul, David; Leyden, Peter
Cc: Sheridan, Patrick
Subject: Leaving 3 South

Importance: High

Follow Up Flag: Follow up
Flag Status: Flagged

I am just sending this email out to inform you all of my resignation, I know that you all probably know this already but I felt it would be remiss of me not to drop a few lines upon leaving.

I have enjoyed my sort time in post and have tried my best to keep patient safety and quality of care to a maximum at all times. This however has been one of the main reasons that I felt I needed to move on, as I'm sure you are aware we have quite a few vacancies on the ward and with the posts not being filled and being expected to keep beds open to maximum I have felt at times that patient quality of care was not present. This is through no fault of the nurses at ward level as they all try very hard but it's extremely difficult to deliver good quality care when the staff feel so exhausted and morale is in their boots.

I WILL BE SENDING Mark Haynes an email explaining in more depth how I think management could take the ward forward, but I fear that management just don't want to know.

I wish the ward success in the future and hope that the staff get the recognition that they so deserve.

Regards

Catherine Hunter

From: Hayes, Nicola [Personal Information redacted by the USI]
Sent: 01 June 2009 12:38
To: O'Brien, Aidan
Cc: Donaghy, Colm; Wright, Elaine; McAlinden, Mairead; Radcliffe, Sharon; Gibson, Simon; Mackle, Eamon; Brown, Robin; Tedford, Shirley; Martin, Clare
Subject: Urology Services
Attachments: Mr O'Brien re Services 1.6.09 signed.pdf

Hello Mr O'Brien

Please find attached correspondence from Joy Youart in response to your letter of 29.5.09.

Kind regards.

Nicky

Nicky Hayes

Personal Assistant to Mrs Joy Youart, Acting Director of Acute Services Southern Health & Social Care Trust Craigavon Area Hospital

[Personal Information redacted by the USI] (Direct Line)

**Southern Health
and Social Care Trust**

Acting Director of Acute Services

Administration Floor

Craigavon Area Hospital

Mr Aidan O'Brien
Consultant Urological Surgeon
Southern Health & Social Care Trust
Craigavon Area Hospital

1 June 2009

Our Ref: JY/njh

Your Ref:

Dear Aidan

Urology Services

Many thanks for your letter dated 29 May 2009 regarding the recent response to the consultation on the surgical reconfiguration of beds and making the time to come and see me directly on Friday.

The eight points presented in your paper on Wednesday were very helpful in reaching consensus and agreement. As requested in your letter, I am more than happy to respond to each point and outline the role of the Urology Ward Manager.

Can I at the outset, thank you and your colleagues for all the time and commitment you have personally given to move us forward to a consensus position. I very much appreciate how difficult this has been, but now feel we can all move forward with an agreed position. I will take the points in order as presented in your paper.

Point 1

Both Mairead McAlinden and myself are committed to the transfer of flexible cystoscopies and the expanded use of both the Thorndale Unit and other Trust facilities. I know already the options regarding a link corridor are being explored as a matter of priority and see no barriers presently to this occurring in the short term.

Point 2

I feel we have all been striving to achieve this point and work is currently underway with all specialties, to maximise day surgical facilities. This is now part of an action plan.

Point 3

I am delighted that there is agreement to utilise Ward 3 South for elective day surgical patients. This I believe will be further facilitated by the development of care pathways in Urology. I have asked Heather Trouton and Robin Brown to support and assist your team in developing those care pathways.

Point 4

I acknowledge the commitment to admit all patients to Ward 3 South and could I suggest that the team liaise with Connie Connolly and Heather Trouton to facilitate this.

/cont.2..

Mr A O'Brien re Urology Services 1.6.09 cont....

Point 5

I acknowledge there is a degree of flexibility required in utilising the elective short stay ward. I am hopeful that by developing care pathways as outlined above, this will assist in determining the best area for post-operative management.

I would like to suggest that the procedures that could utilise this facility are identified and we work through the implementation of these over the next month with the team.

Point 6

The Urology Unit will provide care for long stay and non-elective patients as appropriate, I am sure that the work to develop care pathways will assist with this. I am happy to provide support for this to be taken forward.

Point 7

I can only reiterate my thanks to the team in accepting this proposal that the Urology Unit will be located in the ward area, to which all general surgical non-elective patients will be admitted.

Point 8

I would like to outline for you the role I have discussed with Shirley Tedford. Firstly, I recognise the role she has played in co-ordinating the numerous activities in Urology, which are much wider than a Ward Manager's role. This has been a wide span of responsibility and I feel we need to recognise and give her the time to undertake the diverse role required.

With this in mind, I feel the role needs to expand to one of Nurse Clinical Lead/Co-ordinator for Urology Services. The role will encompass providing nursing leadership/co-ordination to both the Urology Unit and the patients who are being admitted to both the day case and short stay areas.

The role will also cover the services in Urodynamics and the Thorndale Unit, establishing and supporting the areas outlined alone in Point 1.

I have also discussed with Shirley the development with yourselves of care pathways with the assistance of Mr Robin Brown.

The Ward will be managed by Sheila Mulligan with nursing and clinical leadership input from Shirley.

I know they have both discussed this and are in agreement. They feel they can manage this on a day-to-day basis. I believe this will have a number of benefits to Shirley in her new role:-

- Dedicated time to develop the Urology Service without the day-to-day demands of running a 36 bedded ward ensuring clinical quality in the Urology area
- Time to develop care pathways with the clinical team

/cont..3..

Mr A O'Brien re Urology Services 1.6.09 cont....

- Providing clinical support to Urology nurses in both the Urology Unit, Day Case & Short Stay areas
- Development of the services that can be provided in the Thorndale Unit and Urodynamics
- Time to liaise with community colleagues in the development of protocols for aspects of care that can be delivered in a community setting.

I know when we spoke on Friday, you felt this was a role that had been suggested a while ago and you indicated your support for such a role. I really appreciate that this has been a challenging time for you and the team and I hope this letter provides the reassurance and commitment from the Senior Management Team you require.

I look forward to taking forward these developments with you and your team in a spirit of openness and partnership working.

Finally, may I thank you personally for all the time and commitment you have given to enable us to move forward on all of these points.

With best wishes.

Yours sincerely

Mrs Joy Youart
Acting Director of Acute Services

cc Mr C Donaghy, Chief Executive
Mrs M McAlinden, Director of Performance & Reform
Mr S Gibson, Assistant Director of Acute Services (Surgery & Elective Care)
Mr E Mackie, Associate Medical Director (Surgery & Elective Care)
Mr R Brown, Clinical Director (Surgery & Elective Care – DHH Site)
Sr S Tedford, Ward 2 South (Urology)

Memorandum **By E-Mail**

To: Mr Aidan O'Brien, Consultant Urologist
From: Mrs Heather Trouton, Assistant Director of Acute Services –
Surgery and Elective Care
Date: 1st July 2011
Subject: **Issues and Actions from Meeting held on 9th June 2011**

Following our discussions on Thursday 9th June 2011 please see following a summary of our discussions and actions agreed.

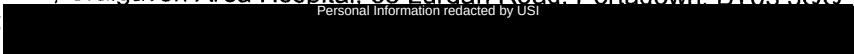
1. Dr Rankin outlined the Trust requirement for updated Job Plans to be complete prior to end of June 2011. Dr Rankin also placed the meeting in the context of the Regional Urology Review and the necessity of demonstrating the provision of an effective, efficient and productive Urology Service if further funding was to be secured from the Regional Board. This productivity was also set in the context of the SBA Capacity Modelling exercise underway for all specialties across all Trusts.

2. Job Planning

- Mr O'Brien to submit current breakdown of activities to Mr Mackle for planning into updated Job Plan as per Trust action for all Consultants Trust wide to agree an updated Job Plan by end of June 2011.
- Update – this was submitted on Thursday 16th June 2011. Draft Job Plan to be constructed for discussion.

3. Review Backlog

- Heather Trouton to meet with Mr O'Brien to discuss way forward in managing review backlog in a timely manner. Heather Trouton to set up meeting. Also to ensure that responsibility is taken to manage all outpatient appointments in such a way as to only review those who clinically require review and thereby reduce the formation of a review backlog unnecessarily.
- A discussion was also has regarding appropriate communication with patients who have had their review appointment delayed due to the current backlog or review appointments.

Surgery and Elective Care Division, Acute Services Directorate,
Admin Floor, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
E-mail: 

Personal information redacted by USI

4. Patient Admission for Surgery

- Patients are not to be brought in the days prior to surgery for IV fluids and IV antibiotics without discussion with and agreement from both Ms Sloan (as CD) and a Consultant Microbiologist (Dr Damani/Raj).
- All patients are to be brought in for elective surgery on the morning of surgery with the exception of the very complex patient who requires essential inpatient management prior to major surgery.

5. Urodynamics

Consultant input – it was agreed following discussion that Mr O'Brien would require 20 minutes per patient to review the results of their urodynamics studies and agree/provide a management plan for each patient. This would be factored into workload but does not require a full dedicated urodynamics session.

6. Pooled Lists

Agreement on the need to manage all daycase patients in a chronological manner. To support Mr O'Brien in managing the chronological booking process Mrs Sharon Glenny, Operational Support Lead and Mrs Andrea Cunningham, Service Administrator for Urology will contact Mr O'Brien to discuss support/input required.

7. Cancer Pathway

Discussion was had around Specialist Interest within Urology.

With regard to Outpatient time required to see Day 4 Cancer patient it was agreed that a 30 minute slot would be required.

8. Discussion regarding the leadership requirement of all senior staff (inclusive of Consultants) to give confidence to all ward/department nursing staff regarding patient care and to take action to improve patient management rather than projecting a negative and critical attitude within the clinical team.

I would appreciate if you would advise if the above is an accurate reflection of discussions had and actions agreed or if any amendments are sought.

Mrs Heather Trouton

Assistant Director of Acute Services – Surgery and Elective Care

Copy

Personal Information redacted by USI

30 January 2012.

Dr. Gillian Rankin,
Director of Acute Services,
Southern Health and Social Care Trust,
Craigavon Area Hospital,
Craigavon,
BT63 5QQ.

Dear Dr. Rankin,

I wish to take this opportunity to formally submit, in writing, a grievance regarding the deductions made to the payments owed to me on foot of a claim for extra contractual work. These deductions amount to a breach of agreement with management regarding the rate of remuneration for the sessions claimed, a rate subsequently reaffirmed to me by management.

In the autumn of 2010, it was agreed by the Head of ENT and Urology that I would be remunerated one additional sessional payment for conducting combined urodynamic studies and oncology reviews all day Fridays in the Thorndale Unit. I enclose a copy of the claim form submitted 2nd March 2011, consisting of a claim for 15 such sessions in addition to 4 sessions of Inpatient Operating and 2 sessions of Urodynamic Studies completed on Saturdays.

When I received payment of Personal Information redacted by the USI gross in April 2011, I was unable to recognise the amount. In contacting the Payroll Department, I was advised that payments for additional Friday sessions had been halved, whilst the remaining sessions had not been paid at all. When I enquired why deductions had been made, the Payroll personnel informed me that they were unable to decipher the signature of the person who had made the deductions. For that reason, I was provided with a copy of the claim form (enclosed). It was evident to me that the deductions were made by Mr. Eamon Mackle. I subsequently received payment for the unpaid Saturday sessions in May 2011.

To date, I have not received full payment in respect of these sessions, nor have I received any communication regarding same, apart from verbal confirmation of the agreement.

This has occurred against the background of an earlier claim for urodynamic studies submitted 17th January 2011. I made monthly enquiries until August 2011 regarding lack of payment, only to be advised by Payroll on each occasion that a claim had yet to be received. I wrote to the Head of ENT and Urology in August 2011 to express my concerns. I was advised that the claim had been authorised by Ms. Corrigan, by Ms. Trouton and then by Mr. Mackle, but had been mislaid thereafter. I had to submit yet another claim for those sessions in September 2011, payment received in October 2011, nine months after the initial submission.

The deductions referred to above were a breach of an agreement, and to compound matters, the deductions were made without my authority or knowledge. I am making a formal request to have this matter investigated and to be provided with an explanation as to why these deductions have been made. At the time of writing, I have completed further claim forms for extra contractual work which I have not submitted as I simply do not have the confidence that they will be processed in a proper and timely manner. Finally, I am requesting that management honour the agreement that was made with me by providing full remuneration for the additional sessions that I have undertaken,

Yours Sincerely,

Aidan O'Brien.



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: 31/10/2019

HSCB Unique Case Identifier:

Personal Information
redacted by USI

Service User Details: (*complete where relevant*)

D.O.B:

Personal Information
redacted by USI

Gender: M

Age: 70

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

Patient 9, a 70-year-old man, was referred to urology services in Craigavon Area Hospital (CAH) via the Emergency Department (ED) following an episode of retention of urine in May 2019. He was reviewed by Dr.1 who noted a raised PSA. Suspicious of prostate cancer, Dr.1 commenced Patient 9 on Bicalutamide (50mgs od) whilst awaiting transurethral resection of the prostate (TURP).

A TURP was performed. The findings were thought to be in keeping with bladder outlet obstruction due to bladder neck hypertrophy (enlargement). The bladder neck and prostate gland were partially resected and histology showed benign disease only. Patient 9 was able to pass urine prior to discharge home. A routine review for September 2019 did not happen. Patient 9 presented in ED in May 2020 complaining of abdominal pain and urinary retention. Following digital rectal examination an initial diagnosis of bowel cancer was made; histological examination later concluded Patient 9 had advanced prostate cancer.

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 recently SHSCT)

Mrs Patricia Kingsnorth – Acting Acute Clinical and Social Care 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 quality care.
- Examine any areas of good practice and opportunities for sharing learning from the incidents.
- To share the review with the Director of Acute Services/ Medical Director/ staff involved/ patient.
- To share with the HSCB.

Review of Medical Notes

Interviews with Staff

Family Engagement – discussion with patient

Review of the Northern Ireland Health Care Record

MDT pathway for Cancer Management

Comparative analysis against Regional and National Guidelines

5.0 DESCRIPTION OF INCIDENT/CASE

At presentation, **Patient 9** was a 70-year-old gentleman who attended the Emergency Department (ED) in Craigavon Area Hospital (CAH) on 1 May 2019 complaining of severe abdominal pain and urinary retention. He was catheterised and referred to urology.

Patient 9 was seen on 24 May 2019 by Dr.1 (Consultant Urologist) who noted a history of lower urinary tract symptoms and a failed trial removal of catheter (TROC). A serum prostate specific antigen (PSA), (which is a blood test that indicates the risk of the presence of prostate cancer), was elevated. Following examination, Dr.1 was suspicious of the presence of significant prostate cancer. He initiated partial androgen blockade by prescribing bicalutamide (50mgs, once daily) whilst awaiting a prostatic resection which was arranged for 12 June 2019.

On 12 June 2019, **Patient 9** attended for TURP. The procedure was performed by Dr.1 who noted that the prostate gland did not look “particularly enlarged or obstructive”. Severe bladder neck hypertrophy and a trabeculated bladder were seen, (trabeculation represents bladder muscle that has thickened over time, possibly, but not exclusively as a result of obstruction to outflow of urine). The findings were thought to be in keeping with bladder outlet obstruction due to bladder neck hypertrophy (enlargement). The bladder neck and prostate gland were partially resected and **Patient 9** was able to pass urine prior to discharge home.

Patient 9 was reviewed on 2 July 2019 when he was noted to have suffered an increase in urinary symptoms since discharge. It was noted there was no evidence of malignancy on histopathological examination, however, Dr.1 documented in the patient’s GP letter that he suspected there may be a cancer in the unresected prostate gland and therefore arranged a repeat PSA level, an ultrasound scan of the urinary tract and a MRI scan of the prostate. Depending on the PSA result, Dr.1 stated in the GP letter that he was considering performing a prostatic biopsy of the gland remnant but deferred this until a planned review in September 2019.

No appointment is recorded until **Patient 9** attended the Emergency Department (ED) at CAH on 8 May 2020. He complained of severe urinary symptoms and was found to be in retention of urine. He was also noted to have some diarrhoea with associated rectal

5.0 DESCRIPTION OF INCIDENT/CASE

bleeding and tenesmus (an uncomfortable feeling or pain indicating a need to open

the bowels). He was reviewed by Dr.2 (a specialist surgical trainee, ST4) who documented that Patient 9 was known to urology services and queried if he had been lost to follow up. On digital rectal examination Dr.2 felt a rectal mass and suspected prostate cancer. Bloods for a PSA level was taken. Patient 9 was catheterised and allowed home with a referral to both urology and colo-rectal surgery.

According to a letter, dated 12 May 2020, from Dr.1 to Patient 9 following a virtual clinic review, Doctor 1 prescribed bicalutamide (50mg) for the suspected prostate cancer, in addition to tamsulosin (0.4mg) for the urinary symptoms. He had asked for Patient 9's GP to arrange for the district nurse/ practice nurse to review Patient 9 on 18 May 2020 for a trial removal of catheter (TROC).

On 18 May 2020 Patient 9 attended for the TROC as arranged. He was unable to void urine and as a bladder scan showed 500mls of residual urine a catheter was reinserted. He was reviewed by Dr.3 (specialist urology trainee, ST3) who noted that the serum PSA level (9.5ng/ml) was elevated. Dr.3 also noted that during Patient 9's attendance at ED that Dr.2 had recorded that the prostate felt malignant. Dr.3 requested a MRI scan of the prostate and pelvis and wrote a referral letter to request an outpatient review by Dr.1. In addition, a red flag referral to general surgery was made and a letter for information was sent to Patient 9's GP.

On 27 May 2020, Patient 9 attended for the MRI scan, which demonstrated a pelvic mass that was highly suspicious of prostate cancer causing an urethro-rectal fistula.

On 12 June 2020, Patient 9 attended for a CT scan which showed a large rectal mass with small volume groin nodes but no distant metastasis.

Patient 9 was reviewed by Dr.4 (General Surgery Consultant) on 30 June 2020 who performed a biopsy of the mass per rectum. Histology confirmed poorly-differentiated (aggressive) prostate adenocarcinoma (Gleason 9/10).

Patient 9's case was discussed at the urology MDM (2 July 2020) which noted a locally advanced prostate cancer. The MDM recommended prompt urology review, to commence androgen deprivation therapy (ADT), and that a bone scan was arranged.

Dr.5 (Consultant Urologist) saw Patient 9 (6 July 2020) and found that he continued with rectal bleeding and tenesmus. Patient 9 had stopped his bicalutamide (May 2020) and, so, was on no treatment for his prostate cancer. The MDM recommendations were followed. Further discussion at MDM was planned for when the bone scan results were available. It was intended that if there was no metastatic disease, he would be referred to oncology.

Patient 9 attended the ED (27 July 2020) with ongoing problems with his urinary catheter which was changed earlier in the day but was still not draining. His catheter was changed again and he was commenced on oral antibiotics. He was discharged home.

Two days later (29 July 2020) Patient 9 returned to the ED with urinary retention after again having his catheter changed in the community. He was noted to have a very low urine

5.0 DESCRIPTION OF INCIDENT/CASE

output through the catheter despite good hydration. Patient 9 reported passing urine per rectum. Faeces were seen in the catheter bag.

Patient 9 was admitted under the care of Dr.6 (Consultant Urologist) as he was in painful urinary retention, but the urology team were unable to pass a urethral catheter. He was taken to theatre for the open insertion of a suprapubic catheter under general anaesthetic.

A bone scan did not show metastases.

Patient 9 was reviewed by the acute oncology service during this admission; palliative treatment was recommended. It was decided that Patient 9 would need a defunctioning faecal stoma and possibly an ileal conduit (stoma bag for the bladder). Patient 9 was reviewed by the stoma nurse regarding future stoma.

The surgeons planned surgery for the defunctioning colostomy when Patient 9 felt able: he wanted to return home to recuperate before undergoing any further intervention. He was discharged home on 1 August 2020.

Patient 9's case was discussed at MDM on 6 August 2020. The recommendation for de-functioning colostomy was confirmed, but the supra pubic catheter was to be maintained for urinary drainage. Palliative radiotherapy could be considered after Patient 9's surgery and he was to remain on hormone therapy.

On 13 August 2020 Patient 9 attended the ED complaining of severe abdominal pain and was noted to have a recto-vesical fistula. He was admitted under the general surgical team and underwent an emergency laparotomy and defunctioning sigmoid loop colostomy on 14 August 2020. He was discharged home with a planned review by the urology team.

On 19 October 2020 Patient 9 was reviewed by Dr.5 (Consultant Urologist), it was noted that Patient 9 was having intermittent episodes of diarrhoea and penile discomfort. His PSA was noted to have risen to 17.30ng/ml and a referral was made to Clinical Oncology in Belfast City Hospital for further assessment.

6.0 FINDINGS

Patient 9 presented in urinary retention and demonstrated features of possible prostate cancer. This possibility should have been pursued by the request of a MRI of the prostate and pelvis and ultrasound guided needle biopsy of the gland. Alternatively, an urgent TURP and the needle biopsies could have been performed simultaneously after the MRI scan. This would have established the diagnosis and, following staging with a bone scan, the patient could have been referred for a specialist opinion on radical therapy.

- The review team believe that Dr.1 suspected prostate cancer based on clinical examination and raised PSA. Following TURP, which showed benign disease, there was no intention to consider this further until 3 months after presentation.

6.0 FINDINGS

- Although the possibility of prostate cancer was considered from the time of presentation - the PSA was elevated - there was no record in the medical notes of a digital rectal examination (DRE).
- During the operation further signs might have been elicited and appropriate (ultrasound guided needle) biopsies could have been performed. A transrectal biopsy, performed at the time of the TURP, would have secured the diagnosis.
- TURP is not an adequate way to biopsy the prostate gland. NICAN Urology Clinical Guidelines 2016 indicate that TURP is a poor clinical tool for cancer diagnosis and recommend prostate biopsy by the trans-rectal or trans-perineal approach.
- The Review Team conclude that the signs of localised prostate cancer were apparent from the time of presentation and that the 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 together with a bone scan.
- Arrangement could then have been made to start androgen deprivation therapy (a LHRH analogue) before referral on to a clinical oncologist for consideration of external beam radiotherapy (EBRT) with a realistic prospect of effective disease control.
- Dr.1 still suspected cancer within the prostate gland in a GP letter (dated 24 May 2019) but deferred definitive investigation until a review planned for September 2019.
- Patient 9's appointment in September was not made and he was lost to follow up.
- Patient 9 presented to Emergency Department (ED) on 8 May 2020 with urinary tract symptoms and signs of locally progressive prostate disease.
- After interactions with Urology and Lower Gastro-Intestinal Surgical colleagues, Patient 9 was diagnosed with high grade carcinoma of prostatic origin, Gleason score 9. The patient had locally advanced disease and a colo-vesical fistula.
- When Patient 9 was reviewed at a virtual clinic in May 2020 by Dr 1, he was commenced on bicalutamide 50mgs. Bicalutamide (50mg) is currently only indicated as a preliminary anti-flare agent 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 Clinical 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 Dr.1 was the regional chair of this group and

6.0 FINDINGS

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.
- The review team believe that Patient 9 could not and did not give informed consent to this alternative pathway.
- Patient 9 was not referred to a Urology Cancer Nurse Specialist no phone numbers were provided, despite Patient 9's delayed diagnosis and immediate complex needs.
- The review team met with Patient 9 and his wife as part of the family engagement for the SAI. He described feeling isolated with no guidance on how to seek support or further care when he needed it. This resulted in numerous attendances to the Emergency Department with blocked catheters and urinary retention which Patient 9 found to be quite distressing. He was advised that the ED was the wrong place for him and that he should seek help from his GP. His experience in ED was further compounded by the Covid-19 restrictions.
- The review team acknowledge that the ED was not the most appropriate route for Patient 9 to access. However, Patient 9 did not have access to a urology CNS to support him and his family with his diagnosis and despite having complex healthcare needs.
- The Southern Health and Social Care Trust Urology Cancer Peer Review submission 2017 states "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." (1)

Multidisciplinary Team Meetings

- Patient 9 was not referred to MDM in a timely fashion because of non-adherence to diagnostic pathways Northern Ireland Cancer Network (NICAN) Urology Cancer clinical Guidelines 2016 and a delayed diagnosis of cancer.
- The MDM was quorate 11% 2017, 22% 2018, 0% 2019 and 5% 2020

7.0 CONCLUSIONS

The possibility of localised prostate cancer should have been considered from the time of presentation; although there is no record of a digital rectal examination the PSA was elevated. Further, signs should have been elicited during the TURP and appropriate biopsies could have been performed. TURP does not provide an adequate biopsy of the prostate gland.

A MRI scan prompted by a digital rectal examination together with the elevated PSA might have revealed the need for biopsy. A transrectal biopsy performed either before or at the time of the TURP would have secured the diagnosis. Arrangements could have been made to start appropriate hormone therapy (a LHRH analogue) prior

to referral to a clinical oncologist for an opinion on external beam radiotherapy with a realistic prospect of effective disease control.

To compound this, the patient was apparently lost to follow up after his appointment in July 2019.

Patient 9 is likely to have suffered an unnecessary outcome owing to delays in the investigation of his symptoms and signs, the unconventional treatment of prostate cancer, and failures in follow up procedures.

Had the appropriate investigations and treatment been instituted in a timely fashion, there is likelihood that Patient 9 would have enjoyed a good quality of life for an extended period.

8.0 LESSONS LEARNED

The effective management of urological cancers requires 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 the completion and survivorship.

A single member of the team should not choose to, or be expected to, manage all the clinical, supportive, and administrative steps of a patient's care.

A key worker, usually a cancer nurse specialist, should be independently assigned to every patient learning of a new cancer diagnosis.

Any divergence from a MDT recommendation should be justified by further MDT discussion and the informed consent of the patient.

The clinical record should include the reason for any deferments in management decisions.

After any patient interaction, best practice includes the prompt communication, with the patient and their General Practitioner, of the rationale for any decisions made.

The MDM must have an open supportive culture allowing members to raise clinical concerns

References

1. Peer review Self-Assessment report for NICaN 2017.

9.0 RECOMMENDATIONS AND ACTION PLANNING

Recommendation 1

The MDT should audit all aspects of its primary function.

9.0 RECOMMENDATIONS AND ACTION PLANNING**Recommendation 2**

The multi-disciplinary team meeting is primarily a forum in which the relative merits of all appropriate treatment options for the management of their disease can be discussed. Any other function is secondary to, and if necessary be sacrificed to, this aim.

Recommendation 3

The multi-disciplinary team meeting should be quorate, and all participants must feel able to contribute to discussion.

Recommendation 4

An operational system that allows the future scheduling of any investigations or appointments should be available during all clinical interactions.

Recommendation 5

The Trust must ensure that patients are discussed appropriately at MDM and by the appropriate professionals, especially as disease progresses.

Recommendation 6

The Southern Health and Social Care Trust must develop cancer service governance processes to identify deficits in care and to escalate these appropriately.

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 AHPs

HSCB

PHA

Checklist for Engagement / Communication with Service User¹ / 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)*

Reporting Organisation SAI Ref Number:	Personal Information redacted by the USI	HSCB Ref Number:	Personal Information redacted by the USI
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SECTION 1

INFORMING THE SERVICE USER ¹ / FAMILY / CARER					
1) Please indicate if the SAI relates to a single service user, a number of service users or if the SAI relates only to a HSC Child Death notification (<i>SAI criterion 4.2.2</i>) Please select as appropriate (✓)	Single Service User	x	Multiple Service Users*		HSC Child Death Notification only
Comment: <i>*If multiple service users involved please indicate the number involved</i>					
2) Was the Service User ¹ / Family / Carer informed the incident was being investigated as a SAI? Please select as appropriate (✓)	YES	x	NO		
If YES , insert date informed : 26 October 2020					
If NO , please select only one rationale from below, for NOT INFORMING the Service User / Family / Carer that the incident was being investigated 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:					
For completion by HSCB/PHA Personnel Only (Please select as appropriate (✓))					
Content with rationale?	YES		NO		

SHARING THE REVIEW REPORT WITH THE SERVICE USER ¹ / FAMILY / CARER				
<i>(complete this section where the Service User / Family / Carer has been informed the incident was being investigated as a SAI)</i>				
3) Has the Final Review report been shared with the Service User ¹ / Family / Carer? Please select as appropriate (✓)	YES		NO	x
If YES , insert date informed:				
If NO , please select only one 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				
c) Report not shared but contents discussed <i>(if you select this option please also complete 'I' below)</i>				
d) No contact or Next of Kin or Unable to contact				

¹Service 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 Users¹ / Families/Carers following a SAI

SHARING THE REVIEW REPORT WITH THE SERVICE USER¹ / FAMILY / CARER*(complete this section where the Service User / Family / Carer has been informed the incident was being investigated as a SAI)***Continued overleaf**

- | | | |
|--|--|--|
| 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 ¹ 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	
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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 COMPLETED¹Service 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 Users¹ / Families/Carers following a SAI



Quality Care - for you, with you

Urology Cancer MDT Operational Policy - Agreement Cover Sheet

This MDT Operational Policy has been agreed by:

Position Director of Acute Services
Name Mrs Esther Gishkori
Organisation Southern Health & Social Care Trust
Date Agreed 1st September 2017

Personal Information redacted by USI

Signed

Position Clinical Director Cancer Services
Name Dr Rory Convery
Organisation Southern Health & Social Care Trust
Date Agreed 1st September 2017
Signed

Personal Information redacted by USI

Position MDT Lead Clinician (on behalf of MDT members)
Name Mr Anthony Glackin
Organisation Southern Health & Social Care Trust
Date Agreed 1st September 2017

Personal Information redacted by USI

Signed

The MDT members agreed this Operational Policy on:

Date Agreed 1st September 2017

Operational Policy Review Date 1st September 2018

Root Cause Analysis report on the review of a Serious Adverse Incident

Organisation's Unique Case Identifier:

Personal Information redacted
by the USI

Date of Incident/Event: 6 January 2016

HSCB Unique Case Identifier:

Personal Information redacted by USI

Service User Details:

D.O.B:

Personal Information redacted by USI

Gender: F

Age: 66 yrs

Responsible Lead Officer: Connie Connolly

Designation: Lead Nurse Acute Governance

Report Author: Review Team

Date report signed off: 15 March 2017

Date submitted to HSCB: 16 March 2017

1.0 EXECUTIVE SUMMARY

Patient 10 is a 66 year old lady with a past medical history of colon cancer in 2010 and breast cancer in 2013.

While **Patient 10** was under review and follow up by the Breast Surgeons in June 2014, a Computer Tomography Scan (CT Scan) of the abdomen and pelvis was arranged and this was performed on 24 June 2014. This CT scan reported a number of cysts in both kidneys. On the right side, there was a large upper pole cyst, a small lower pole cyst and a cyst on the anterior aspect of the right lower pole which had increased in size with increased complexity from scans completed in 2010. An Ultra Sound Scan (USS) of kidneys was recommended and this was completed on 24 July 2014. A Magnetic Resonance Image with contrast (MRI) was advised, and this was done on 26 September 2014. The MRI report did not comment on the anterior cyst about which concerns were raised, but did confirm a cyst with no abnormal enhancement.

On the basis of this incomplete MRI report, **Patient 10**'s GP made routine referral to the Urology Team in Craigavon Area Hospital (CAH). This GP letter was received by the CAH Booking Centre on 29 October 2014. This letter was given to the Urology Surgeon of the week on 30 September 2014 to triage. There is no evidence that this GP referral letter was triaged or returned to the Booking Centre for processing. As a result of triage omission, **Patient 10** was managed as a 'New Routine' patient as per the Trust's process in place at the time and waited until 6 January 2016 to be seen by a Consultant Urologist. A wait of 64 weeks.

Patient 10 was diagnosed with a probable cystic renal tumour. Surgery was scheduled for 25 January 2016 but this was postponed due to the recurrence of breast cancer at this same time. Right partial nephrectomy was performed on 31 October 2016.

The Review Panel agree that there are 3 main contributing factors which directly impacted **Patient 10**'s delay in diagnosis. The first contributing factor was the content of the MRI report dated on the 29 September 2014. The wording of the report appears truncated and does not reference the main clinical focus, which was anterior cyst on the right kidney. The Reporter did not grade the cyst. As a result, the Breast Surgeon Dr 3 and the GP Dr 5 reading this report, did not appreciate there was growth in size of the right cyst. This was a significant missed opportunity for clinicians to expedite **Patient 10**'s referral to Urology.

Secondly, following the CT of chest and abdomen of 29 October 2014 which noted a complex right renal cyst, the letter to **Patient 10** from Dr 3 did not include this information and the result did not trigger a referral to Urology. Again this represents a missed opportunity to expedite **Patient 10**'s care.

The third contributory factor is that **Patient 10**'s GP referral letter was not triaged by the Urology Consultant on call. The Review Panel agree that review of radiology at triage is likely to have resulted in an upgrade of the referral to Red Flag in October 2014. As a result of no triage and the Trust's reliance on the routine category assigned by the GP to the referral, **Patient 10** waited 16 months to be assessed by the Urology Team and diagnosed with renal carcinoma.

2.0 THE REVIEW TEAM

Mr Anthony Glackin Consultant Urologist

Dr Aaron Milligan Consultant Radiologist

Christine Rankin Acting Booking Manager

Connie Connolly Lead Nurse Acute Governance

3.0 SAI REVIEW TERMS OF REFERENCE

Terms of Reference for the Serious Adverse Incident Investigation are as follows:

- To carry out a review into the care provided to **Patient 10** in Craigavon Area Hospital, from 24 June 2014 until 6 January 2016
- To carry out this review into the care provided to **Patient 10** using the National Patient Safety Agency Root Cause Analysis methodology
- To use a multidisciplinary team approach to the review
- To provide an agreed chronology based on documented evidence and staff accounts of events
- To identify the key contributory factors which may have had an influence or contributed to **Patient 10**'s delay in treatment.
- To ensure that recommendations are made in line with evidence based practice.
- To set out the findings, recommendations, actions and lessons learnt in an anonymous report
- To adhere to the principles of confidentiality throughout the review.
- To report the findings and recommendations of the review through the Director of Acute Services SHSCT, to the relatives of **Patient 10** and the staff associated with **Patient 10**'s management

4.0 REVIEW METHODOLOGY

- To carry out a review into the care provided to **Patient 10** within the SHSCT from 8 April 2014 until 1 March 2016. Records electronic records available on the Patient Administration System (PAS), Northern Ireland Electronic Care Record (NIECR) the Northern Ireland Picture Archiving and Communication System (NIPACS) will be examined in conjunction with all Clinical and Nursing documentation.
- To carry out this review into the care provided to **Patient 10** using the National Patient Safety Agency Root Cause Analysis methodology
- To use a multidisciplinary team approach to the review
- To provide an agreed chronology based on documented evidence and staff accounts of events
- To identify the key contributory factors which may have had an influence or contributed to the timing of **Patient 10**'s clinical management.
- To ensure that recommendations are made in line with evidence based practice. Accompanying appendices to the report will provide evidence of recent researched-based management of
- To set out the findings, recommendations, actions and lessons learnt in an anonymous report
- To adhere to the principles of confidentiality throughout the review.
- To report the findings and recommendations of the review through the Director of Acute Services SHSCT, to **Patient 10** and the staff associated with **Patient 10**'s care

This list is not exhaustive

5.0 DESCRIPTION OF INCIDENT/CASE

On 18 November 2010, Patient 10 had CT of Abdomen and Pelvis (CTAP) and was reported on 3 December 2010 which stated simple renal cyst particular on the right.

On 13 January 2013 CTAP reported by Dr 10. Bosniak type 1 cyst right kidney noted.

On 24 June 2014, Patient 10 had a CTAP with contrast as ordered by Dr 1. Dr 7's report in relation to the CTAP was issued on 7 July 2014 and reported multiple and bilateral simple cysts. A cyst arising from the anterior aspect of the right lower pole demonstrates subtle layering with high density in its medial aspect. The cyst appears minimally larger. A cyst in the anterior aspect of the right lower pole appears minimally larger and complex with high density in its medial aspect. Localised ultrasound was recommended to ensure no soft tissue component.

On 24 July 2014, Dr 1 ordered at ultrasound of the urinary tract. Dr 2's report on 30 July 2014 concluded a right lower pole complex renal cyst? Solid component. Advised MRI with intravenous (i/v) contrast to determine if the solid component enhances.

On 23 September 2014, Patient 10 seen by Dr 3 who ordered CT of Chest and Abdomen (CT CA).

On 26 September 2014, Patient 10 had a MRI of renal tract completed at the request of, or requested on behalf of, Dr 1. Dr 2's report on 29 September 2014 compared the previous CT 25/06/14 and USS 24/07/14. There is a large well-defined ovoid cystic mass, arising from the upper pole cortex of the right kidney. Appearances are consistent with cyst.

On 29 October 2014, Patient 10 attended for CT CA with i/v contrast. Dr 4 compared CT on 20/06/14 and on 1 November 2014 reported simple cyst seen in the upper pole. Complex cyst right kidney. On the same day, a routine GP referral was received in CAH Booking Centre from Dr 5 requesting assessment and advice in relation to the MRI findings reported on 26/09/14 re: large renal cyst and mentioning a history of bowel cancer and breast cancer.

On 7 November 2014, letter sent to Patient 10 from Dr 3 informing her of unchanged findings of CT CA done on 29 October 2014, and that there would be further Surgical Outpatient review. The CT reported a complex right renal cyst. This finding was not included in the letter Patient 10 and was not escalated to either Urology or Radiology for further opinion.

On 6 January 2016, Patient 10 was seen by Dr 8 in Urology Outpatients in response to GP referral on 29 October 2014. The MRI images were reviewed by Dr 8 in advance of the consultation. Dr 8 noted that the MRI report from 29/09/14 did not comment on the anterior lower pole of the right kidney. Dr 8 spoke with Dr 7 regarding the findings. In retrospect, Dr 7 reported the complex cyst on the right kidney had internal solid nodules with one area showing some enhancement with contrast. This raised the possibility of cystic renal cancer. Surgery arranged for 13th January 2016.

On 12th January 2016, Patient 10 was reviewed by Dr 3 with an enlarged left axillary noted

5.0 DESCRIPTION OF INCIDENT/CASE

on CT. A malignant node in the left axilla with invasive lobular carcinoma was confirmed.

15 February 2016 Patient 10 had a left axillary node clearance. Staging and further management of Patient 10's renal cyst has been postponed.

Patient 10 is recovering from a laparoscopic partial nephrectomy for confirmed papillary renal cell carcinoma which was performed on 31 October 2016.

6.0 FINDINGS

The Specialists within the Review Panel individually assessed each of Patient 10's radiological investigations in the timeframe between 24 June 2014 and 6 January 2016. The report by Dr 2 on 29 September 2014 references the findings of the USS and CT images done in June and July 2014. The Panel agree that when Dr 2 mentioned the earlier findings within the 29 September 2014 MRI report, it implied that the ovoid cystic mass noted had been seen and had been investigated. The inclusions of previous imaging findings are ambiguous. The consensus is that Dr 2's reported findings in relation to Patient 10's MRI of both kidneys were misleading and were inappropriately condensed. The Panel contribute this to human error. This error was the primary contributing factor to the delayed recognition of a potential renal cancer and its subsequent management.

The Review Panel agree that the absence of a complete right kidney assessment, and the wording of the MRI report, made it extremely difficult for clinicians to detect the missing clinical detail. This provides sufficient rationale to why Patient 10 was not referred to Urology for immediate assessment by Dr 3 or the GP Dr 5. The CT chest and abdomen of 29 October 2014 reported a complex right renal cyst. This important finding was not included in the letter by Dr 3 to Patient 10 on 7 November 2014 and was not referred on for urological opinion. This represents a missed opportunity to expedite investigation of a reported abnormality.

The Review Panel reviewed the GP Referral Letter management for Patient 10 in October 2014. In summary; Dr 6 was the Consultant Urologist on-call on 30 October 2014 and was responsible for the triage of the GP letters for that week. Patient 10 was one of eight letters for Triage.

The Triage form for 30 October 2014 was not returned to medical records for processing. After 10 working days, the booking centre e-mailed Dr 6's personal secretary seeking management advice for the 8 patients with outstanding triage. After no reply, a second email request was sent to Dr 6's personal secretary seeking management advice which was outstanding from 30 October 2014. At this point the informal booking centre default process for patients with no referral triage was initiated. The informal default triage management process was introduced in May 2014 to ensure the GP's referrals were allocated to a 'waiting list' in the event that the triage was not returned. A default management process was formally circulated on 6 November 2015. The pathway for GP referrals without triage is for the medical records team to accept the GP Grading, code the patient specialty as 'General Urology' and allocate the next available new patient appointment. The length of time until

6.0 FINDINGS

assessment is solely dependent on the Urology waiting time- which was a minimum of 42 weeks in 2014. The default management process provides an explanation to why Patient 10's 'Routine' referral letter was not upgraded and why Patient 10 was not seen by the Urology Team until 16 January 2016.

Patient 10 is now recovering from a laparoscopic excision of a papillary renal carcinoma which was done on 30 October 2016. This procedure was superseded by breast surgery in 2016 for breast lobular carcinoma on 14 February 2016. It had been agreed by the Oncology and Urology teams that the breast histology was priority and treatment proceeded in advance of renal surgery.

Relevant members of the Review Team completed a 'look-back' exercise in relation to the remaining 7 other GP letters to establish the patient management and outcome. The Panel can confirm that the other 7 patients have been seen by the Urology Team on or before 26 January 2016, and have not been known to have been exposed to significant harm.

7.0 CONCLUSIONS

The MRI report by Dr 2 on 29 September 2014 as previously discussed, was misleading and was inappropriately condensed. The quality of the information resulted in the evolving right renal cyst being overlooked by Drs 3 and Dr 5.

The SHSCT Radiology Team continuously review and audit the quality and accuracy of their reporting. On this occasion, the MRI report irregularities were not detected until viewed by a Urology Consultant.

All available evidence suggests that Dr 6 did not triage Patient 10's GP referral letter on the week ending 30 October 2014. The default triage management process was initiated which resulted in Patient 10 waiting 64 weeks for Urological assessment.

The Review Panel agree that in relation to Patient 10, 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.

While the remit of this Serious Adverse Incident (SAI) Review was to examine the factors in Patient 10's delayed management of papillary renal cancer. The Review Panel were provided evidence 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 continues to be initiated secondary to the omission of Triage by individual members of the urology team and not the entire Urology Team.

8.0 LESSONS LEARNED

There will always be an element of human error in the interpretation and reporting of radiological imaging.

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.

9.0 RECOMMENDATIONS AND ACTION PLANNING

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 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.

10.0 DISTRIBUTION LIST

Patient
10

HSCB

SHSCT Litigation

SHSCT Medical Director

SHSCT Director of Acute Services

AMD for Surgery and Elective Care

AMD for Integrated Maternal/Women's Health and Clinical Services

AD's for Surgery and Elective Care, Integrated Maternal/Women's Health/Clinical Services
and Functional Support Services

Chair of Surgical Morbidity and Mortality

Checklist for Engagement / Communication with Service User¹/ 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)

Reporting Organisation SAI Ref Number:	ID Personal Information redacted by USI	HSCB Ref Number:	Personal Information redacted by USI
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SECTION 1

INFORMING THE SERVICE USER ¹ / FAMILY / CARER				
1) Please indicate if the SAI relates to a single service user, a number of service users or if the SAI relates only to a HSC Child Death notification (SAI criterion 4.2.2) Please select as appropriate (✓)	Single Service User	x	Multiple Service Users*	HSC Child Death Notification only
Comment: <i>*If multiple service users involved please indicate the number involved</i>				
2) Was the Service User ¹ / Family / Carer informed the incident was being investigated as a SAI? Please select as appropriate (✓)	YES	x	NO	
If YES, insert date informed : 6 January 2016				
If NO, please select only one rationale from below, for NOT INFORMING the Service User / Family / Carer that the incident was being investigated 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:				
For completion by HSCB/PHA Personnel Only (Please select as appropriate (✓))				
Content with rationale?	YES		NO	

SHARING THE REVIEW REPORT WITH THE SERVICE USER ¹ / FAMILY / CARER (complete this section where the Service User / Family / Carer has been informed the incident was being investigated as a SAI)				
3) Has the Final Review report been shared with the Service User ¹ / Family / Carer? Please select as appropriate (✓)	YES		NO	x
If YES, insert date informed:				
If NO, please select only one 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				
c) Report not shared but contents discussed (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				

Continued overleaf

SHARING THE REVIEW REPORT WITH THE SERVICE USER¹ / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being investigated as a SAI)

	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 ¹ 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	x
	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	x
	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	x
	If YES, insert date report shared :			
	If NO, please provide details:			

DATE CHECKLIST COMPLETED	15 March 2017
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Serious Adverse Incident Review**Organisation's Unique Case Identifier: ID** Personal Information redacted by USI**Patient** Patient 10 **H&C** Personal Information redacted by USI**Introduction**

In considering the comments which I had regarding the final draft of the report of the Review Panel investigating the above serious adverse incident, I concluded that there were a number of factual errors, omissions and inferences in their report, and to the extent that I considered it necessary to relate Patient 10's clinical history below.

Clinical History

Patient 10 was 59 years old when acutely admitted to Craigavon Area Hospital on 5th January 2010, under the care of Dr 1, having had abdominal pain and nausea during the previous ten days. On CT scanning of her abdomen and pelvis on 6th January 2010, she was reported to have significant sigmoid colonic diverticular disease with an extraluminal collection which was considered to have probably resulted from perforation of a diverticulum. She was managed conservatively and successfully, enabling her discharge on 13th January 2010.

The CT scan of 6th January 2010 was also reported to have demonstrated the presence of multiple, simple, right renal cysts, the largest coming from the upper pole, and measuring 5.6 cm. The left kidney was reported to be unremarkable.

Patient 10 had a barium enema performed as an outpatient on 17th February 2010 when she was reported to have a long shouldered stricture of the proximal sigmoid colon in keeping with a primary malignancy. From subsequent documentation available on NIECR, it would appear that she underwent a sigmoid colectomy on 9th March 2010 and that pathological examination of the resection specimen confirmed the presence of a pT4b N1 M0 colonic adenocarcinoma, for which she subsequently had adjuvant chemotherapy.

During her postoperative recovery period, she had a CT scan of her chest, abdomen and pelvis performed on 22nd March 2010. The report of 25th March 2010 included that multiple renal cysts were present, the largest located at the upper pole of the right kidney and measuring 6.3 cm in diameter.

The first annual CT scan of the patient's chest, abdomen and pelvis was requested by an oncologist, was performed on 18th November 2010 and reported on 03rd December 2010. Apart from the reported lack of evidence of metastatic disease, she was reported to have a 'simple renal cyst particular in right. No solid renal mass'.

This CT scan is also the earliest for which digitalised images have been archived and available for review. On review, it is evident that there were three, exophytic, cystic lesions

arising from the right kidney. The largest lesion arose from the upper pole and had a mean density of 23 Hu (deviation 30 Hu). The smallest arose from the lower pole and had a mean density of 20 Hu (deviation 27). The third lesion, the index lesion of later concern, had a mean density of 28 Hu (deviation 31) and a diameter of 28.5 mm. All three had the appearances of simple renal cysts.

The next CT scan was requested by Dr 1, was performed on 22nd December 2011 and reported on 24th December 2011. The report included reference to 'simple cysts noted in the right kidney. No renal mass of significance'. Review of the archived images would agree with the report that all three lesions had the appearances of simple cysts, with the index lesion having a mean density of 24 Hu (deviation 30).

The next CT scan was again requested by Dr 1, was performed on 21st December 2012 and reported by Dr 10 on 13th January 2013. The only reference to the right renal lesions was of a 'Bosniak type 1 cyst present right kidney'. However, review of the archived images found a subtle but definite change in the appearance of the index lesion compared to previously, in that it appeared to be denser, with an increase in its mean density to 32 Hu (deviation 47), and particularly in its medial portion where the mean density was 51 Hu (deviation 39). No appreciation of this change was reported.

Patient 10 then had a lobulated carcinoma of her right breast managed by wide local excision and sentinel node biopsy in October 2013, followed by radiotherapy and hormonal therapy. She had also contacted the Out of Hours service on three occasions on 28th February 2014 and 1st March 2014, following her return [Personal Information redacted by USI] she had dysuria and increased frequency of micturition for a period of one week, but had developed fever, flank pain and visible haematuria since her return. She was prescribed Amoxicillin for presumed urinary infection which was confirmed on urinary culture on 03rd March 2014 and on 12th March 2014 when the infecting organism was found to be resistant to Amoxicillin. Urinary microscopy and culture were both normal on 07th May 2014.

The next CT scan was again requested by Dr 1 as before, was performed on 24th June 2014 and reported by Dr 7 on 7th July 2014. Multiple and bilateral simple renal cysts were reported. The index lesion was reported as a 'cyst arising from the anterior aspect of the right lower pole demonstrates subtle layering with high density in its (sic) medial aspect which was probably present previously. The cyst appears minimally larger'. In the conclusion, it was reported that the appearances may have represented a haemorrhagic or proteinaceous cyst, but a localised ultrasound was recommended to ensure that there was no soft tissue component. Review of the archived images would indicate that the mean densities of the entire lesion and of its medial region had remained unchanged since December 2012, but that the density deviations had reduced significantly to 20 and 13, respectively, indicating that the subtle changes of December 2012 had been consolidated in the interim.

Dr 1 wrote to Patient 10 on 10th July 2014 advising that there was a 'cyst in your right kidney which is almost certainly a water-filled cyst with no consequence and has been noted before but the radiologist has suggested confirming this with an ultrasound'. Dr 1 advised that he

would arrange the ultrasound scan and that he would review Patient 10 in or around September 2014.

Dr 1 requested the ultrasound scan on 10th July 2014. It was performed on 24th July 2014 and reported by Dr 2 on 30th July 2014. The report was the first enumerated description by a radiologist of all three right renal lesions. The index lesion was described as a complex lower pole cyst noted anteriorly, 3.7 cm in diameter, containing echogenic, well defined material posteriorly, possibly solid. Dr 2 advised renal MRI scanning with IV contrast to determine if the solid component enhanced.

Renal MRI scanning was requested by, or on behalf of, Dr 1 on 08th September 2014. It was performed on 26th September 2014 and reported by Dr 2 on 29th September 2014. The report read 'Comparison to previous ultrasound dated 24th July 2014 and CT dated 24th June 2014. There is a large, well-defined, ovoid, cystic mass arising from the upper pole cortex of the right kidney, measuring 8.7 cm x 5.3 cm in size. The lesion is T2 hyperintense, T1 hypointense and demonstrates no abnormal enhancement. The MR appearances are consistent with a cyst'. There was no description of the other two right renal lesions.

In the interim, Patient 10 was reviewed by Dr 3 at the Breast Clinic on 23rd September 2014 when Patient 10 reported that she had had pain on the right side during the previous two weeks, initially on inspiration, by then if she moved suddenly. She reported that the pain had improved since taking Ibuprofen. She was found to have some tenderness in the lateral right breast, particularly around her scar. Dr 3 noted that Patient 10 was awaiting MRI scanning following CT and ultrasound scanning for a right renal lesion. Dr 3 advised that she had organised a CT scan of the patient's chest. A CT scan of chest and abdomen was in fact requested.

The CT scan was performed on 29th October 2014 and reported by Dr 4 on 1st November 2014. The report referred to a '3.6 cm, exophytic, complex cyst seen in the lower pole of the left (sic) kidney anteriorly containing solid and cystic component. Simple cyst seen in the upper pole measuring 7 cm. Left kidney show no focal lesion'. Then in conclusion, Dr 4 referred to a 'complex cyst right kidney (previously investigations noted).

Dr 5, a GP, referred Patient 10 as a routine referral on 29th October 2014. The reason for referral was 'Large renal cyst 8.7 cm x 5.3 cm' and with the comment that 'this 64 year old lady with a h/o bowel cancer and more recently breast cancer had an MRI scan done in Sept'14 for persistent R renal angle pain. She is otherwise well but has some nocturia. MRI scan showed a well-defined ovoid cystic mass, arising from the upper pole cortex of the right kidney, measuring 8.7 cm x 5.3 cm. The lesion is T2 hyperintense, T1 hypointense and demonstrates no abnormal enhancement. MR appearances are consistent with a cyst. I would be grateful for your assessment and advice.'

Dr 3 wrote to Patient 10 on 7th November 2014 advising that the CT scan of 29th October 2014 had 'shown no worrying abnormality. The cyst on your right kidney, as previous investigations had noted, was remarked upon again.' Patient 10 was further reviewed at the Breast Clinic by another doctor on 4th March 2015 when no reference was made to the index right renal lesion. Moreover, Patient 10 had been reviewed by her breast oncologist on 7th October 2014 and on 14th April 2015, without reference to the index right renal lesion.

The routine referral by Dr 5 resulted in Patient 10 having a urological outpatient consultation with Dr 8 on 6th January 2016 when the significance of the index right renal lesion was appreciated, and which was explained to Patient 10 and to her husband who accompanied her. Dr 8 requested a further CT scan of chest, abdomen and pelvis, and provisionally arranged a date for renal surgery on 25th January 2016.

CT scanning was performed on 8th January 2016. The index right renal lesion was reported to be a complex cyst and to have increased in size to 3.8 cm (from 2.85 cm in November 2010 and from 3.6 cm in October 2014). Its density characteristics had not changed significantly since 2014. The CT scan was also reported to have demonstrated partially healed fractures of the right sixth and seventh ribs, and most importantly, the presence of an enlarged, left axillary lymph node measuring 2.2 cm in diameter.

Patient 10 was advised of these findings at further review by Dr 8 on 11th January 2016 when she was advised that she would be reviewed at the Breast Clinic on 12th January 2016, and that it had been possible to bring forward her admission for renal surgery to 16th January 2016.

Patient 10 was reviewed by Dr 3 at the Breast Clinic on 12th January 2016 when a core biopsy was taken from the left axillary lymph node mass. Histopathological examination was reported on 14th January 2016, confirming that the axillary lymphadenopathy was due to metastatic lobular breast carcinoma. At further review on 15th January 2016, it was agreed that the management of the metastatic breast carcinoma should take precedence. She proceeded to have left axillary lymphadenectomy in February 2016, followed by systemic chemotherapy and radiotherapy.

Following completion of treatment of metastatic breast carcinoma, Patient 10 was admitted electively on 31st October 2016 for laparoscopic right partial nephrectomy which was performed by Dr 8 that day. She was discharged on 5th November 2016. Histopathological examination of the resection specimen confirmed that the lesion was a Fuhrman grade III, papillary, renal cell carcinoma which was predominantly encapsulated but with a nodular infiltration of renal parenchyma to within 0.2 mm of the inked resection margin.

Dr 8 has since advised Patient 10 that the tumour had been completely removed, and that hopefully surgery will have been curative.

Comments

In compiling Patient 10's clinical history, I did so prospectively from January 2010. Whilst not a radiologist, I was able to appreciate that there had been a change in the appearance of the index right renal lesion on CT scanning performed on 21st December 2012 and reported by Dr 10 on 13th January 2013. This change was later referred to by Dr 7 in his report of the appearance of the index lesion on CT scanning performed in June 2014 as subtle layering with high density in its medial aspect, and which was probably present previously. Retrospective measurement of densities confirms that the change was definitely present previously in December 2012. It is regrettable that an appreciation had not been included in

the report of January 2013. Had it been so, the further assessment and management of the lesion may have proceeded during 2013, rather than two to three years later.

Patient 10 developed a coliform urinary infection [Personal Information redacted by the USI] during the last week of February 2014. She contacted the Out of Hours service on three occasions during 28th February 2014 and 1st March 2014 as she had developed worsening and systemic symptoms, including visible haematuria. Even though the infecting organism was resistant to the antibiotic initially prescribed, there is no documentary evidence of recurrence of visible haematuria. Therefore, there was no indication for referral of Patient 10 to the urological service, in accordance with referral guidelines which pertained then or revised since.

I believe that it is understandable that Dr 7 did not bring his appreciation of the change in the appearance of the index lesion to the attention of the urological service in July 2014, as he considered that the significance of the change was equivocal, and for which reason he advised further assessment by ultrasound scanning. However, had he done so, the management of the lesion would have been progressed in the months thereafter.

Dr 1 was regrettably premature in his letter of reassurance to Patient 10 on 10th July 2014 when ultrasound scanning was requested. Dr 1 may not have appreciated the potential significance of the changed appearances of the index lesion as reported by Dr 7.

The report of the ultrasound scan of the 24th July 2014 by Dr 2 was characteristic of his detailed, scrupulous reportage in that it was the first report to describe all three right renal lesions. He advised MRI scanning with intravenous contrast to determine whether the possibly solid material, within the cyst, enhanced. It is regrettable that Dr 2 did not refer the patient to Urology MDM at this time, particularly in light of his reasonably significant index of concern regarding the lesion, and the fact that the incremental assessment of the lesion was not known to the urological service. Dr 2 would have frequently brought such cases to the attention of MDM in such circumstances, and was facilitated to do. Another opportunity to bring the patient and her lesion to the attention of the urological service was missed.

There is no record on PAS or on NIECR of Patient 10 having been reviewed by Dr 1 in September 2014, or subsequently. As I presume that she underwent colonic resection in March 2010 in a non-NHS institution, I presume that Dr 1 may have reviewed Patient 10 privately in September 2014 when renal MRI scanning was requested. However, the lack of documentation resulting from subsequent review by Dr 1 deprives one of assessing the response of Dr 1 to the report of the MRI scan of 26th September 2014.

The MRI scan was performed on 26th September 2014 and reported on 29th September 2014 by Dr 2 who had advised it be done in the first instance. In the first sentence of his report, he had compared the findings to those of the previous ultrasound and CT scans. It has been my impression that the report as presented was probably the first paragraph of a report in which the large upper pole cyst was described in that first paragraph, and that the other two right renal lesions would be described in subsequent paragraphs, as would have been expected of Dr 2. Had he been interrupted? Could further paragraphs or portions of the report been lost or deleted by some technical glitch? In any case, I believe that this was the most significant, missed opportunity to bring Patient 10 to the attention of the urological service.

Patient 10 was then reviewed, with respect to her breast cancer, on 23rd September 2014, by Dr 3, and not by Dr 2 as reported by the Review Panel in their final draft report. Dr 3 documented that Patient 10 had right breast and chest wall pain and tenderness, and not right renal angle or flank pain. By way of reassurance, Dr 3 requested a CT scan of chest and abdomen, performed on 29th October 2014 and reported by Dr 4 on 1st November 2014, and in which he reported that there was an exophytic complex cyst seen in the lower pole of the left kidney anteriorly containing solid and cystic components, then reported that the left kidney showed no focal lesion and concluded by reporting that there was a complex cyst of the right kidney. Again, this represented a further missed opportunity to bring Patient 10 to the attention of the urological service, by whatever means.

Dr 3 then wrote to Patient 10 on 7th November 2014 that the CT scan of 29th October 2014 had shown no worrying abnormality and that the cyst on her right kidney, as previous investigations had noted, was remarked upon again. However, the cyst to which Dr 3 referred was the complex cyst described on CT scanning, and not to be confused with the large, simple cyst described on MRI scanning.

One can only conclude that Dr 3 did not appreciate the potential significance of a complex cyst. As a consequence, no referral to urology was made.

By then, Dr 5, a GP in the practice in which Patient 10 was registered as a patient, had referred Patient 10 as a routine referral, on 29th October 2014, requesting assessment and advice regarding Patient 10 whom Dr 5 related had had an MRI scan performed in September 2014 for persistent right renal angle pain, and that the MRI scan had shown a large, simple cyst arising from the upper pole of her right kidney. Dr 5 was mistaken in asserting that the MRI scan had been performed in the investigation of pain of any kind. Whilst I have not met Patient 10 I doubt whether she ever did have any right renal angle pain. As documented above, the pain was related to her right breast and chest. Moreover, the Review Panel were mistaken in their report that Dr 5 had requested assessment and advice in relation to the MRI findings regarding a large renal cyst and recent breast cancer. The referral sought assessment and advice regarding the finding of a large, simple, right renal cyst in a Patient 10 lady, with a history of bowel cancer and more recently breast cancer, and which Dr 5 believed may have been causing right renal angle pain. The referral letter was not triaged by Dr 6.

Patient 10 was reviewed by her oncologist on 7th October 2014 and again on 14th April 2015, without reference to the right renal lesion. She was again reviewed by another doctor at the Breast Clinic on 04th March 2015. Even though this was the service that requested the CT scan of 29th October 2014, there was no reference to the complex renal cystic lesion reported, and no referral made to the urological service by any means.

As a consequence of failure of triage, the default triage management process resulted in Patient 10 having to wait 64 weeks from the time of GP referral until the appointment with Dr 8 on 06th January 2016 when the significance of the index right renal lesion was appreciated by the urological service for the first time since its existence in December 2012. Somewhat reassuringly, it had only increased in diameter from 2.85 cm to 3.8 cm in that time. Laparoscopic right partial nephrectomy was deferred until 30 October 2016 following

completion of management of the metastatic breast carcinoma detected on further staging CT scanning performed in January 2016.

I agree with Dr 8 in his reassurance to Patient
10 in November 2016 that surgery has probably been curative. It probably would have been even more reassuring if there had been a wider normal resection margin, though I believe that the evidence for that is scant. There is the additional concern regarding the high Fuhrman grade and whether it would have been lower had the lesion been resected at an earlier date. Nevertheless, the overwhelming probability is that surgery will have been curative, and that the delay in surgery will not have resulted in a negative outcome.

Comments regarding Triage

In replying with comments regarding the final draft report, I have attempted to do so comprehensively, fairly and honestly. With regard to the referral letter of 29th October 2014, if I had triaged the letter on or after 30th October 2014, I would have retained its routine status. If I were to triage it afresh today, I do believe that I would do likewise. Why?

This was a referral which was graded as routine by Dr 5. I do agree with Dr 8 in his letter of 6th January 2016 that it was entirely reasonable that the referral was routine, even though the patient had a history of bowel and breast carcinoma, and even though Dr 5 believed, probably mistakenly, that the cyst may have been causative of persistent, right renal angle pain. Such referrals are not uncommon. In a minority of cases, larger simple cysts do cause discomfort or pain. The impression that I would have had from the referral letter would have been that her pain had been comprehensively investigated, including by MRI scanning, and that the cyst potentially causative of pain was unequivocally proven to be large and simple. Therefore, I would certainly not have considered upgrading it to Red Flag status. I also do not believe that I would have upgraded it to Urgent status, as the likelihood of a large simple cyst being the cause of persistent pain would have been minimal.

The Review Panel have not offered any explanation as to why the status of the referral should have been upgraded, and to which status. I do not know whether it was because of the history of bowel and breast cancer, or whether the Panel were of the view that the report of the MRI scan, and by inference, of any other scans should have been reviewed on NIECR or NIPACS, or indeed whether the images should have been reviewed in addition. If this were the case, then the content of all letters of referral would be ignored, and a complete review conducted on line. As a consequence, it would never be considered defensible to triage a referral on the contents of the letter alone, and as a consequence, considerable cumulative time would be required to do so.

I have believed, and have expressed the view, that the inclusion of the triage of all letters of referral in the duties and responsibilities of the urologist of the week was inappropriate. The introduction of the 'urologist of the week' was borne out of a realisation that the increasing numbers of inpatients and the complexities of their morbid and comorbid status were such that they would be better served by a 'urologist of the week' than by the previous 'urologist on call'. This reality has been acknowledged and implemented by many other specialties.

The purpose and priorities of the 'urologist of the week' are for the consultant to deliver hands-on clinical and operative management of all urological inpatients, all other inpatients in the hospital whose assessment and management was sought, all patients in the Emergency Department whose assessment and management was sought, and importantly, all such patients in other hospitals in our area of responsibility, and particularly, Daisy Hill and South West Acute Hospitals. Optimising the outcomes of all of these patients requires time and commitment. It should not be inappropriately delegated to junior doctors. It requires every attempt be made to carry out definitive surgical management if possible. It should not be compromised by triage of non-red flag referrals. In consideration of their inferred clinical priority, I have always agreed that red flag referrals be triaged by the urologist of the week, and which I have always done, even if I had not always managed to completely do so by the end of the week in question.

I have previously tried to conduct detailed triage of the non-red flag referrals whilst being urologist of the week. I would have reviewed all details on NIECR and reviewed all images, if any, on NIPACS, irrespective of the content of the letters. However, I was not prepared to compromise inpatient management by doing so. I was not prepared to spend time triaging non-red flag referrals rather than operating on patients if at all possible. With around 280 patients on an three year, inpatient waiting list, I could not justify discharging acutely admitted inpatients to that waiting list.

I also found it impossible to have the time to do so when not 'urologist of the week' because of additional work load, due to the continued pressure to minimise the incidence of poor clinical outcomes of patients awaiting long periods of time for admission and readmission for surgery. In 2014, I had arranged and undertaken 22.25 additional, elective, inpatient operating sessions 4 additional, elective, day surgical sessions, and some 19 additional, specialty clinic sessions. I had also previewed, chaired and reviewed all cases discussed at MDM each week, from April 2012, until the introduction of a rota in September 2014.

I do not have any means of knowing how many inpatients I was responsible for from 29th October 2014 to 31st October 2014, or how many emergency operations I performed during that time. I do know that I previewed all of the cases for the Urology MDM of Thursday 30th October 2014. This would have typically taken some three hours during the evening or night of 29th October 2014, in addition to chairing the MDM on 30th October 2014, and spending typically one hour with the cancer tracker that evening reviewing and signing off the outcomes of MDM. I also reviewed ten cancer patients on the morning of Friday 31st October 2014.

I do believe that the inclusion of triage of all non-Red Flag referral letters in the duties of a consultant urologist when urologist of the week has been inappropriate and regrettable. I do believe that it has, on occasion, compromised inpatient care and has, on occasion, resulted in deferment of definitive management of inpatients. It was for all of these reasons that I had advised personnel from the Appointments Office, when we met them to discuss the issue, that I had found it impossible to triage non-Red Flag referrals, whilst urologist of the week, and that another system or method or time was needed for them to be done, if by a consultant at all, and which I believed and advised was not in itself necessary.

Conclusion

Patient 10 had a complex right renal cystic lesion since December 2012. During the next two years, its potential significance had either not been appreciated, or had been appreciated but not reported by at least two radiologists, and not reported to the urological service. Similarly, the potential significance of the lesion had not been appreciated by at least two clinicians who had requested further imaging which had been advised by radiologists in the investigation of the lesion from June 2014 to March 2015, and had similarly failed to refer Patient 10 to the urological service. I believe that the Review Panel may have failed to appreciate the significance of the cyst having changed between 2011 and 2012.

Even though there were failures on the part of clinicians and radiologists who had assessed and investigated Patient 10 and the index right renal lesion, I found the Review Panel's emphasis on the lack of triage of the letter of routine referral as the main cause of delay in Patient 10 having a urological appointment, as remarkably asymmetric. I do believe that it would have been reasonable and defensible to have relied upon the information contained in the letter of referral, and to have maintained the referral as routine. Therefore, lack of triage did not impact upon the time to consultation.

I also do believe that the triage on non-red flag referrals should be revisited, with a commitment to accommodate all views, to discuss who, when and how this challenge can be satisfactorily resolved.

Aidan O'Brien.

25 January 2017



29 March 2017

Our Ref:

Personal Information
redacted by USI

Your Ref:

Private & Confidential

Patient 10

Personal Information redacted by USI

Dear Patient 10

I refer to the telephone call you had with Roisin Farrell on 29 March 2017 advising you that the Serious Adverse Incident report is now complete.

I have enclosed the SAI report. As discussed, we will be in contact with you in due course with a date to meet with the Chair and Acute Governance Facilitator to discuss the report.

Yours sincerely

Personal Information redacted by USI

Mrs Esther Gishkori
Director of Acute Services

enc

Clinical and Social Care Governance Team
Directorate of Acute Services
The Maples, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ

Telephone: Personal Information redacted by USI
E-Mail: Irrelevant information redacted by the USI



31 March 2017

Our Ref:

Personal Information
redacted by USI

Your Ref:

Private & Confidential

Patient 10

Personal Information redacted by USI

Dear

Patient 10

Further to our most recent telephone conversation, I wish to confirm that a meeting has been arranged to discuss the final report of the Serious Adverse Incident investigation which has taken place.

The meeting will take place on:

DATE Monday 10 April 2017
TIME 9.30am
VENUE Meeting Room 2
Admin Floor
Craigavon Area Hospital

In attendance at the meeting will be

- Mr Anthony Glackin, Consultant Urologist, Chair of review team.
- Mrs Connie Connolly, Governance Facilitator

My office has previously shared a copy of the final SAI report with you. If you require any further information please do not hesitate to contact me on

Personal Information redacted by
the USI

Yours sincerely

Personal Information redacted by USI

Mrs Esther Gishkori
Director of Acute Services

Clinical and Social Care Governance Team
Directorate of Acute Services
The Maples, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ

Telephone:

Personal Information redacted by
USI



Acute Services Directorate

SAI [Patient 10] [Personal Information redacted]

Meeting Room 2, Admin Floor

Craigavon Area Hospital

PRESENT:

Mr Anthony Glackin, Consultant Urologist, Chair
Mrs Connie Connolly, Lead Nurse Acute Governance
Mrs Roisin Farrell, Acute Governance administrator
[Patient 10], patient
[Patient 10's Husband], Husband of patient.

Mrs Connolly welcomed [Patient 10's Husband] & [Patient 10] to the meeting. She introduced the staff and outlined the process and format of the meeting. She confirmed with [Patient 10's Husband] & [Patient 10] they had received a copy of the report.

[Patient 10's Husband] said they had read and understood the report.

Mr Glackin asked if there were any specific issues.

[Patient 10] advised she had an understanding of the report and what happened was quite clear.

[Patient 10's Husband] report there were 4 x-ray's/ scans /MRI reported. The first was requested by Mr Hewitt. After the scan [Patient 10] received a letter reporting the scan was ok but had shown a couple of cysts which he believed to be water filled, Mr Hewitt requested a further scan to confirm his suspicion. This is where [Patient 10's Husband] feels the mistake was made as there was no mention of the third cyst. [Patient 10] had another scan along with her routine monogram which was reported as clear.

[Patient 10's Husband] questioned if the same radiologist reported on all scans?

Mrs Connolly replied no. [Patient 10] asked was this reason there was more than one doctor named on the report. Mrs Connolly confirmed that was the reason.

Mr Glackin stated the key element identified in the SAI report was some scan/x-ray/MRI reports were not as comprehensive as they should have been. He added there were errors and omissions from radiology.

[Patient 10's Husband] acknowledged the SAI report was comprehensive and the report had highlighted 3 mistakes. Mr Glackin agreed there were 3 issues identified by the report.

[Patient 10's Husband] asked if there were any other scans showing cancer other than the ones reported. Mr Glackin advised as far as he was aware all were reported correctly. He advised when the imaging was reviewed retrospectively there was a small cyst on one kidney; this was on some reports but not on the report that was requested. He believed the cyst was there for quite some time before surgery but was not reported on.

[Patient 10] advised it came as a shock when she attended Mr Haynes to be told she had cancer as she was feeling well and considered cancelling the appointment. She said over

this last year she has had horrendous year with a roller coaster of emotions. She has thought several times of what if but feels if she dwelled "it would only eat you up". ^{Patient 10} had to focus on her breast surgery and treatment before she could focus on her other cancer. She added that during her illness she fractured her spine which delayed her recuperation and had her chemotherapy delayed. She added the surgery was very traumatic.

^{Patient 10} added she had received excellent treatment and care from all medical and nursing staff during the past while.

She spoke of the mixed emotions she had when she received the report as she felt very very confused as there was 3 mistakes made which has since made her scared of something else happening and she dreads getting results of her tests. She advised she has an appointment on 11.4.17 and was dreading getting those results.

Mrs Connolly empathised with ^{Patient 10} and advised her emotions were normal considering what she went through.

^{Patient 10} advised she was surprised to receive the report in the format she did. She was aware Mr Haynes was reporting the incident but the family thought no more of it until she received a letter advising the report was complete.

Mrs Connolly advised ^{Patient's Husband} & ^{Patient 10} then review team were aware ^{Patient 10} was going through treatment and that was the reason they decided to delay sending the report to them. ^{Patient 10} appreciated the delay in sending the report. She added whilst it was not a good report from a medical point of view she hoped the report would highlight the issues raised and try to prevent similar happening again.

Mr Glackin advised ^{Patient's Husband} & ^{Patient 10} there was a long establish process in place a multi-disciplinary meeting takes place to highlight issues raised, this works well when brought to the attention of those at the meeting but fails when not brought to the meeting.

^{Patient 10} expressed her hopes the report would help someone else and ^{Patient 10's Husband} added his hope was it would benefit the hospital in general. Mr Glackin informed ^{Patient's Husband} & ^{Patient 10} the recommendations were put in place.

^{Patient 10} advised his wife has a scan tomorrow and wants to make absolutely sure and have the confidence that the report will be accurate. ^{Patient 10} advised the scan has been organised by Mr Haynes for CT of upper abdomen and pelvic area. She added she has four different cancers and is being prioritised due to this.

Mr Glackin offered with the permission of ^{Patient 10} he would speak to Mr Hayes regarding the scan.

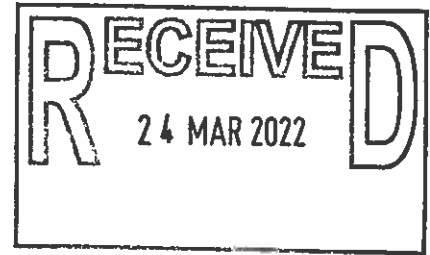
^{Patient 10's Husband} added a great system needs good staff to operate the system and hoped the system would be improved and work better.

Mrs Connolly added the report was not to name and shame or to upset the family it is to identify failings and put a process in place to improve the service.

^{Patient 10} concluded by saying she hoped the report and the issues identified would help other families. ^{Patient 10's Husband} finished by expressing his appreciation of the detail within the report.



Urology Services Inquiry



Urology Services Inquiry Questionnaire

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.
- 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: Personal Information redacted by USI
- 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

Name	Patient 10's Husband
Address	Personal information redacted by USI
Contact Telephone Number	Personal information redacted by USI
Mobile Phone Number	
Email Address	Personal information redacted by USI
HSC Number (if known)	My late wife's Patient 10 H&C No. Personal Information redacted by USI

	Yes/No
With regard to Section A above, have you read the ' Personal Details ' section of the 'Guide to Completing the USI Questionnaire'?	Yes
Are you completing this questionnaire as a patient/former patient? (If your answer is Yes, go to Section B)	No

Are you completing this questionnaire as a relative of a patient/former patient?	No
If you are completing this questionnaire as a relative of a patient/former patient , do you have the express authority of the patient to engage with the Inquiry and provide information that relates to their care and treatment? (If your answer is Yes, go to Section B)	N/A
If you are completing this questionnaire as a relative of a deceased patient , have you discussed providing information concerning the deceased patient with other relatives/former next of kin and no objection is being raised. (If your answer is Yes, go to Section B)	Yes

If you are completing this questionnaire and you are not the patient/former patient or a relative of one please state your role.	N/A
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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.

[illegible]

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.

No complaint was made personally by Patient 10. However she was informed by Mr Haynes, when she met him on 6/1/2016 that a radiologist's report from 29/9/2014 had missed a 3rd cyst which had shown up on an MRI scan on 26/9/2014. He confirmed that he had reported this as a Serious Adverse Incident. N.B. - this was only in relation to the mistake in the radiologist's report from 29/9/2014. However, in the investigation of this Serious Adverse Incident it was discovered that other errors had been made in Patient 10's care. c.f. pages 6 & 7 of The Serious Adverse Incident Report dated 16/3/2017. One of these further errors involved the Urology Department. On 1/11/2014 Patient 10 G.P. requested an appointment for Patient 10 for assessment and advice in relation to the MRI findings in the scan on 26/9/2014 and reported on the 29/9/2014. This request should have been triaged but was not. c.f. page 6 of The Serious Adverse Incident Report at paragraphs 3,4,5 & 6 of findings. Dr. 6 referred to in these paragraphs I understand to be Mr Aidan O'Brien.

Patient 10 and I met with the Southern Trust on 10/4/2017 to discuss The Serious Adverse Incident Report. We were assured that as a result of this investigation steps were already being taken to ensure that these errors would not happen again

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.

c.f. No. 1 of this section

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.

c.f. No. 1 of this section

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).

c.f. No. 1 of this section

5. If your concern or complaint was made in writing, please provide copies of that correspondence if possible.

c.f. No. 1 of this section

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?

c.f. No. 1 of this section

7. Please advise the outcome of any concern made or complaint raised by you.

c.f. No. 1 of this section

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.

None

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).

N/A

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.

When Dr Paisley requested the appointment with Urology Department Patient 10 was not aware of the triage system. The delay in being seen by Urology was not a concern as she had been told the two cysts were nothing to worry about. It was only on receiving The Serious Incident Report that she became aware of the triage system in Urology. She was shocked, angry and disappointed that not only had her appointment not been triaged but 7 other patients in the same week had also not been triaged. She was concerned that this was not therefore a simple mistake and that she had been overlooked but it looked like a systematic failure for patients. The extent of this error certainly undermined her confidence in the entire system for her care. The major concern was, of course, if she had been seen sooner would there have been a better outcome for her i.e. would earlier scans have been ordered and would they have picked up subsequent cancers earlier.

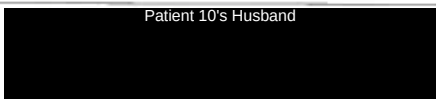
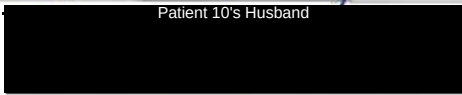
Additional sheets, if needed, can be attached

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?	No

SECTION G – Signature

Signed:	 Patient 10's Husband
Name in Block Capitals:	 Patient 10's Husband
Date:	18/3/22

SECTION H - Returning your Questionnaire

Please ensure that you have enclosed the following items:

8. A fully completed questionnaire.

(Check the questionnaire has been signed and dated).

9. All supporting documentation and/or correspondence.

(Please provide copies and **NOT** originals of your supporting material).

10. If you require additional sheets to complete your responses to this questionnaire, please ensure that they are securely attached.

11. If you require assistance completing this questionnaire please do not hesitate to contact our office directly on telephone number: Personal Information redacted by the USI

Completed questionnaires can be emailed to evidence@usi.org.uk or returned by post to:-

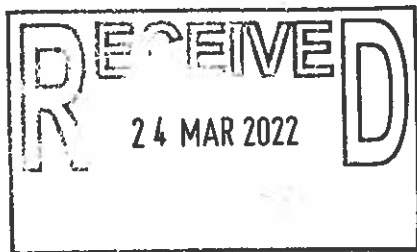
The Urology Services Inquiry

1st Floor Bradford Court

1 Bradford Court

Belfast

BT8 6RB

**PAT-000037**

Patient 10's Husband

Personal information redacted by USI

Christine A Smith, QC
Urology Services Inquiry
1 Bradford Court
Belfast
BT8 6RB

17th March 2022

Dear Ms Smith,

I have received your letter of 10th inst. together with the Terms of Reference for the Inquiry.

I am enclosing the replies to the questionnaire. As my late wife **Patient 10** had a complex medical history in the 10 years prior to her death I am enclosing a short summary of **Patient 10**'s medical history leading to her contact with Urology Department – Appendix 1 to the Questionnaire.

I am also enclosing a copy of a Serious Adverse Incident Report (The Report) dated 16/3/2017 – Appendix 2. You will note from The Report that there were other serious errors made in **Patient 10**'s treatment. The Report is only sent to you to show you the context in which **Patient 10** had contact with the Urology Department. Under the terms of your inquiry I do not expect any investigation or comment on the other non-urological matters contained in The Report.

Patient 10 and I attended at Craigavon Area Hospital on 10/4/2017 to discuss and examine The Report. We confirmed we were taking no further action, legal or otherwise. We were assured at that meeting that the Trust had already initiated procedures to address the serious failings outlined in The Report.

For ease of reading The Report I outline below the relevant doctor and surgeons' names referred to in The Report. The names I have left out relate to non-urological matters. I have only included Me Hewitts, Dr Paisleys and Mr Haynes' names as they are not associated with any errors in The Report.

THE REPORT

DR 1 - Mr G Hewitt – Bowel Surgeon

DR 5 – Dr Paisley – **Patient 10**'s G.P. requested the appointment on 1/11/2014 in Urology

DR 6 – Mr Aidan O'Brien – Urologist on call who should have triaged the appointment requested by DR 5 (Dr Paisley) on 1/11/2014

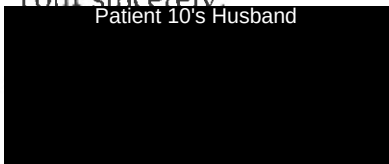
DR 8 – Mr Haynes – Urology Surgeon

Please feel free to contact me should you require further information or clarification on any matter.

I wish you and your fellow panel members every success in carrying out your very important task.

Your sincerely,

Patient 10's Husband

A large black rectangular box redacting the signature of Patient 10's Husband.

APPENDIX 1

SHORT SUMMARY OF Patient 10'S MEDICAL HISTORY LEADING UP TO HER CONTACT WITH UROLOGY DEPARTMENT

Patient 10 was diagnosed with colon cancer in 2010. The operating surgeon at that time was Mr G. Hewitt. She received chemotherapy and up to her death in 2021 that cancer did not reoccur. She continued to see Mr Hewitt twice annually up to the time of her death.

Patient 10 was diagnosed with a separate breast cancer in 2013 and received treatment.

In September 2014 Mr Hewitt requested an MRI scan on Patient 10. The Report (dated 29/9/2014) on this scan correctly identified 2 water filled cysts which were of no concern – it is important to note that this report missed a 3rd cyst which turned out to be cancerous. Patient 10's G.P. , Dr Paisley mentioned the two water filled cysts to Patient 10 and told her these could be drained by a simple procedure in Urology Department. Dr. Paisley, on 1/11/2014, contacted C.A.H. booking centre for assessment and advice in relation to these cysts. This contact by Dr Paisley should have been triaged but was not. The surgeon on call who did not triage was Mr Aidan O'Brien. Instead of being red flagged and seen immediately Patient 10 was not seen in Urology until 6/1/2016 – a wait of 64 weeks.

On 6/1/2016 she was seen by Mr Haynes in Urology. Mr Haynes not only read the MRI report dated 29/9/2014 but he checked the MRI scan itself. He discovered the 3rd cyst which had not been reported on in the report of 29/9/2014. He immediately reported this as a serious adverse incident which is the suspect of The Serious Incident Report dated 16/3/2017 (The Report).

APPENDIX 2



SAI

Personal Information redacted by USI

Patient 10

Root Cause Analysis report on the review of a Serious Adverse Incident

Organisation's Unique Case Identifier: ID Personal Information redacted
by USI

Date of Incident/Event: 6 January 2016

HSCB Unique Case Identifier: Personal Information redacted
by USI

Service User Details:

D.O.B: Personal Information redacted by USI Gender: F Age: 66 yrs

Responsible Lead Officer: Connie Connolly

Designation: Lead Nurse Acute Governance

Report Author: Review Team

Date report signed off: 15 March 2017

Date submitted to HSCB: 16 March 2017



1.0 EXECUTIVE SUMMARY

Patient 10 is a 66 year old lady with a past medical history of colon cancer in 2010 and breast cancer in 2013.

While Patient 10 was under review and follow up by the Breast Surgeons in June 2014, a Computer Tomography Scan (CT Scan) of the abdomen and pelvis was arranged and this was performed on 24 June 2014. This CT scan reported a number of cysts in both kidneys. On the right side, there was a large upper pole cyst, a small lower pole cyst and a cyst on the anterior aspect of the right lower pole which had increased in size with increased complexity from scans completed in 2010. An Ultra Sound Scan (USS) of kidneys was recommended and this was completed on 24 July 2014. A Magnetic Resonance Image with contrast (MRI) was advised, and this was done on 26 September 2014. The MRI report did not comment on the anterior cyst about which concerns were raised, but did confirm a cyst with no abnormal enhancement.

On the basis of this incomplete MRI report, Patient 10's GP made routine referral to the Urology Team in Craigavon Area Hospital (CAH). This GP letter was received by the CAH Booking Centre on 29 October 2014. This letter was given to the Urology Surgeon of the week on 30 September 2014 to triage. There is no evidence that this GP referral letter was triaged or returned to the Booking Centre for processing. As a result of triage omission, Patient 10 was managed as a 'New Routine' patient as per the Trust's process in place at the time and waited until 6 January 2016 to be seen by a Consultant Urologist. A wait of 64 weeks.

Patient 10 was diagnosed with a probable cystic renal tumour. Surgery was scheduled for 25 January 2016 but this was postponed due to the recurrence of breast cancer at this same time. Right partial nephrectomy was performed on 31 October 2016.

The Review Panel agree that there are 3 main contributing factors which directly impacted Patient 10's delay in diagnosis. The first contributing factor was the content of the MRI report dated on the 29 September 2014. The wording of the report appears truncated and does not reference the main clinical focus, which was anterior cyst on the right kidney. The Reporter did not grade the cyst. As a result, the Breast Surgeon Dr 3 and the GP Dr 5 reading this report, did not appreciate there was growth in size of the right cyst. This was a significant missed opportunity for clinicians to expedite Patient 10's referral to Urology.

Secondly, following the CT of chest and abdomen of 29 October 2014 which noted a complex right renal cyst, the letter to Patient 10 from Dr 3 did not include this information and the result did not trigger a referral to Urology. Again this represents a missed opportunity to expedite Patient 10's care.

The third contributory factor is that Patient 10's GP referral letter was not triaged by the Urology Consultant on call. The Review Panel agree that review of radiology at triage is likely to have resulted in an upgrade of the referral to Red Flag in October 2014. As a result of no triage and the Trust's reliance on the routine category assigned by the GP to the referral, Patient 10 waited 16 months to be assessed by the Urology Team and diagnosed with renal carcinoma.

2.0 THE REVIEW TEAM

Mr Anthony Glackin Consultant Urologist

Dr Aaron Milligan Consultant Radiologist

Christine Rankin Acting Booking Manager

Connie Connolly Lead Nurse Acute Governance

3.0 SAI REVIEW TERMS OF REFERENCE

Terms of Reference for the Serious Adverse Incident Investigation are as follows:

- To carry out a review into the care provided to **Patient 10** in Craigavon Area Hospital, from 24 June 2014 until 6 January 2016
- To carry out this review into the care provided to **Patient 10** using the National Patient Safety Agency Root Cause Analysis methodology
- To use a multidisciplinary team approach to the review
- To provide an agreed chronology based on documented evidence and staff accounts of events
- To identify the key contributory factors which may have had an influence or contributed to **Patient 10**'s delay in treatment.
- To ensure that recommendations are made in line with evidence based practice.
- To set out the findings, recommendations, actions and lessons learnt in an anonymous report
- To adhere to the principles of confidentiality throughout the review.
- To report the findings and recommendations of the review through the Director of Acute Services SHSCT, to the relatives of **Patient 10** and the staff associated with **Patient 10**'s management



4.0 REVIEW METHODOLOGY

- To carry out a review into the care provided to Patient 10 within the SHSCT from 8 April 2014 until 1 March 2016. Records electronic records available on the Patient Administration System (PAS), Northern Ireland Electronic Care Record (NIECR) the Northern Ireland Picture Archiving and Communication System (NIPACS) will be examined in conjunction with all Clinical and Nursing documentation.
- To carry out this review into the care provided to Patient 10 using the National Patient Safety Agency Root Cause Analysis methodology
- To use a multidisciplinary team approach to the review
- To provide an agreed chronology based on documented evidence and staff accounts of events
- To identify the key contributory factors which may have had an influence or contributed to the timing of Patient 10's clinical management.
- To ensure that recommendations are made in line with evidence based practice. Accompanying appendices to the report will provide evidence of recent researched-based management of
- To set out the findings, recommendations, actions and lessons learnt in an anonymous report
- To adhere to the principles of confidentiality throughout the review.
- To report the findings and recommendations of the review through the Director of Acute Services SHSCT, to Patient 10 and the staff associated with Patient 10's care

This list is not exhaustive

5.0 DESCRIPTION OF INCIDENT/CASE

On 18 November 2010 Patient 10 had CT of Abdomen and Pelvis (CTAP) and was reported on 3 December 2010 which stated simple renal cyst particular on the right.

On 13 January 2013 CTAP reported by Dr 10. Bosniak type 1 cyst right kidney noted.

On 24 June 2014, Patient 10 had a CTAP with contrast as ordered by Dr 1. Dr 7's report in relation to the CTAP was issued on 7 July 2014 and reported multiple and bilateral simple cysts. A cyst arising from the anterior aspect of the right lower pole demonstrates subtle layering with high density in its medial aspect. The cyst appears minimally larger. A cyst in the anterior aspect of the right lower pole appears minimally larger and complex with high density in its medial aspect. Localised ultrasound was recommended to ensure no soft tissue component.

On 24 July 2014, Dr 1 ordered at ultrasound of the urinary tract. Dr 2's report on 30 July 2014 concluded a right lower pole complex renal cyst? Solid component. Advised MRI with intravenous (i/v) contrast to determine if the solid component enhances.

On 23 September 2014, Patient 10 seen by Dr 3 who ordered CT of Chest and Abdomen (CT CA).

On 26 September 2014 Patient 10 had a MRI of renal tract completed at the request of, or requested on behalf of, Dr 1. Dr 2's report on 29 September 2014 compared the previous CT 25/06/14 and USS 24/07/14. There is a large well-defined ovoid cystic mass, arising from the upper pole cortex of the right kidney. Appearances are consistent with cyst.

On 29 October 2014 Patient 10 attended for CT CA with i/v contrast. Dr 4 compared CT on 20/06/14 and on 1 November 2014 reported simple cyst seen in the upper pole. Complex cyst right kidney. On the same day, a routine GP referral was received in CAH Booking Centre from Dr 5 requesting assessment and advice in relation to the MRI findings reported on 26/09/14 re: large renal cyst and mentioning a history of bowel cancer and breast cancer.

On 7 November 2014, letter sent to Patient 10 from Dr 3 informing her of unchanged findings of CT CA done on 29 October 2014, and that there would be further Surgical Outpatient review. The CT reported a complex right renal cyst. This finding was not included in the letter Patient 10 and was not escalated to either Urology or Radiology for further opinion.

On 6 January 2016, Patient 10 was seen by Dr 8 in Urology Outpatients in response to GP referral on 29 October 2014. The MRI images were reviewed by Dr 8 in advance of the consultation. Dr 8 noted that the MRI report from 29/09/14 did not comment on the anterior lower pole of the right kidney. Dr 8 spoke with Dr 7 regarding the findings. In retrospect, Dr 7 reported the complex cyst on the right kidney had internal solid nodules with one area showing some enhancement with contrast. This raised the possibility of cystic renal cancer. Surgery arranged for 13th January 2016.

On 12th January 2016, Patient 10 was reviewed by Dr 3 with an enlarged left axillary noted



5.0 DESCRIPTION OF INCIDENT/CASE

on CT. A malignant node in the left axilla with invasive lobular carcinoma was confirmed.

15 February 2016 Patient 10 had a left axillary node clearance. Staging and further management of Patient 10's renal cyst has been postponed.

Patient 10 is recovering from a laparoscopic partial nephrectomy for confirmed papillary renal cell carcinoma which was performed on 31 October 2016.

6.0 FINDINGS

The Specialists within the Review Panel individually assessed each of Patient 10's radiological investigations in the timeframe between 24 June 2014 and 6 January 2016. The report by Dr 2 on 29 September 2014 references the findings of the USS and CT images done in June and July 2014. The Panel agree that when Dr 2 mentioned the earlier findings within the 29 September 2014 MRI report, it implied that the ovoid cystic mass noted had been seen and had been investigated. The inclusions of previous imaging findings are ambiguous. The consensus is that Dr 2's reported findings in relation to Patient 10's MRI of both kidneys were misleading and were inappropriately condensed. The Panel contribute this to human error. This error was the primary contributing factor to the delayed recognition of a potential renal cancer and its subsequent management.

The Review Panel agree that the absence of a complete right kidney assessment, and the wording of the MRI report, made it extremely difficult for clinicians to detect the missing clinical detail. This provides sufficient rationale to why Patient 10 was not referred to Urology for immediate assessment by Dr 3 or the GP Dr 5. The CT chest and abdomen of 29 October 2014 reported a complex right renal cyst. This important finding was not included in the letter by Dr 3 to Patient 10 on 7 November 2014 and was not referred on for urological opinion. This represents a missed opportunity to expedite investigation of a reported abnormality.

The Review Panel reviewed the GP Referral Letter management for Patient 10 in October 2014. In summary; Dr 6 was the Consultant Urologist on-call on 30 October 2014 and was responsible for the triage of the GP letters for that week. Patient 10 was one of eight letters for Triage.

The Triage form for 30 October 2014 was not returned to medical records for processing. After 10 working days, the booking centre e-mailed Dr 6's personal secretary seeking management advice for the 8 patients with outstanding triage. After no reply, a second email request was sent to Dr 6's personal secretary seeking management advice which was outstanding from 30 October 2014. At this point the informal booking centre default process for patients with no referral triage was initiated. The informal default triage management process was introduced in May 2014 to ensure the GP's referrals were allocated to a 'waiting list' in the event that the triage was not returned. A default management process was formally circulated on 6 November 2015. The pathway for GP referrals without triage is for the medical records team to accept the GP Grading, code the patient specialty as 'General Urology' and allocate the next available new patient appointment. The length of time until



6.0 FINDINGS

assessment is solely dependent on the Urology waiting time- which was a minimum of 42 weeks in 2014. The default management process provides an explanation to why Patient 10's 'Routine' referral letter was not upgraded and why Patient 10 was not seen by the Urology Team until 16 January 2016.

Patient 10 is now recovering from a laparoscopic excision of a papillary renal carcinoma which was done on 30 October 2016. This procedure was superseded by breast surgery in 2016 for breast lobular carcinoma on 14 February 2016. It had been agreed by the Oncology and Urology teams that the breast histology was priority and treatment proceeded in advance of renal surgery.

Relevant members of the Review Team completed a 'look-back' exercise in relation to the remaining 7 other GP letters to establish the patient management and outcome. The Panel can confirm that the other 7 patients have been seen by the Urology Team on or before 26 January 2016, and have not been known to have been exposed to significant harm.

7.0 CONCLUSIONS

The MRI report by Dr 2 on 29 September 2014 as previously discussed, was misleading and was inappropriately condensed. The quality of the information resulted in the evolving right renal cyst being overlooked by Drs 3 and Dr 5.

The SHSCT Radiology Team continuously review and audit the quality and accuracy of their reporting. On this occasion, the MRI report irregularities were not detected until viewed by a Urology Consultant.

All available evidence suggests that Dr 6 did not triage Patient 10's GP referral letter on the week ending 30 October 2014. The default triage management process was initiated which resulted in Patient 10 waiting 64 weeks for Urological assessment.

The Review Panel agree that in relation to Patient 10, 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.

While the remit of this Serious Adverse Incident (SAI) Review was to examine the factors in Patient 10's delayed management of papillary renal cancer. The Review Panel were provided evidence 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 continues to be initiated secondary to the omission of Triage by individual members of the urology team and not the entire Urology Team.

8.0 LESSONS LEARNED

There will always be an element of human error in the interpretation and reporting of radiological imaging.

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.

9.0 RECOMMENDATIONS AND ACTION PLANNING

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 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.

**10.0 DISTRIBUTION LIST**Patient
10

HSCB

SHSCT Litigation

SHSCT Medical Director

SHSCT Director of Acute Services

AMD for Surgery and Elective Care

AMD for Integrated Maternal/Women's Health and Clinical Services

AD's for Surgery and Elective Care, Integrated Maternal/Women's Health/Clinical Services
and Functional Support Services

Chair of Surgical Morbidity and Mortality

David Cardwell



SHSCT GOVERNANCE TEAM (IR2) Form -NEW June 2018

Incident Details ID & Status		Personal Information redacted by the USI		
Incident Reference ID				
Submitted time (hh:mm)		12:53		
Incident IR1 details				
Notification email ID number		Personal Information redacted by the USI		
Incident date (dd/MM/yyyy)		06/01/2016		
Time (hh:mm)		09:30		
Does this incident involve a patient under the age of 16 within a Hospital setting (inpatient or ED)				
Does this incident involve a Staff Member?				
Description		Patient 10 HCN [redacted] DOB [redacted] Had a CT scan 24/6/2014 as follow-up of bowel cancer. CT showed an abnormal renal cyst with two further cysts in the right kidney. US performed 24/7/2014 showed solid elements within the anterior lower pole cyst and recommended an MRI to further evaluate. MRI performed 2/9/2014 reported 'Comparison to previous ultrasound dated 24/07/2014 and CT dated 24/06/2014. There is a large well-defined ovoid cystic mass, arising from the upper pole cortex of the right kidney, measuring 8.7 cm x 5.3 cm in size. This lesion is T2 hyperintense, T1 hypointense, and demonstrates no abnormal enhancement. The MR appearances are consistent with a cyst'. No comment made on the MRI report regarding the anterior lower pole which had concerning features on CT and US. Had a further CT on 29/10/2014 as follow-up for breast cancer which again reported '3.6 cm exophytic complex cyst is seen in the lower pole of the left kidney anteriorly containing solid and cystic component. Simple cyst seen in the upper pole measuring 7 cm. Left kidney show no focal lesion...Complex cyst right kidney.(previously investigations noted)'. Patient 10 was referred to the urology department on 29/10/2014 for assessment and advice regarding the cyst with the MRI report. referral was marked as routine by the JGP (on basis that MRI had reported a benign cyst). Referral was not triaged on receipt. Patient 10 sent OP appointment for 6/1/2016. Consultant had noted in clinic preparation that the MRI report had not commented on the abnormal cyst and requested a further review by a consultant radiologist who reported the abnormal cyst as a likely cystic renal cancer. Patient 10 was seen in clinic on 6/1/16. the sequence of events was outlined and surgical treatment of a suspected cystic renal cancer recommended after completion of up to date staging with a further CT scan.		
Enter facts, not opinions. Do not enter names of people				
Action taken		There has been a resultant 18 month delay in OP review and recommendation of treatment for a suspected kidney cancer. Patient and husband fully informed of events and shown reports and imaging.		
Enter action taken at the time of the incident				
Learning Initial				
Reported (dd/MM/yyyy)		06/01/2016		
Reporter's full name		Mark Haynes		
Reporter's SHSCT Email Address				
Opened date (dd/MM/yyyy)		06/01/2016		
Were restrictive practices used?				
Name		Patient 10		
This will auto-populate with the patient/client's name if the person-affected details have been entered for this incident.				
Location of Incident				
Site		Craigavon Area Hospital		
Loc (Type)		Outpatient Clinic		
Loc (Exact)		Urology Clinic		
Directorate		Acute Services		
Division		Surgery and Elective Care		
Service Area		General Surgery		
Speciality / Team		Urology Surgery		
Staff initially notified upon submission				
Recipient Name	Recipient E-mail	Date/Time	Contact ID Telephone Number Job Title	
Contact ID [redacted] not found	Eamon.Mackie [redacted]	06/01/2016 12:54:12	[redacted]	
Smyth, Paul MR	paul.smith [redacted]	06/01/2016 12:54:11	[redacted]	Head of Unscheduled Care
Trouton, Heather	heather.trouton [redacted]	06/01/2016 12:54:11	[redacted]	Assistant Director of Acute Services
Connolly, Connie	connie.connolly [redacted]	06/01/2016 12:54:11	[redacted]	Acting Acute Governance Co-Ordinator

Below are the 5 categories which qualify a RIDDOR Reportable Incident (click on blue links for further definition):

1. Employee or self-employed person working on Trust premises is killed or suffers a [major injury](#)
2. A member of the public on Trust premises is killed or taken to hospital
3. An incident connected with the Trust where an employee, or self-employed person working on Trust premises, suffers an "over 3 day injury" (being incapacitated to do their normal duties for more than three consecutive days (not counting the day of the accident but including weekends and rest days). Incapacitation means that the member of staff is absent or unable to do their normal work e.g. placed on lighter duties which are not part of their normal work)
4. [Dangerous Occurrence](#) attributable to the work of the Trust
5. A doctor has notified you in writing that a Trust employee suffers from a [reportable work-related disease](#)

Is this a NIAIC Incident

No

NIAIC (Northern Ireland Adverse Incident Centre) incidents relate to medical devices. If a medical device is involved in an incident consider the list below to identify if the incident is NIAIC reportable;

- design or manufacturing problems
- inadequate servicing and maintenance
- inappropriate local modifications
- unsuitable storage and use conditions
- selection of the incorrect device for the purpose
- inappropriate management procedures
- poor user instructions or training (which may result in incorrect user practice)

Investigation

Investigator **Connie Connolly
Martina Corrigan**

Date started (dd/MM/yyyy) **06/01/2016**

Actual Impact/Harm **Major**

This has been populated by the reporter. To be quality assured by the investigating manager.

Risk grading

Click [here](#)

When the incident has a Severity (actual impact/harm, grading of insignificant to moderate, you need to plot on the matrix opposite the Potential impact/harm. Deciding what are the chances of the incident happening again under similar circumstances. (Likelihood) and multiply that by the potential impact if it were to reoccur (consequence) The overall risk grading for the event will be determined by plotting: consequence multiplied by likelihood = risk grading. Refer to impact table here:

	Consequence				
	Insignificant	Minor	Moderate	Major	Catastrophic
Likelihood of recurrence					
Almost certain (Expected to occur daily)	☐	☐	☐	☐	☐
Likely (Expected to occur weekly)	☐	☐	☐	☐	☐
Possible (Expected to occur monthly)	☐	☐	☐	☒	☐
Unlikely (Expected to occur annually)	☐	☐	☐	☐	☐
Rare (NOT expected to occur for years)	☐	☐	☐	☐	☐
Grade: High Risk					

Action taken on review

Enter here any actions you have taken as a result of the incident occurring; e.g. communicating with staff / update care plan / review risk assessment (corrective and preventative action)

060116cc- this has been moved to review. Streamed to SEC for management but will also involve Radiology and functional support. Communication emails sent to ATTICs, Functional Services and Patient Care same and access provided. To be prepared for SAI screening. HOS aware. 230316cc- this has been screened and validated as a Level 2 SAI. Will be managed via SAI process. Screening documentation attached. Closed to await SAI

Action Plan Required?

No

A formal action plan is required for all Moderate to Catastrophic incidents. If you tick yes an "Action plan" section will appear below. Use this to create your action plan.

Action Plan

No actions.

Lessons learned

Lessons learned **await**

If you think there are any lessons from an incident which could be shared with other teams please record here. If not please type "none".

Route involved

Correct route

Falls Information

Please Quality Assure all information as part of your investigation

Did the fall occur in Hospital or
Community Setting?

Specific Location of Fall

Exact location of Fall

**Please describe in free-text exactly
where the fall occurred**

Injury Suspected?

Harm?

Buzzer / bell available within reach
before fall?

Floor surface

Footwear suitable?

Walking aid in use / reach?

Mental State

First fall this admission or repeat?

Days since admission

Was the patient receiving medication
which may affect the risk of falling?

Family informed of fall?

Outcome of Bedrails Assessment

Pressure UlcersWas this incident in respect of a Pressure
Ulcer?**Equipment details**

Product type

Brand name

Serial no

Description of device

Current location

CE marking?

Description of defect

Model/size

Documents added

Created	Type	Description
29/01/2018		TOR 23.11.16
29/01/2018		Report
29/01/2018		Letter advising report complete 24.3.17
29/01/2018		Cover letter and report issued registered post 31.3.17
29/01/2018		Confirmation of meeting on 10.4.17 posted 31.3.17
29/01/2018		Notes of meeting approved
29/01/2018		Report closed 26.1.18
23/03/2016	Form	SAI notification
23/03/2016	Form	SAI screening form
06/01/2016	PDF Document	US report 240714
06/01/2016	E_Mail	Email correspondence with radiology consultant
06/01/2016	PDF Document	CT report 291014
06/01/2016	PDF Document	CT report 240614
06/01/2016	PDF Document	MRI report 260914

ID
Personal
Information
redacted by
the USI**People Affected**

ID	Title	Forenames	Surname	Type	Current approval status
 Personal Information redacted by the			Patient 10	Patient/Client/Service User	Unapproved

Employees

ID	Title	Forenames	Surname	Type	Current approval status
 Personal Information redacted by the	Mr	Mark	Haynes	Staff - Medical and Dental	Unapproved

Other Contacts**No Other Contacts**

Carroll, Ronan

From: Corrigan, Martina
Sent: 09 May 2022 16:46
To: Carroll, Ronan
Subject: FW: Datix Incident Report Number [redacted]

-----Original Message-----

From: Carroll, Ronan <Ronan.Carroll [redacted]>
Sent: 07 January 2016 08:48
To: Corrigan, Martina <Martina.Corrigan [redacted]>
Cc: Boyce, Tracey <Tracey.Boyce [redacted]>; Trouton, Heather <Heather.Trouton [redacted]>; Gracey, David <David.Gracey [redacted]>; Hall, Stephen <Stephen.Hall [redacted]>; Robinson, Jeanette <Jeanette.Robinson [redacted]>
Subject: RE: Datix Incident Report Number [redacted]

Martina
When screened and a determination made of the level we will of course provide a consultant radiologist to be part of the process Ronan

-----Original Message-----

From: Corrigan, Martina
Sent: 06 January 2016 17:15
To: Carroll, Ronan
Subject: FW: Datix Incident Report Number [redacted]

Hi Ronan

For information regarding the radiology bit, I will be dealing with the untriaged bit.

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: [redacted]
Mobile: [redacted]
Email: martina.corrigan [redacted]

-----Original Message-----

From: datix@southerntrust.hscni.net [mailto:datix@southerntrust.hscni.net]
Sent: 06 January 2016 12:54
To: Corrigan, Martina
Subject: Datix Incident Report Number [redacted]

An incident report has been submitted via the DATIX web form.

The details are:

Form number: [redacted]

Description:

Patient Patient 10, HCN Personal Information redacted by USI, DOB Personal Information redacted by USI Had a CT scan 24/6/2014 as follow-up of bowel cancer.

CT showed an abnormal renal cyst with two further cysts in the right kidney.

US performed 24/7/2014 showed solid elements within the anterior lower pole cyst and recommended an MRI to further evaluate.

MRI performed 2/9/2014 reported 'Comparison to previous ultrasound dated 24/07/2014 and CT dated 24/06/2014. There is a large well-defined ovoid cystic mass, arising from the upper pole cortex of the right kidney, measuring 8.7 cm x 5.3 cm in size. This lesion is T2 hyperintense, T1 hypointense, and demonstrates no abnormal enhancement. The MR appearances are consistent with a cyst'. No comment made on the MRI report regarding the anterior lower pole which had concerning features on CT and US.

Had a further CT on 29/10/2014 as follow-up for breasts cancer which again reported '3.6 cm exophytic complex cyst is seen in the lower pole of the left kidney anteriorly containing solid and cystic component. Simple cyst seen in the upper pole measuring 7 cm. Left kidney show no focal lesion...Complex cyst right kidney.(previously investigations noted)'

Patient 10 was referred to the urology department on 29/10/2014 for assessment and advice regarding the cyst with the MRI report. referral was marked as routine by the | GP (on basis that MRI had reported a benign cyst). Referral was not triaged on receipt.

Patient 10 sent OP appointment for 6/1/2016. Consultant had noted in clinic preperation that the MRI report had not commented on the abnormal cyst and requested a further review by a consultant radiologist who reported the abnormal cyst as a likely cystic renal cancer.

Patient 10 was seen in clinic on 6/1/16. the sequence of events was outlined and surgical treatment of a suspected cystic renal cancer recommended after completion of up to date staging with a further CT scan.

Please go to http://vsrdatixweb/Datix/Development/index.php?action=incident&recordid=Personal Information redacted by USI to view and approve it.