Buckley, LauraC

From: Gishkori, Esther [redacted]
Sent: 02 February 2017 16:51
To: Hynds, Siobhan
Cc: Carroll, Ronan
Subject: RE: Action note - 26th January - AOB draft SH comments

Siobhan,
Yes, I would like that as I'm sure would Ronan.
Ronan and I are at a finance workshop on Monday but I imagine it to be over at 3.30ish.
Could you come to my office for 4pm?
I would make sure we were there to meet you.
Thanks
Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office [redacted] **Mobile** [redacted]
[redacted]

From: Hynds, Siobhan
Sent: 02 February 2017 16:42
To: Gishkori, Esther
Cc: Carroll, Ronan
Subject: RE: Action note - 26th January - AOB draft SH comments

Esther

Dr Khan and I had hoped to meet with Mr O'Brien this week to outline the monitoring arrangements however we noted Ronan was on leave until Monday. We have notified Mr O'Brien that we do not have the detail as yet but will inform him as soon as possible. It is important that we have this as early as possible next week in order for us to brief Mr O'Brien with a view to him potentially returning to work following his OH appointment on 9 February. If he is passed fit on the 9th February, it will be expected that he will return with the monitoring/supervision framework in place on the 10th. Colin Weir is fully aware of this and it will be necessary I assume to involve the other CD to ensure the monitoring is robust and do-able.

Would it be possible to meet with you and/or Ronan on Monday or Tuesday to discuss? I can make myself available at any stage?

Many thanks

Siobhan

From: Gishkori, Esther
Sent: 02 February 2017 16:36
To: Hynds, Siobhan

Southern Health and Social Care Trust

Quality Care - for you, with you

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

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

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

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

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

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

CONCERN 1

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

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

Hynds, Siobhan

From: Hynds, Siobhan [redacted]
Sent: 03 March 2017 00:19
To: Khan, Ahmed
Cc: Chada, Neta
Subject: MHPS Case
Attachments: Terms of Reference for Investigation January 2017 DRAFT FINAL.docx

Dr Khan

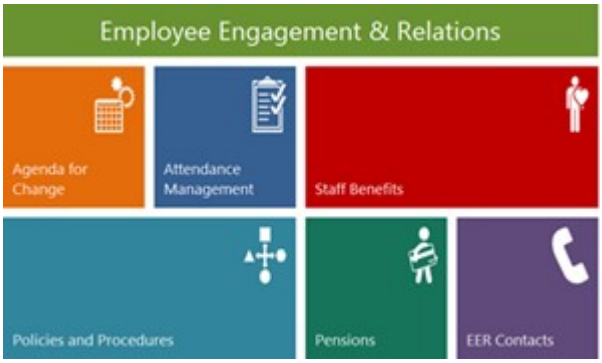
Please see attached draft Terms of Reference for your agreement. These need to be issued to Mr O'Brien when agreed.

Did you get speaking with Grainne Lynn, NCAS about the action plan?

Thanks

Siobhan

Mrs Siobhan Hynds
Head of Employee Relations
Human Resources & Organisational Development Directorate
Hill Building, St Luke's Hospital Site
Armagh, BT61 7NQ
Tel: [redacted] Mobile: [redacted] Fax: [redacted]



Click on the above image for SharePoint: Employee Engagement & Relations information

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Hynds, Siobhan

From: Hynds, Siobhan [redacted]
Sent: 30 March 2017 20:25
To: Khan, Ahmed
Cc: Wright, Richard
Subject: FW: CONFIDENTIAL NCAS EMAIL
Attachments: NCAS Email 300317 case+18665+confidential.pdf

Importance: High

Dr Khan

Please find attached e-mail in relation to the AOB case. Dr Wright is currently absent so I have sent this onto you in his absence. Is there any update for Dr Lynn, NCAS at this point?

If you need any update from the investigation please let me know.

Regards,

Siobhan

From: Thompson, Norma
Sent: 30 March 2017 13:54
To: Wright, Richard; Hynds, Siobhan
Cc: Gibson, Simon; Parks, Zoe
Subject: CONFIDENTIAL NCAS EMAIL

Hi Richard / Siobhan – see attached just in from NCAS encrypted mail service – who does this case refer to? I don't have anything saved on our doctors' electronic files with this case number – is it re. Mr O'Brien? Just so I can save it to his file and if you could also forward me any other correspondence in relation to this case as well that would be great.

Richard – would you give Grainne a call when you get back from leave then as per her email.

Kind regards
Norma
Head of Revalidation Support Team
Tel: [redacted]

Martina
As discussed yesterday – can u provide this update asap pls
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Personal Information redacted by USI

From: Khan, Ahmed
Sent: 12 April 2017 12:55
To: Gishkori, Esther; Carroll, Ronan
Cc: Hynds, Siobhan
Subject: MHPS case

Dear Esther & Ronan,
I would be grateful for an update regarding adherence to action plan for Mr O'Brien's MHPS Case.

Siobhan, for information.

Regards
Dr Ahmed Khan
AMD& Case Manager

Sent from my BlackBerry 10 smartphone.

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

INTERNAL: EXT Personal Information redacted by USI ***if dialling from Avaya phone. If dialling from old phone please dial*** Personal Information redacted by USI
EXTERNAL : Personal Information redacted by USI
Mobile: Personal Information redacted by USI

From: Carroll, Ronan
Sent: 04 May 2017 12:21
To: Corrigan, Martina
Subject: FW: MHPS case

Martina
Can we get this done pls for tomorrow
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by USI

From: Khan, Ahmed
Sent: 04 May 2017 12:20
To: Carroll, Ronan
Cc: Hynds, Siobhan
Subject: RE: MHPS case

Ronan, Please send monthly update by end of next week (12th May).
Thanks,
Ahmed

Dr Ahmed Khan
Consultant Paediatrician
Associate Medical Director &
MHPS Case Manager
SHSCT

From: Carroll, Ronan
Sent: 14 April 2017 16:44
To: Khan, Ahmed
Cc: Hynds, Siobhan; Chada, Neta
Subject: FW: MHPS case
Importance: High

Ahmed
As requested – update on AOB AP
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by USI

Gibson, Simon

From: Carroll, Ronan [redacted]
Sent: 15 May 2017 09:08
To: Corrigan, Martina
Cc: Hynds, Siobhan; Khan, Ahmed
Subject: RE: MHPS case update on 12 May 2017

tks

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob [redacted]

From: Corrigan, Martina
Sent: 12 May 2017 19:19
To: Carroll, Ronan
Subject: RE: MHPS case update on 12 May 2017

Ronan

Mr O'Brien has been off all this week on annual leave.

I checked the charts out to him and there are 67 in his office but there were 11 returned but another 10 added for him to have a look at with results I have the comparable lists and I will continue to monitor this on a weekly basis.

Regards

Martina

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

INTERNAL: [redacted] ***if dialling from Avaya phone. If dialling from old phone please dial*** [redacted]
EXTERNAL : [redacted]
Mobile: [redacted]

From: Corrigan, Martina
Sent: 05 May 2017 15:11
To: Carroll, Ronan
Subject: RE: MHPS case update on 5 May 2017

Ronan

I have updated this but note that Dr Khan wants monthly update which would be end of next week – do you want to send or will I update again next week?

Concern 1

Mr O'Brien has not been oncall since 6-12 April as per last update. He is due to be Urologist oncall from 18 May and I will update once he has finished this week.

Concern 2

Apart from the 13 already identified missing notes Mr O'Brien has 68 further charts in his office which are all recent and are awaiting for results. There are no other missing charts and no evidence of charts being taken off-site.

Concern 3

I can confirm that all clinics that Mr O'Brien has done since his return to work have been dictated on by digital dictation and all patients have a plan and outcome included.

Concern 4

Mr O'Brien has had theatre lists on 5th and 26th April and on 3rd May
There were a total of 17 patients listed and I can confirm none were previous private patients

Martina

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

Changed My Number

INTERNAL: Personal Information redacted by USI ***if dialling from Avaya phone. If dialling from old phone please dial*** Personal Information redacted by USI
EXTERNAL : Personal Information redacted by USI
Mobile: Personal Information redacted by USI

From: Carroll, Ronan
Sent: 04 May 2017 12:21
To: Corrigan, Martina
Subject: FW: MHPS case

Martina
Can we get this done pls for tomorrow
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by USI

From: Khan, Ahmed
Sent: 04 May 2017 12:20
To: Carroll, Ronan
Cc: Hynds, Siobhan
Subject: RE: MHPS case

Ronan, Please send monthly update by end of next week (12th May).
Thanks,
Ahmed

Hynds, Siobhan

From: Hynds, Siobhan [redacted]
Sent: 25 June 2017 19:35
To: Khan, Ahmed
Cc: Chada, Neta
Subject: FW: MHPS case update on 23 June 2017

Importance: High

Dr Khan

Please see update in respect of the operational action plan in place for Mr O'Brien for your information.

I will seek an update on issue 2 by end of June and will let you know how this is progressing.

Regards,

Siobhan

From: Carroll, Ronan
Sent: 23 June 2017 17:48
To: Corrigan, Martina
Cc: Hynds, Siobhan; Weir, Colin
Subject: RE: MHPS case update on 23 June 2017
Importance: High

Martina
Tks for this largely +ve update. Re Concern 2 I would ask that notes are dealt with by 30th June, otherwise we are return ing to the previous position
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]

From: Corrigan, Martina
Sent: 23 June 2017 15:36
To: Carroll, Ronan
Subject: FW: MHPS case update on 23 June 2017

Ronan

Update as of today 23 June 2017

Concern 1

Mr O'Brien was last oncall from 13 – 19th May and I can confirm all letters were triaged within the timescales his next oncall is from 29th June until 5 July.

Concern 2

Apart from the 13 already identified missing notes Mr O'Brien has 85 further charts in his office. This amount has been increasing each week and whilst some are moving on there are some that haven't been actioned. I have

Gibson, Simon

From: Carroll, Ronan [redacted]
Sent: 11 July 2017 17:57
To: Khan, Ahmed
Cc: Hynds, Siobhan
Subject: FW: MHPS case update on 11 July 2017

Importance: High

Ahmed
Please see update. I have highlighted an area which is a variance to his action plan. As stated Martina has emailed AOB for a resolution.
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]

From: Corrigan, Martina
Sent: 11 July 2017 17:41
To: Carroll, Ronan
Cc: Weir, Colin
Subject: FW: MHPS case update on 11 July 2017

Update as of today 11 July 2017

Concern 1

Mr O'Brien was last oncall from 29 June until 7 July and I can confirm all letters on etriaged were triaged however the booking centre advises that there are still 30 outstanding 'paper' referrals that he has not returned although I do know that he is working this week on his Annual Leave as has been emailing me about theatre lists and he did return some triage today. I have sent him an email about this, this afternoon.

Concern 2

Apart from the 13 already identified missing notes Mr O'Brien has 90 further charts in his office. This amount has been increasing each week and whilst some are moving on there are now quite a few that haven't been actioned. I have emailed Mr O'Brien again today and I again reminded him that as part of the action plan that *Notes should never be stored off site and should only be tracked out and in your office for the shortest time possible* and I asked him to please address as many of these as he could. There are no other missing charts and no evidence of charts being taken off-site.

Concern 3

I can confirm that all clinics that Mr O'Brien has done since his return to work have been dictated on by digital dictation and all patients have a plan and outcome included.

Concern 4

Mr O'Brien has had one theatre list since the last report on 28 June which had 5 patients listed and I can confirm none were previous private patients

25 July 2017

FILE REFERENCE: 9

AIDAN O'BRIEN
~~**(COLIN, MARTINA, RONAN)**~~
COLIN WEIR
MARTINA CORRIGAN
RONAN CARROLL

Audio Transcription Prepared by:

Angela Harte

[redacted]

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comments, so it's obviously Noleen that's tracking them out and sending them to your office with the result on the front of the chart. So it's just that --

MR O'BRIEN: There is no need for chart to be there.

MARTINA CORRIGAN: Okay.

MR O'BRIEN: And I've told Noleen that.

MARTINA CORRIGAN: Okay.

MR O'BRIEN: Even, you know, the past two weeks when Noleen was off, there were still charts coming into my office. I don't ask them. If I don't ask for them, I'm not the person responsible for storing them. There's no need for them. It is an obsolete system.

MARTINA CORRIGAN: Okay. Yeah. Yeah. We can --

COLIN WEIR: So is there -- so those charts don't necessarily need anything done with them then or does it need an outcome?

MR O'BRIEN: No. The number as of last Friday actually the number is 25.

COLIN WEIR: Yeah.

MR O'BRIEN: Because I returned so many charts.

COLIN WEIR: All right.

MR O'BRIEN: Completely pointless --

COLIN WEIR: Okay. It's just --

MR O'BRIEN: -- time-consuming exercise people bringing charts into your office, leaving them there on top of your desk with a normal PSA that you -- I just don't understand the reason for it.

RONAN CARROLL: Was that -- I suppose I'm just trying to understand but it's good when you don't need them but why would that -- would that have (inaudible)?

MR O'BRIEN: I was told by the secretaries actually that they're told that's what they have to do by their line managers.

RONAN CARROLL: Oh. So how do we stop?

COLIN WEIR: For me, my practice is no charts in my office at all. They go --

MR O'BRIEN: On Friday I did an audit. There were seven of the charts in my office that I had asked for.

COLIN WEIR: Right.

MR O'BRIEN: Two of them were medico~~al~~ legal. Two are for police reports.

~~MARTINA CORRIGAN~~ MR O'BRIEN: And there's one for reconstruction which is (inaudible).

MR O'BRIEN: And one for reconstruction which I have returned because -- and I don't really need it -- but I have returned it as it seems to be an issue that you retain a chart on Personal information redacted

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Toal, Vivienne

From: Khan, Ahmed [redacted]
Sent: 24 May 2018 11:14
To: Toal, Vivienne
Subject: RE: Return to Work Action Plan February 2017 FINAL.

Vivienne, I have been receiving it until earlier this year from Ronan Carroll, haven't received it in few months now. Have spoken to him recently & he will forward this to me.
Is the report ready ?
Regards,
Ahmed

From: Toal, Vivienne
Sent: 23 May 2018 07:40
To: Khan, Ahmed
Subject: FW: Return to Work Action Plan February 2017 FINAL.

Ahmed
See below re AOB

Have you been getting these updates on a regular basis in terms of assurance?

Vivienne

From: Hynds, Siobhan
Sent: 23 May 2018 00:48
To: Toal, Vivienne
Subject: FW: Return to Work Action Plan February 2017 FINAL.

Hope this helps!

From: Corrigan, Martina
Sent: 22 May 2018 17:29
To: Hynds, Siobhan; Carroll, Ronan
Subject: RE: Return to Work Action Plan February 2017 FINAL.

Hi Siobhan

Apart from one deviation on 1 February 2018 when Mr O'Brien had to be spoken to regarding a delay in Red Flag Triage and he immediately addressed it, I can confirm that he has adhered to his return to work action plan, which I monitor on a weekly basis.

CONCERN 1 – one deviation when the red flag was not triaged for 6 days – he was spoken to and it was resolved that evening and his reason was due to the busyness of his oncall week when he had spent quite a bit of it in emergency theatre.
CONCERN 2 – adhered to – no notes are stored off premises nor in his office
CONCERN 3 – adhered to – Mr O'Brien uses digital dictation and dictates on all charts after clinics and he has an outcome on all patients including DNA patients

From: Carroll, Ronan
Sent: 18 October 2018 12:39
To: Gibson, Simon; Weir, Colin; Khan, Ahmed; Haynes, Mark
Subject: RE: Return to Work Action Plan February 2017 FINAL.
Importance: High

Simon
I think you are stating the obvious.
With Martina having been off since June the overseeing function has not taken place and in the day to day activities was overlooked
But We need to understand why this the dictation has gone out, this could explain the volume of notes or there may be some other reason
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by USI
Ext Personal Information redacted by USI

From: Gibson, Simon
Sent: 18 October 2018 12:31
To: Weir, Colin; Khan, Ahmed; Carroll, Ronan; Haynes, Mark
Subject: RE: Return to Work Action Plan February 2017 FINAL.

Dear Ronan

What is most concerning here is that there were monitoring and supervision arrangements put in place, which we confirmed to a range of interested parties.

If he has a backlog of clinic letters and discharges going back to June, have these arrangements fallen down?

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by USI
Personal Information redacted by USI
Personal Information redacted by USI

From: Weir, Colin
Sent: 18 October 2018 11:33
To: Khan, Ahmed; Gibson, Simon; Carroll, Ronan; Clayton, Wendy; Haynes, Mark
Subject: FW: Return to Work Action Plan February 2017 FINAL.
Importance: High

Ahmed/Simon

Please for your urgent consideration and action

See email correspondence below. Please see attached excel spreadsheet and go to Oct TAB or see below in email trail

Mr O'Brien has accumulated a large backlog of dictated letters and large numbers of charts in his office.

I am his Clinical Director

I have NOT seen the review and results and recommendations into his practice, but I am assuming he is in breach of this given these findings

Can you instruct me on how you would like to proceed.

I can certainly meet his with Ronan to discuss and record outcome from any meeting with him but I need to know if any sanctions need to be put in place if he has breached any of the review requirements or if your office wish to take this over?

Colin

From: Clayton, Wendy
Sent: 18 October 2018 11:07
To: Weir, Colin
Subject: FW: Return to Work Action Plan February 2017 FINAL.
Importance: High

From: Carroll, Ronan
Sent: 17 October 2018 15:52
To: Young, Michael; Haynes, Mark
Cc: Clayton, Wendy
Subject: FW: Return to Work Action Plan February 2017 FINAL.
Importance: High

Michael/Mark
Please see update from Wendy

1. Dictation to be completed
2. Notes in office

Aidan needs spoken with and asked to address dictation asap & to return notes (possible notes are for dictation)
I am in CAH tomorrow pm

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by USI

From: Clayton, Wendy
Sent: 17 October 2018 15:11
To: Carroll, Ronan; Corrigan, Martina
Subject: RE: Return to Work Action Plan February 2017 FINAL.

See below dictation report. There are approx 82 charts in the office on level 2. Do you need me to try and find out how long they have been there?

UROLOGY				Backlog - Number of c
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinic letters to be dictated**	**oldest date of clinic letters to be dictated**

Mr Jakob				
Mr Glackin	5	6	7	06/06/2018 (1 letter)
Mr Haynes	0	0	19	26.09.18
Mr O'Brien	17	0	91	15.06.18
Mr O'Donoghue				
Mr Young	12	0	0	0
Sub Speciality Totals	**34**	**6**	**117**	

From: Clayton, Wendy
Sent: 16 October 2018 19:41
To: Carroll, Ronan; Corrigan, Martina
Subject: RE: Return to Work Action Plan February 2017 FINAL.

I have check PAS and there are 82 charts tracked out specifically to Mr O'Brien

I will ask Collette for an update typing backlog report which will show clinic/results to be dictated, hopefully this will be through tomorrow.

Wendy

Wendy Clayton
Acting HOS for G Surg, Breast & Oral Services
SEC
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From: Carroll, Ronan
Sent: 15 October 2018 23:01
To: Clayton, Wendy; Corrigan, Martina
Subject: FW: Return to Work Action Plan February 2017 FINAL.
Importance: High

Wendy
Can i ask you as a matter of urgency to update the position re Notes checked out to AOB (74) & Digital Dictation also 91 letters pls
Ronan

Ronan Carroll

Gibson, Simon

From: Carroll, Ronan [redacted]
Sent: 18 October 2018 21:10
To: Khan, Ahmed; Gibson, Simon
Subject: RE: Return to Work Action Plan February 2017 FINAL.

Importance: High

Ahmed
I am in London tomorrow sorry . I have sent simon some information re backlog
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob [redacted]
Ext [redacted]

From: Khan, Ahmed
Sent: 18 October 2018 16:29
To: Gibson, Simon; Carroll, Ronan
Subject: RE: Return to Work Action Plan February 2017 FINAL.
Importance: High

Hi, this is clearly unacceptable practice from both the clinician and responsible managers. I am meeting with Siobhan tomorrow regarding this MHPS at 11.30 to 12.30 in DHH , can you attend this (face to face or Telephone)?
Thanks
AK

From: Gibson, Simon
Sent: 18 October 2018 13:12
To: Carroll, Ronan; Weir, Colin; Khan, Ahmed; Haynes, Mark
Subject: RE: Return to Work Action Plan February 2017 FINAL.

Dear Ronan

OK – if you can work to find out why the dictation has gone out, I'll pick up with Ahmed in terms of Colin's original questions.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
[redacted]

Gibson, Simon

From: Carroll, Ronan [redacted]
Sent: 24 October 2018 15:48
To: Khan, Ahmed
Cc: Gishkori, Esther; Gibson, Simon; Hynds, Siobhan; Toal, Vivienne; Weir, Colin
Subject: RE: AOB notes and dictation

Importance: High

Dr Khan
Happy to ensure AP is monitored.
Could I ask that the oversight committee write to Mr O'Brien reminding him of his obligations/responsibilities to comply with this AP and that it will be monitored.
Regards
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]

From: Khan, Ahmed
Sent: 23 October 2018 16:08
To: Carroll, Ronan
Cc: Gishkori, Esther; Gibson, Simon; Hynds, Siobhan; Toal, Vivienne
Subject: RE: AOB notes and dictation

Ronan, The action plan must be closely monitored with weekly report collected as per AP. Can you also clarify that yesterday, 22/10/18 there were 91 outstanding dictations and today only 16 (Oldest 28/9/18)?

Thanks,
Ahmed

From: Gibson, Simon
Sent: 23 October 2018 15:57
To: Carroll, Ronan; Khan, Ahmed; Hynds, Siobhan; Toal, Vivienne
Cc: Gishkori, Esther
Subject: RE: AOB notes and dictation

Dear Ahmed

I assume that would be a question for you as Case Manager (or the Oversight Committee)?

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
[redacted]
[redacted]

Personal Information redacted by USI

From: Carroll, Ronan
Sent: 23 October 2018 15:34
To: Gibson, Simon; Khan, Ahmed; Hynds, Siobhan; Toal, Vivienne
Cc: Gishkori, Esther
Subject: RE: AOB notes and dictation
Importance: High

Re the outcome of today's meeting can I ask are we to continue monitoring AOB against the 4 elements of the AP?
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by USI
Ext Personal Information redacted by USI

From: Carroll, Ronan
Sent: 23 October 2018 15:05
To: Gibson, Simon; Khan, Ahmed; Hynds, Siobhan; Kerr, Vivienne
Subject: RE: AOB notes and dictation

Yes

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by USI
Ext Personal Information redacted by USI

From: Gibson, Simon
Sent: 23 October 2018 15:05
To: Carroll, Ronan; Khan, Ahmed; Hynds, Siobhan; Kerr, Vivienne
Subject: RE: AOB notes and dictation

P.S - Maybe should have gone to Viv Toal?

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by USI
Personal Information redacted by USI
Personal Information redacted by USI

From: Carroll, Ronan
Sent: 23 October 2018 15:02
To: Khan, Ahmed; Hynds, Siobhan; Gibson, Simon; Kerr, Vivienne
Subject: FW: AOB notes and dictation
Importance: High

Please see updated position – apologies for the delay

Ronan Carroll

Comac, Jennifer

From: Khan, Ahmed
Sent: 23 October 2018 16:57
To: O'Brien, Aidan
Cc: Wilkinson, John; Hynds, Siobhan
Subject: RE: Information Request
Attachments: Action note - 22nd December - AOB.DOCX; Appendix 27 IEAP Executive Summary April 08.doc; leto_161229_advice+letter_18665.pdf; NCAS Correspondence - Sept16.pdf; Return to Work Action Plan February 2017 FINAL (2).pdf

Dear Mr O'Brien,

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

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

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

- **Copy of the minutes of the meeting of the Oversight Group December 2016 attached.**

- **Copy correspondence with NCAS in September & December 2016 attached.**

- **Copy of the Integrated Elective Access Protocol attached. It has been previously clarified with Mr O'Brien that this is the document referred to at the outset of the investigation. It has previously been clarified with Mr O'Brien that there is no separate Southern Trust Policy or Procedure on Triage.**

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

Regards,
Ahmed

Dr Ahmed Khan
Case Manger

Corrigan, Martina

From: Corrigan, Martina
Sent: 16 September 2019 16:37
To: Khan, Ahmed
Cc: Hynds, Siobhan
Subject: AOB concerns - escalation
Attachments: Backlog report; FW: Red Flag Cystoscopy; red flags for triage; red flags for Triage; FW: Urology TDU triage; Outstanding triage as of 16 Sept 19

Dear Dr Khan

As requested, please see below which I am escalating to you (emails attached showing where I have been asking him to address)

CONCERN 1 –not adhered to, please see escalated emails. As of today Monday 16 September, Mr O'Brien has 26 paper referrals outstanding, and on Etriage 19 Routine and 8 Urgent referrals.

CONCERN 2 – adhered to – no notes are stored off premises nor in his office (this is only feasible to confirm as there have been NO issues raised regarding missing charts that Mr O'Brien had)

CONCERN 3 – not adhered to – Mr O'Brien continues to use digital dictation on SWAH clinics but I have done a spot-check today and:

Clinics in SWAH
EUROAOB – 22 July and 12 August all patients have letters on NIECR
Clinics held in Thorndale Unit, Craigavon Area Hospital
CAOBTDUR - 20 August 2019 had 12 booked to clinic 11 attendances & 1 CND but no letters at all
CAOBUO – 23 August 2019 – 10 attendance and only 1 letter on NIECR
CAOBUO – 30 August 2019 – 12 booked to clinic, 1 CND, 1 DNA and 0 Letters on NIECR
CAOBUO – 3 September – 8 booked to clinic – 0 letters on NIECR
I have asked Katherine Robinson to double-check that these are not in a backlog for typing and I will advise

CONCERN 4 – adhered to – no more of Mr O'Brien's patients that had been seen privately as an outpatient has been listed,

Should you require anything further, please do not hesitate to contact me.

Regards

Martina

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

Telephone:
Personal Information redacted by USI (Internal)
Personal Information redacted by USI (external)
Personal Information redacted by USI (mobile)

I do not know whether I will have time to meet with you as I work through lunch doing flexible cystoscopies for patients attending for urodynamic studies as well as reviewing cancer patients.
I am happy to make time to meet, though risking patients waiting etc.

I would be grateful if you would advise in advance of the nature of the deviation,

Thank you,

Aidan.

From: Corrigan, Martina
Sent: 05 November 2019 13:29
To: O'Brien, Aidan
Cc: McNaboe, Ted
Subject: Meeting this Friday 8 November 2019
Importance: High

Dear Aidan,

Ted and I have been asked to meet with you to discuss a deviation from your return to work action plan when you were oncall in September.

We are both available this Friday at 1pm. The meeting will take place in Ted's office on 3 South.

Can you confirm if this will suit please?

Thanks

Martina

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

Telephone:
EXT Personal Information redacted by USI (Internal)
Personal Information redacted by USI (External)
Personal Information redacted by USI (Mobile)

Personal Information redacted by USI
[redacted]

Mrs Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital,
Craigavon.
BT63 5QQ

07 November 2019.

Dear Martina,

I write in response to your request that I meet with you and Mr. McNaboe tomorrow, Friday 08 November 2019, to discuss deviations from a Return to Work Plan. I am happy to meet with both of you to discuss any issues, though I do find it inappropriate and stressful to do so in the midst of a Cancer Review Clinic.

When I met with the Investigation Case Manager on 09 February 2017, I was advised, in writing, of 'the action plan for Mr. O'Brien's return to work pending conclusion of the formal investigation process under Maintaining High Professional Standards Framework'. The Case Manager concluded the investigation with his Determination of 28 September 2018, and which he presented to me on 01 October 2018. In his Determination, the Case Manager wrote that the 'purpose of this plan was to ensue risks to patients were mitigated during the course of the formal investigation process'.

In the Determination, the Case Manager also recommended that a further 'action plan should be put in place with the input of Practitioner Performance Advice (NCAS), the Trust and Mr. O'Brien for a period of time agreed by the parties'. It was recommended that this 'action plan must address any issues with regard to patient related admin duties and there must be an accompanying agreed balanced job plan to include appropriate levels of administrative time and an enhanced appraisal programme'. The Trust has failed to implement this recommendation to date.

It is evident that the issues that you wish to discuss, cannot be considered deviations from a Return to Work Plan which expired in September 2018.

Yours sincerely,

Personal Information redacted by the USI
[redacted]

Aidan O'Brien

While I appreciate that there is a divergence in views about the process we have in place to manage referrals, he is being asked to comply with this as is until it is collectively agreed that the system should be changed.

Lauren bf 2 weeks please

Thanks Maria

From: Hynds, Siobhan
Sent: 08 November 2019 10:10
To: OKane, Maria; Khan, Ahmed; Haynes, Mark; Carroll, Ronan
Subject: RE: FW: Backlog Report - October 2019
Importance: High

Maria

Mr O'Brien is clearly deviating from the action plan that was put in place as a safeguard to avoid this type of backlog and he is also an outlier in terms of his other Urology colleagues by some way.

Has there been any direct discussion with Mr O'Brien about this? Could I suggest a meeting of the case manager(Dr Khan) with Ronan and Mark to discuss the data and decide on the necessary next steps. As a matter of urgency there needs to be a clear plan in terms of clearing any outstanding work. Given some dictation is now going back to June 18 we need to understand if there is any impact on patients and we need to discuss the process for monitoring as this hasn't flagged.

Siobhan

From: OKane, Maria
Sent: 05 November 2019 08:33
To: Khan, Ahmed; Hynds, Siobhan; Haynes, Mark; Carroll, Ronan
Subject: Fwd: FW: Backlog Report - October 2019

Dear Ahmed / Siobhan you will have a view about this please ?

Ronan can you describe the systematic process in place please to capture the relevant information agreed with case managers please? Thanks Maria

---------- Forwarded message ----------
From: "Haynes, Mark" [redacted]
Date: Nov 5, 2019 6:37 AM
Subject: FW: Backlog Report - October 2019
To: "Khan, Ahmed" [redacted],"OKane, Maria" [redacted],"McClements, Melanie" [redacted],"Carroll, Ronan" [redacted]
Cc:

FYI re oversight.

Relevant info for oversight is highlighted below for October;

It should be noted that those present agreed that the weaknesses identified in the current process described above may cause challenges in taking forward this issue with Mr O'Brien

In concluding the discussion, those present felt that the best way to move this topic forward was for a group of interested staff to:

1. *Agree and describe why this information is being collated: for example, is it largely for resource / secretarial workload*
2. *Disaggregate into two areas those indicators for which clinicians are responsible and those indicators for which administrative staff are available*
3. *Agree and describe a consistent process for how this information is collated, and the method by which the information can be independently verified*
4. *Provide a Trust wide standard of performance in relation to these performance indicators which all clinical staff should be expected to adhere to*
5. *Agree the process for escalation for when monthly information indicates a deviation from this Trust wide standard of performance*

Considering the processes outlined above in the wider sense of supporting medical staff who have had issues identified, I feel there would be benefits in an urgent discussion regarding the day-to-day management of Mr O'Brien by his operational line management team to ensure that supervision of his administrative duties are being carried out as expected. This would allow an opportunity to identify if there are any concerns starting to emerge, so that appropriate supports can be offered to Mr O'Brien, to ensure that concerns do not continue.

Happy to discuss.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by the USI
Personal Information redacted by the USI
Personal Information redacted by USI

From: OKane, Maria
Sent: 17 November 2019 12:11
To: Hynds, Siobhan; Khan, Ahmed; Haynes, Mark; Carroll, Ronan; Gibson, Simon
Cc: Weir, Lauren
Subject: RE: FW: Backlog Report - October 2019

Thanks Siobhan.

Simon can I ask that you coordinate a meeting which I am asking you to minute please asap to

1. describe in detail the management plan around this ,
2. the expectation re compliance
3. and the escalation.

It will be important before all of you meet with Mr O'Brien that you have this process well described and documented – process mapping this might be the most useful approach.

Corrigan, Martina

From: Gibson, Simon <[redacted]>
Sent: 24 January 2020 12:57
To: OKane, Maria; Weir, Lauren
Cc: Carroll, Ronan; Haynes, Mark; Corrigan, Martina; Hynds, Siobhan; McNaboe, Ted; Khan, Ahmed; Carroll, Anita; McClements, Melanie; Toal, Vivienne
Subject: FW: For Response - Meeting Request - AOB

Dear Maria

As requested below, I co-ordinated and chaired this meeting. The purpose of the meeting was agreed as consideration of the below points laid out in your e-mail of 17th November, specifically:

1. describe in detail the management plan around the backlog report ,
2. the expectation re compliance
3. and the escalation

to assist a meeting with Mr O'Brien to discuss his deviation from the action plan

Present at the meeting were:

- Simon Gibson
- Ronan Carroll
- Martina Corrigan
- Mark Haynes
- Ahmed Khan

The Backlog Report

The Backlog Report was commenced in approximately 2016, (it existed before though detail and format may have been different) to quantify workload between secretarial and audio-typist staff and allow movement of work where necessary. Information was gathered by completion of a template by secretaries themselves on a monthly basis, when they were asked to quantify the level of work awaiting to be done either by their consultant or themselves.

This information was compiled into a report and circulated to consultant staff, and copied to relevant Heads of Service and Assistant Directors. It was not forwarded to medical staff acting in their capacity as CD or AMD. There appears to be variable consideration of this report by specialties within either patient safety meetings or specialty meetings. It should be noted that one of the reasons this report did not receive regular consideration was that there was some scepticism of the accuracy of this data, as it did not reconcile with individuals own recollection of behaviour or workload of colleagues. In essence, it was felt that there may have been inaccuracies in the data provided by staff. This data was never independently verified, and there was no electronic method of collecting this data. It was never raised in the Patient Safety meetings in Urology, and was not regularly discussed at the Urology specialty meeting.

Expectation re compliance

None of those present at the meeting were aware of any written standards in relation to what was considered reasonable for dictation of results or letters after clinics. The Trust has never stated a standard, and those present were not aware of any standard set externally by Royal Colleges or other organisations. Therefore, on the occasions when this data was considered, there was no agreed standard to use as a gauge against reported performance.

Escalation

As there was some cynicism in relation to the validity of the data, combined with a lack of standards to assess compliance, there was no agreed process for escalating any concerns regarding non-compliance in relation to the monthly backlog report.

Gibson, Simon

From: Khan, Ahmed [redacted]
Sent: 24 January 2020 12:33
To: Gibson, Simon
Cc: Montgomery, Ruth; Corrigan, Martina; Carroll, Ronan; Haynes, Mark; Carroll, Anita
Subject: RE: For Response - Meeting Request - AOB

Simon, thanks. As I mentioned, our discussion has heighted a bigger issue of information collection, reports sharing & escalation to all relevant people. Although it is import to address this issue however specifically for this MHPS case its vital to have robust process in place. No further comments. Please note, I don't need to be part of wider discussion with in acute directorate.
Regards, Ahmed

From: Carroll, Anita
Sent: 24 January 2020 12:22
To: Gibson, Simon; Haynes, Mark; Carroll, Ronan; Corrigan, Martina; Khan, Ahmed
Cc: Montgomery, Ruth
Subject: RE: For Response - Meeting Request - AOB

Some wee changes / comments see below in yellow , but largely fine

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From: Gibson, Simon
Sent: 21 January 2020 20:54
To: Haynes, Mark; Carroll, Anita; Carroll, Ronan; Corrigan, Martina; Khan, Ahmed
Cc: Montgomery, Ruth
Subject: RE: For Response - Meeting Request - AOB

Dear all – Below is a draft note of our meeting, written as a response to Maria's e-mail seeking this information. Could I ask you to consider this and make and amendments back to me before cop Friday please.

Dear Anita – would welcome your thoughts, and those of your staff, if any of the below misses out key steps/issues.

Dear Maria

As requested below, I co-ordinated and chaired this meeting. The purpose of the meeting was agreed as consideration of the below points laid out in your e-mail of 17th November, specifically:

1. describe in detail the management plan around the backlog report ,
2. the expectation re compliance
3. and the escalation

to assist a meeting with Mr O'Brien to discuss his deviation from the action plan

Present at the meeting were:

- Simon Gibson
- Ronan Carroll
- Martina Corrigan
- Mark Haynes
- Ahmed Khan

The Backlog Report

24.2 However, on reflection I believe that I could maybe have been more proactive in dealing with challenges in the MHPS investigation. I believe there are some mitigating factors:

a. I think most important factor was that I had no previous experience of conducting such a complex MHPS investigations as a Case Manager. I reviewed all the relevant Guidelines and the MHPS framework document. However, with no previous experience I wasn't fully equipped to carry out such a complex MHPS case investigation. I received MHPS training after the investigation had commenced.

b. I also believe that having no dedicated / protected time for the Case Manager role in my job plan was also an important factor. Initially, it was meant to be for only a couple of months but ended up taking much longer. I was carrying out a very busy clinical and management job in Children's directorate at the same time. After my appointment as Acting Medical Director, I was very mindful of my competing demands as senior management team and Trust Board member and its responsibilities. Therefore, I requested to step down from the Case Manager role. However, this wasn't accepted by the Oversight Committee. (Email attached). **This can be located at Attachment folder S21 31 of 2022- Attachment 69 (a) and 69 (b).**

c. After the formal MHPS process started in January 2017, clarity of roles and responsibilities between Oversight Committee and Case Manager was lacking when I saw some decisions were taken by the Committee prior to coming to me as a case manager. An example was replacing case investigator role. As the Medical Director (Dr Richard Wright) was my line manager and in the Committee, I took a step back.
d. The information I received initially about the case was inadequate and inconsistent.
e. The case investigation evolved into a case of a more complex nature with more and more unexpected findings emerging.
f. The resources allocated to carry out such a complex investigation were inadequate.

24.3 However I believe these factors did not damage the quality of the end product (my Case Manager's Determination). They largely just caused the process to be slower than I think it ought to have been.

Hynds, Siobhan

From: ahmed.khan [redacted]
Sent: 21 June 2018 23:32
To: Hynds, Siobhan
Subject: MHPS Case report to AOB

Follow Up Flag: Follow up
Flag Status: Flagged

Siobhan,
I have agreed to continue as case manager for this MHPS case on a condition that I will not be in position to go through this report until after returned from A/L (1st week of August) and even then I will have to be freed up to review report and draft recommendations with your support.
In the mean time you can send Mr O'Brien a letter to collect investigation report for factual accuracy.
Regards,
Ahmed

Timescale and decision

37. The Case Investigator should, other than in exceptional circumstances, complete the investigation within 4 weeks of appointment and submit their report to the Case Manager within a further 5 working days. The Case Manager must give the practitioner the opportunity to comment in writing on the factual content of the report produced by the Case Investigator. Comments in writing from the practitioner, including any mitigation, must normally be submitted to the Case Manager within 10 working days of the date of receipt of the request for comments. In exceptional circumstances, for example in complex cases or due to annual leave, the deadline for comments from the practitioner should be extended.

38. The report should give the Case Manager sufficient information to make a decision on whether:

- no further action is needed;
- restrictions on practice or exclusion from work should be considered;
- there is a case of misconduct that should be put to a conduct panel;
- there are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer;
- there are concerns about the practitioner's clinical performance which require further formal consideration by NCAS ;
- there are serious concerns that fall into the criteria for referral to the GMC or GDC;
- there are intractable problems and the matter should be put before a clinical performance panel.

CONFIDENTIALITY

39. Employers must maintain confidentiality at all times, and should be familiar with the guiding principles of the Data Protection Act. No press notice can be issued, nor the name of the practitioner released, in regard to any investigation or hearing into disciplinary matters. They may only confirm that an investigation or disciplinary hearing is underway.

40. Personal data released to the Case Investigator for the purposes of the investigation must be fit for the purpose, and not disproportionate to the seriousness of the matter.

TRANSITIONAL ARRANGEMENTS

41. On implementation of this framework, the new procedures must be followed, as far as is practical, for all existing cases taking into account the stage the case has reached.

RESPONSE TO REPORT OF FORMAL INVESTIGATION

I am writing this report in response to the report of formal investigation from Dr Neta Chada. My response is structured in parallel to the Dr Chada's report. In responding to the report, I have considered to set the reasons for the investigation in an historical context. Thereafter, I have commented upon the investigative process and the report itself. Lastly, I respond directly to the five terms of reference.

Historical Context

Igraduated in Medicine from the Queen's University of Belfast in 1978. After basic, postgraduatea surgical training in Northern Ireland, including a year as Demonstrator in Anatomy, and duringa which time I had spent some time in every surgical specialty, except for Urology, I applied for aa post as a Registrar in Urology at Belfast City Hospital in 1984. During my tenure in that post froma August 1984, I became increasingly impressed with Urology as a surgical specialty for a number ofa reasons: the greater ability to apply objective diagnostic tools to assessment of urinary tracta pathology, such as renography and urodynamic studies; the rapidly increasing role of endoscopica and minimally invasive surgery, and most importantly at that time, the varied spectrum ofa malignancies of the urinary tract. I became increasingly interested in new diagnostic tools in thea assessment of bladder carcinoma, such as nuclear image analysis and DNA flow cytometry.a

As DNA flow cytometry was unavailable in Northern Ireland at that time, I applied for and was appointed to the post of Registrar in Urology at St. James' Hospital, Dublin in July 1985, followed by a Research Fellowship at the Meath Hospital, Dublin, in 1986. I was appointed a Senior Registrar in 1988, and completed Higher Surgical Training in Urology on 30 June 1991. During that training, I was particularly aware that it pertained exclusively to adult Urology. As a consequence, I applied for and was appointed Senior Registrar in Paediatric Urology at the Royal Hospital for Sick Children in Bristol, taking up that post on 01 September 1991.

In May 1991, I received a phone call from Mr. Ivan Stirling, (now retired) Consultant Vascular Surgeon at Craigavon Area Hospital, to advise that Mr. W. Graham, Consultant Surgeon at Craigavon Area Hospital, was due to retire on 30 June 1991. He was a general surgeon who had developed an interest in urological surgery. Mr. Stirling advised me that there had been some discussion among colleagues as to whether he should be replaced by a general surgeon or by a urologist, and sought my view. I immediately advised that he should be replaced by a general surgeon and by a urologist. Some days later, I was invited to meet with him, his consultant colleagues and with the Chief Executive, Mr. John Templeton, over lunch. It was during that meeting that they appreciated that I had a two month hiatus prior to taking up the post in Bristol. I was asked whether I would spend some time during that two month period as a Locum Consultant at Craigavon Area Hospital, as Mr. Graham had 77 patients on his waiting list for elective admission for prostatic resection (TURP). After a one week break, I came to Craigavon Area Hospital, performing 77 TURPs, and a left ureteric reimplantation for ureteric stenosis, in seven weeks.

On Wednesday 28 August 1991, I was invited once again to meet with the Chief Executive and the remaining three Consultant General Surgeons, Mr. John O'Neill, Mr. Osmond Mulligan and Mr.

On 30 July 2017 I wrote to D. Khan, Case Manager, detailing my concerns regarding the Investigation to date (Appendix 9).
I did not receive a response.

On 31 July 2018, I submitted to Ms. Hynds, by email, a request for a copy of the minutes of the meeting of the Oversight Group in December 2016, a copy of the correspondence / communication with NCAS in December 2016, an amended copy of the Note of the Meeting of 30 December 2016 (previously requested), an amended copy of the Note of the Meeting on 24 January 2017 (previously requested), a copy of the Trust's Policy and Procedure regarding Triage (previously requested) and a list of the Witnesses and their Statements (Appendix 10).
I did not receive a response until 28 September 2017 when I was provided with a list of Witnesses and their Statements. I was not provided with any of the other requested documentation.

On 03 August 2017, I met with Dr. Chada and Ms. Hynds, accompanied by my son, who wished to advise that we would have considered it reasonable to expect that the Witness Statements would have been provided prior to the Meeting, to enable me to address and respond to them, but he was advised initially that he was not permitted to speak.

On 03 August 2017, I also submitted to Dr. Chada and Ms. Hynds, detailed documentation of all additional inpatient and day case operating during the years 2012 to 2016, and all additional outpatient clinics during 2012 to 2016, in addition to all additional time spent in the roles of Lead Clinician of Urology MDT and of Chair of Urology MDM from 2012 to 2016, (Appendix 11).
None of this documentation has been included in the Report of the Investigation.

At the meeting of 03 August 2017, I was provided with a list of 11 patients who had attended privately, had been added to the waiting list and had been admitted after a short time frame. I was surprised to find that another two TURP patients had been added to the list, as I was certain that only nine patients had been admitted for TURP during 2016, having previously attended privately. Upon review, it was evident that the new list provided on 03 August 2017 contained only three patients who had TURP performed during 2016, the remaining eight patients having other diagnostic or surgical procedures performed. I then reviewed all 46 patients who had TURP performed during 2016. This figure included the 9 patients who had previously attended privately and 37 who had not. The mean time on waiting list for the nine patients who had attended privately was 202 days whilst the mean time for the remaining 37 patients was 219 days. In fact, 5 (56%) of those who attended privately had waited more than 100 days while 14 (38%) of the remaining 37 patients had done so.

On 06 November 2017, I met for the second time with Dr. Chada and with Ms. Hynds to discuss the issue of the private patients. I submitted a detailed account of the management of each of the eleven patients. I also shared my conviction that an analysis of all the TURP patients of 2016 had not complied with the anecdotal allegation that those who had attended privately, had had their surgery performed after a significantly shorter period of time, and that this finding had laid those compiling the information for the Case Investigator to find patients who had had other procedures performed following prior private consultation, and who better fitted the allegation. Regrettably, I

have not since had the opportunity to undertake a similar comparative analysis for those patients and their procedures.

On 06 November 2017, I also provided a spreadsheet addressing the issue of Term of Reference 3, (Appendix 12). This clearly established that not all of the patients who had attended 51 clinics had not letters dictated, and not 61 clinics as the Case investigator had been advised by those collating the information. The total number of patients who had attended those 51 clinics had been 450 patients. Moreover, 261 patients had had letters dictated. These 261 patients were those who were more clinically urgent. This left a total of 189 patients who had not had letters dictated, and not 668 as had been advised by those who had informed the Case Investigator, and whose data the Medical Director found no need to validate. This detailed information submitted on 06 November 2017 was not included in the Report of the Investigation.

On 02 April 2018, I submitted an email to Ms. Hynds, attaching my comments concerning the proposed Respondent Statements of 03 August 2017 and of 06 November 2017, and my comments relating to the Statements of Witnesses, (Appendix 13). It was the earliest date that I could do so. Mindful that I had been advised that Dr. Chada had intended to begin writing the Report on 30 March 2018. I also reminded her that I still awaited amended Notes of the Meetings of 30 December 2016 and of 24 January 2018. I particularly requested that she would clarify whether it was intended to provide amended Notes, and if so, when I might expect to receive them.
I did not receive an acknowledgement or a response.

On 10 June 2018, I sent an email to Ms. Hynds, requesting an update on progress of the Investigation, and responses to the requests submitted previously, (Appendix 14). Having received her response, I determined that I would not enter into further communication. I was also most concerned to find that my comments relating to Witness Statements and to proposed Respondent Statements, submitted on 02 April 2018, may not have been duly considered in the Report which was not submitted to the Case Manager until 12 June 2018.

Investigation Report

The first comment regarding the Investigation Report is that it is entitled 'Investigation Report under the Maintaining High Professional Standards Framework'. There has been no reference whatsoever to the Southern Trust's Policy and Procedure for Handling Concerns about Doctors' and Dentists' Performance (September 2010). I have submitted my views previously concerning this issue. The Southern Trust's Policy and Procedure was obliged of it in response to the Maintaining High Professional Standards Framework. It is the Term and Condition of Employment.

In Section 1, the report states that the team work a 'Consultant of the Week On-call' model, with the consultant of the week responsible for triage of all referrals during their period on-call. I believe that this is, by definition, and crucially, incorrect, and not just a matter of semantics. The model is a 'Consultant of the Week'. As I have already described, I believe the presence or absence of 'on-call' in the perceptions of participants has been critical to the feasibility of triage.

(b) It was found that there was the potential for 783 patients to have been added to the incorrect waiting list. A look back exercise of all referrals by other Consultant Urologists determined that of the 783 un-triaged referrals, 24 would have been upgraded to red-flag status, meaning the timescales for assessment and implementation of their treatment plans was delayed. All un-triaged referrals were added to Trust waiting lists based on the GP referral assessment.

(c) It was found that all other Consultant Urologists undertook triage of all referrals in line with established practice.

(d) It was found that of the 24 upgraded patient referrals, 5 patients have a confirmed cancer diagnosis. All 5 patients have been significantly delayed commencing appropriate treatment plans.

2. (a) It was found that in January 2017 Mr O'Brien returned 307 sets of patient notes which had been stored at his home. Mr O'Brien accepts that there were in excess of 260 patient notes returned from his home in January 2017.

   (b) The notes dated as far back as November 2014. It was found that Mr O'Brien returned patient notes as requested and he asserts therefore there was no impact on patient care.

   (c) It was found that there are 13 sets of patient notes missing. The Case Investigator was satisfied these notes were not lost by Mr O'Brien.

3. (a) It was found that there were 66 undictated clinics by Mr O'Brien during the period 2015 and 2016. Mr O'Brien's accepts this.

   (b) It was accepted by Mr O'Brien that he did not dictate at the end of every care contact but rather dictated at the end of the full care episode. This is not the practice of any other Consultant Urologist. The requirements of the GMC is that all notes / dictation are contemporaneous.

   (c) There are significant waiting list times for routine Urology patients. It is therefore unclear as to the impact of delay in dictation as the patients would have had a significant wait for treatment. The delay however meant that the actual waiting lists were not accurate and the look back exercise to ensure all patients had a clear management plan in place was done at significant additional cost and time to the Trust.

6. It has been found that Mr O'Brien scheduled 9 of his private patient's sooner and outside of clinical priority in 2015 and 2016.

wide failings and I cannot just say it was one person's fault. Yes, there are professional responsibilities on every individual. As clinicians we all have professional responsibilities from the GMC point of view. We have our ability, we have our clinical performance and I feel that your -- I conclude that your failings in terms of your administrative practices should be put to the conduct panel for further assessment but at the same time the Trust should commission an independent review of relevant administrative processes and as also to identify the roles and responsibilities within the acute directorate and learn from that as a system.

That is the conclusion of my findings, I suppose, as a case manager the determination. Again, at your own time you can read the advice from NCAS as well. And obviously I put it as a reference because we all know what is our requirement from the GMC point of view, what is our professional responsibility from the GMC point of view. So I have added a GMC Good Medical Practice guideline as well. I am happy to take any questions.

MR O'BRIEN: I don't have any questions.

MRS O'BRIEN: The only thing I would say is in the MHPS, GMC is not involved at all unless formal exclusion is made. That is clearly in the document. They do not need to be informed unless there is a formal exclusion. ~~(Inaudible)~~You need to read that.

MICHAEL O'BRIEN: Your position is you have read the investigator's report and then you read my father's report and then you weigh up and then the decision on which one you find to be more persuasive on certain points. Is that what you are saying?

DR KHAN: Well, I considered both in making my final determination.

MICHAEL O'BRIEN: I understand. But do you weigh up both? Is that your process?

DR KHAN: There is a process behind that as part of the MHPS. You know, I have Mr O'Brien's, you know, his report and also investigation report.

MICHAEL O'BRIEN: I understand that you have them both.

DR KHAN: Yes.

MICHAEL O'BRIEN: I just wondered, is it your process then that you weigh them up?

DR KHAN: Yes.

MICHAEL O'BRIEN: Okay. That's fine. I just want to ask one more thing.

DR KHAN: And also as part of the conclusion I have shared information with NCAS to get the NCAS view because they are, as part of MHPS, I wanted to make sure that I have input from professional body in terms of the options available to me as case manager, what should be on that as well.

MICHAEL O'BRIEN: I am just curious to see, for example, let's say, ~~that (inaudible)~~ undictated clinics, as you know there are questions over the numbers of undictated

CONFIDENTIAL: PERSONAL

NHS
Resolution

Practitioner Performance Advice (formerly NCAS)
2nd Floor, 151 Buckingham Palace Road
London
SW1W 9SZ
Advice line: 020 7811 2600
Fax: 020 7931 7571
www.ncas.nhs.uk
Personal Information redacted by the USI

21 September 2018

PRIVATE AND CONFIDENTIAL

Dr Ahmed Khan
Medical Director
Southern Health and Social Care Trust
Beechfield House
68 Lurgan Road
Portadown
BT63 5QQ

Ref: 18665 (Please quote in all correspondence)

Dear Dr Khan,

Further to our telephone conversation on 20 September 2018, I am writing to summarise the issues which we discussed for both of our records. Please let me know if any of the information is incorrect.

Practitioner Performance Advice (formerly NCAS) encourages transparency in the management of cases and advises that practitioners should be informed when their case has been discussed with us. I am happy for you to share this letter with Dr 18665 if you consider it appropriate to do so. The practitioner is also welcome to contact us for a confidential discussion regarding the case. We have recently launched a new guide for practitioners, which sets out information about our role and services which may be of interest and is available on our website under publications.

In summary, this reopened case, which I had previously discussed with your colleague, Dr Wright, involves Dr 18665, a senior consultant urologist about whom there had been increasing concerns. An investigation, for which you are the Case Manager, has now been completed – it was very delayed because of the complexities and extent of the issues – and you are considering the options as set out in paragraph 38 of Part I MHPS (Maintaining High Professional Standards in the Modern HPSS). You wanted to seek advice around this. You indicated that since February 2017, Dr 18665 has been working

to an agreed action plan with on-going monitoring so that any risks to patients have been addressed.

There were 5 Terms of Reference for the investigation (although the last related to the extent to which the managers knew of or had previously managed the concerns). You told me that having read the report, the factual accuracy of which Dr 18665 has had a chance to comment on, you have concluded that there was evidence to support many of the allegations with regards to Dr 18665. Specifically, following detailed consideration, you noted that:

a)o There were clear issues of concern about Dr 18665's way of working and hiso management of his workload. There has been potential harm to a large number ofo patients (783) and actual harm to at least 5 patients;o
b)o Dr 18665's reflection throughout the investigation process was concerning and ino particular in respect of the 5 patients diagnosed with cancer;o
c)o As a senior member of staff within the Trust Dr 18665 had a clear obligation too ensure managers within the Trust were fully and explicitly aware that he was noto undertaking routine and urgent triage as was expected;o
d)o There has been significant impact on the Trust in terms of its ability to properlyo manage patients, manage waiting lists and the extensive look back exercise whicho was required to identify patients who may have been affected by the deficiencieso in Dr 18665's practice (and to address these issues for patients);o
e)o There is no evidence of concern about Dr 18665's clinical ability with individualo patients;o
f)o Dr 18665 had advantaged his own private patients over HSC patients on at least 9o occasions;o
g)o The issues of concern were known to some extent for some time by a range ofo managers and no proper action was taken to address and manage the concerns;o

You told me that the SAI (serious adverse incident) investigation, which has patient involvement, is looking at the issue where patients have, or may have been, harmed as a result of failings. You are aware that patients are entitled to know this.

We discussed the current situation and the overriding need to ensure patients are protected. I note that you have a system in place within the Trust to safeguard patients, but we discussed that this needs to be mirrored in the private sector. You explained that Dr 18665 saw private patients at his home and did not have a private sector employer. I would suggest that as paragraph 22 of Section II MHPS states that *"where a HPSS employer has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer"* Dr 18665 should not currently be working privately.

We discussed that the issues identified in the report were serious, and that whilst there are clearly systemic issues and failings for the Trust to address, it is unlikely that in these circumstances the concerns about Dr 18665 could be managed without formal action. We also discussed that whilst the issues did have clinical consequences for patients, as some of the concerns appear to be due to a failure to follow policies and protocols, and possibly also a breach of data protection law, these might be considered to be matters of conduct rather than capability. We noted therefore that it would be open to you in your

role as Case Manager to put the matter forward to a conduct hearing, but that Dr 18665 could also be offered support going forward to ensure that in future he is able to meet and sustain the required and expected standards. You told me that the local GMC ELA is aware of the issue and I advised that you may wish to update her on the position. In the majority of cases, the GMC prefers Trust to conclude their own processes before considering referral, and early referral is only indicated in a minority of cases; but the ELA would be best placed to advise on this.

I told you that, whilst there are no noted clinical performance concerns, Practitioner Performance Advice could offer support via the Professional Support and Remediation (PSR) team by drafting a robust action plan with input both from Dr 18665 and the Trust to address some of the deficiencies which have been identified (around the management of workload, administrative type of issues, for example). The purpose of the plan would be to ensure oversight and supervision of Dr 18665's work so that the Trust is satisfied there is no risk to patients, but also to provide support for Dr 18665, to afford him the best opportunity of meeting the objectives of the plan. We noted that this might involve job planning issues such as reducing Dr 18665's workload, and enhanced appraisal.

Since we spoke, I have talked to PSR, and we will arrange for the forms, which must be completed to formally request PSR support with a plan, to be sent out.

Ienote you said that there are no reported health concerns. However, as this is likely toe continue to be a stressful time for Dr 18665, he should be offered any additional supporte deemed appropriate (access to staff counselling, mentoring, etc.).e

As discussed, we will keep this case open. Please feel free to call at any stage, if you have queries.

Relevant regulations/guidance:

- Local procedures
- General Medical Council Guide to Good Medical Practice
- Maintaining High Professional Standards in the Modern NHS (MHPS)
- The Medical Profession (Responsible Officer) Regulations 2010 and Amendment 2013

Review date: 24 September 2018

Yours sincerely,

Dr Grainne Lynn
Adviser
Practitioner Performance Advice

2.4 JULY 2018 TO NOVEMBER 2018

2.4.1 The facts established are set out at 2.4.2 to 2.4.4 below

2.4.2 This timeframe reflects the period from Mr O'Brien's comments on the Case Investigator's formal MHPS report made on 10 July 2018, to the Case Manager's decision of 28 September 2018 and until Mr O'Brien lodged his grievance dated 27 November 2018 (20 weeks)

2.4.3 In section 2.3.33 above in the table at section G, we note Mr O'Brien's comments:

Mr O'Brien then provided his full response[14] by 10 July 2018 having been given a 24-hour extension. Then there was almost another three-month delay until the Case Manager provided his determination on 1 October 2018."

2.4.4 In his grievance Mr O'Brien set out his concerns about the delay in setting up his grievance and receiving documents he sought from the Trust.

2.4.5 The panel findings on issue at 2.4 are set out in 2.4.5 to 2.4.7 below

2.4.6 In speaking to Dr Khan, Case Manager, we do consider that he clearly reflected on the report and the MHPS options. However, we find that the 21 weeks he took to do so unnecessarily protracted the process. After such a lengthy investigation, Dr Khan's response where no exchanges with Mr O'Brien were required, should have been expedited. It required Dr Khan's analysis and reflection on the facts in the report and how it fitted with MHPS decision-making. **The timescale is not explained sufficiently but Mr O'Brien's grievance is not upheld to the extent that it breached his contract of employment.**

2.4.7 From Mr O'Brien's receipt of the Case Investigators decision on 28 September 2018 until he lodged his Grievance on 28 November 2018, the period is not overly long and he appears to have used the time to prepare his lengthy submission. This is not relevant to the grievance

[14] to the Case Investigator's MHPS report received on 21 June 2018

Southern Health and Social Care Trust

Quality Care - for you, with you

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Maintaining High Professional Standards Formal Investigation

Case Manager Determination

Dr Ahmed Khan, Case Manager

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

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

2.0 Responsibility of the Case Manager

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

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

3.0 Formal Investigation Terms of Reference

The terms of reference for the formal investigation were:

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

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

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

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

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

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

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

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

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

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

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

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

4.0 Investigation Findings

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

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

(b) It was found that there was the potential for 783 patients to have been added to the incorrect waiting list. A look back exercise of all referrals by other Consultant Urologists determined that of the 783 un-triaged referrals, 24 would have been upgraded to red-flag status, meaning the timescales for assessment and implementation of their treatment plans was delayed. All un-triaged referrals were added to Trust waiting lists based on the GP referral assessment.

(c) It was found that all other Consultant Urologists undertook triage of all referrals in line with established practice.

(d) It was found that of the 24 upgraded patient referrals, 5 patients have a confirmed cancer diagnosis. All 5 patients have been significantly delayed commencing appropriate treatment plans.

2. (a) It was found that in January 2017 Mr O'Brien returned 307 sets of patient notes which had been stored at his home. Mr O'Brien accepts that there were in excess of 260 patient notes returned from his home in January 2017.

   (b) The notes dated as far back as November 2014. It was found that Mr O'Brien returned patient notes as requested and he asserts therefore there was no impact on patient care.

   (c) It was found that there are 13 sets of patient notes missing. The Case Investigator was satisfied these notes were not lost by Mr O'Brien.

3. (a) It was found that there were 66 undictated clinics by Mr O'Brien during the period 2015 and 2016. Mr O'Brien's accepts this.

   (b) It was accepted by Mr O'Brien that he did not dictate at the end of every care contact but rather dictated at the end of the full care episode. This is not the practice of any other Consultant Urologist. The requirements of the GMC is that all notes / dictation are contemporaneous.

   (c) There are significant waiting list times for routine Urology patients. It is therefore unclear as to the impact of delay in dictation as the patients would have had a significant wait for treatment. The delay however meant that the actual waiting lists were not accurate and the look back exercise to ensure all patients had a clear management plan in place was done at significant additional cost and time to the Trust.

6. It has been found that Mr O'Brien scheduled 9 of his private patient's sooner and outside of clinical priority in 2015 and 2016.

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

Other findings / context

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

Triage

1. Mr O'Brien provided a detailed context to the history of the Urology service and the workloads pressures he faced. Mr O'Brien noted that he agreed to the triage process but very quickly found that he was unable to complete all triage. Mr O'Brien noted that he had raised this fact with his colleagues on numerous occasions to no avail. Mr O'Brien accepts that he did not explicitly advise anyone within the Trust that he was not undertaking routine or urgent referral triage. Mr O'Brien did undertake red-flag triage.

2. It was known to a range of staff within the Directorate that they were not receiving triage back from Mr O'Brien. A default process was put in place to compensate for this whereby all patients were added to the waiting lists according to the GP catergorisation. This would have been known to Mr O'Brien.

3. Mr Young is the most appropriate comparator for Mr O'Brien as both have historical long review lists which the newer Consultants do not have. Mr Young managed triage alongside his other commitments. Mr Young undertook Mr O'Brien's triage for a period of time to ease pressures on him while he was involved in regional commitments.

Notes

1. There was no proper Trust transport and collection system for patient notes to the SWAH clinic in place.

2. There was no review of notes tracked out by individual to pick up a problem.

3. Notes were returned as requested by Mr O'Brien from his home.

4. It was known that Mr O'Brien stored notes at home by a range of staff within the Directorate.

Undictated clinics

1. Mr O'Brien's secretary did not flag that dictation was not coming back to her from clinics. Mr O'Brien's secretary was of the view that this was a known practice to managers within the Directorate.

2. Mr O'Brien indicated that he did not see the value of dictating after each care contact.

3. Mr O'Brien was not using digital dictation during the relevant period and therefore the extent of the problem was not evident.

5.0 Case Manager Determination

My determination about the appropriate next steps following conclusion of the formal MHPS investigation:

- There is no evidence of concern about Mr O'Brien's clinical ability with patients.

- There are clear issues of concern about Mr O'Brien's way of working, his administrative processes and his management of his workload. The resulting impact has been potential harm to a large number of patients (783) and actual harm to at least 5 patients.

- Mr O'Brien's reflection on his practice throughout the investigation process was of concern to the Case Investigator and in particular in respect of the 5 patients diagnosed with cancer.

- As a senior member of staff within the Trust Mr O'Brien had a clear obligation to ensure managers within the Trust were fully and explicitly aware that he was not undertaking routine and urgent triage as was expected. Mr O'Brien did not adhere to the known and agreed Trust practices regarding triage and did not advise any manager of this fact.

- There has been significant impact on the Trust in terms of its ability to properly manage patients, manage waiting lists and the extensive look back

exercise which was required to address the deficiencies in Mr O'Brien's practice.

- Mr O'Brien did not adhere to the requirements of the GMC's Good Medical Practice specifically in terms of recording his work clearly and accurately, recording clinical events at the same time of occurrence or as soon as possible afterwards.

- Mr O'Brien has advantaged his own private patients over HSC patients on 9 known occasions.

- The issues of concern were known to some extent for some time by a range of managers and no proper action was taken to address and manage the concerns.

This determination is completed without the findings from the Trust's SAI process which is not yet complete.

Advice Sought

Before coming to a conclusion in this case, I discussed the investigation findings with the Trust's Chief Executive, the Director of Human Resources & Organisational Development and I also sought advice from Practitioner Performance Advice (formerly NCAS).

My determination:

1. No further action is needed

Given the findings of the formal investigation, this is not an appropriate outcome.

2. Restrictions on practice or exclusion from work should be considered

There are 2 elements of this option to be considered:

a. A restriction on practice

At the outset of the formal investigation process, Mr O'Brien returned to work following a period of immediate exclusion working to an agreed action plan from

February 2017. The purpose of this action plan was to ensure risks to patients were mitigated and his practice was monitored during the course of the formal investigation process. Mr O'Brien worked successfully to the action plan during this period.

It is my view that in order to ensure the Trust continues to have an assurance about Mr O'Brien's administrative practice/s and management of his workload, an action plan should be put in place with the input of Practitioner Performance Advice (NCAS), the Trust and Mr O'Brien for a period of time agreed by the parties.

The action plan should be reviewed and monitored by Mr O'Brien's Clinical Director (CD) and operational Assistant Director (AD) within Acute Services, with escalation to the Associate Medical Director (AMD) and operational Director should any concerns arise. The CD and operational AD must provide the Trust with the necessary assurances about Mr O'Brien's practice on a regular basis. The action plan must address any issues with regards to patient related admin duties and there must be an accompanying agreed balanced job plan to include appropriate levels of administrative time and an enhanced appraisal programme.

b. An exclusion from work

There was no decision taken to exclude Mr O'Brien at the outset of the formal investigation process rather a decision was taken to implement and monitor an action plan in order to mitigate any risk to patients. Mr O'Brien has successfully worked to the agreed action plan during the course of the formal investigation. I therefore do not consider exclusion from work to be a necessary action now.

3. There is a case of misconduct that should be put to a conduct panel

The formal investigation has concluded there have been failures on the part of Mr O'Brien to adhere to known and agreed Trust practices and that there have also been failures by Mr O'Brien in respect of 'Good Medical Practice' as set out by the GMC.

Whilst I accept there are some wider, systemic failings that must be addressed by the Trust, I am of the view that this does not detract from Mr O'Brien's own individual professional responsibilities.

During te MHPS investigation it was found that potential and actual harm occurred to patients. It is clear from the report that this has been a consequence of Mr O'Brien's conduct rather than his clinical ability. I have sought advice from Practitioner

Performance Advice (NCAS) as part of this determination. At this point, I have determined that there is no requirement for formal consideration by Practitioner Performance Advice or referral to GMC. The Trust should conclude its own processes.

The conduct concerns by Mr O'Brien include:

- Failing to undertake non red flag triage, which was known to Mr O'Brien to be an agreed practice and expectation of the Trust. Therefore putting patients at potential harm. A separate SAI process is underway to consider the impact on patients.

- Failing to properly make it known to his line manager/s that he was not undertaking all triage. Mr O'Brien as a senior clinician had an obligation to ensure, this was properly known and understood by his line manager/s.

- Knowingly advantaging his private patients over HSC patients.

- Failing to undertake contemporaneous dictation of his clinical contacts with patients in line with GMC 'Good Medical Practice'.

- Failing to ensure the Trust had a full and clear understanding of the extent of his waiting lists, by ensuring all patients were properly added to waiting lists in chronological order.

Given the issues above, I have concluded that Mr O'Brien's failings must be put to a conduct panel hearing.

4. There are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer.

There are no evident concerns about Mr O'Brien's health. I do not consider this to be an appropriate option.

5. There are concerns about the practitioner's clinical performance which require further formal consideration by NCAS (now Practitioner Performance Advice)

Before coming to a conclusion in this regard, I sought advice from Practitioner Performance Advice.

The formal investigation report does not highlight any concerns about Mr O'Brien's clinical ability. The concerns highlighted throughout the investigation are wholly in respect of Mr O'Brien's administrative practices. The report highlights the impact of Mr O'Brien's failings in respect of his administrative practices which had the potential to cause harm to patients and which caused actual harm in 5 instances.

I am satisfied, taking into consideration advice from Practitioner Performance Advice (NCAS), that this option is not required.

6. There are serious concerns that fall into the criteria for referral to the GMC or GDC

I refer to my conclusion above. I am satisfied that the concerns do not require referral to the GMC at this time. Trust processes should conclude prior to any decision regarding referral to GMC.

7. There are intractable problems and the matter should be put before a clinical performance panel.

I refer to my conclusion under option 6. I am satisfied there are no concerns highlighted about Mr O'Brien's clinical ability.

6.0 Final Conclusions / Recommendations

This MHPS formal investigation focused on the administrative practice/s of Mr O'Brien. The investigation report presented to me focused centrally on the specific terms of reference set for the investigation. Within the report, as outlined above, there have been failings identified on the part of Mr O'Brien which require to be addressed by the Trust, through a Trust conduct panel and a formal action plan.

The investigation report also highlights issues regarding systemic failures by managers at all levels, both clinical and operational, within the Acute Services Directorate. The report identifies there were missed opportunities by managers to fully assess and address the deficiencies in practice of Mr O'Brien. No-one formally assessed the extent of the issues or properly identified the potential risks to patients.

Default processes were put in place to work around the deficiencies in practice rather than address them. I am therefore of the view there are wider issues of concern, to be considered and addressed. The findings of the report should not solely focus on one individual, Mr O'Brien.

In order for the Trust to understand fully the failings in this case, I recommend the Trust to carry out an independent review of the relevant administrative processes

with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. The review should look at the full system wide problems to understand and learn from the findings.

Cunningham, Hannah

From: Wallace, Stephen [redacted]
Sent: 29 July 2020 12:40
To: Khan, Ahmed
Subject: FW: MHPS Case Manager Determination

From: Khan, Ahmed
Sent: 29 July 2020 12:33
To: Wallace, Stephen
Cc: Hynds, Siobhan
Subject: RE: MHPS Case Manager Determination

Stephen, thanks. It was clear during this investigations; system wide failure happed at many levels within Acute directorate therefore my recommendation was to provide recommendation for system wide problems in acute Directorate & not to just only focus on urology department. Happy to discuss further.

Regards,
Ahmed

From: Wallace, Stephen
Sent: 27 July 2020 13:47
To: Khan, Ahmed
Cc: Hynds, Siobhan
Subject: MHPS Case Manager Determination

Ahmed,

Further to the AOB investigation conducted in 2018 under MHPS framework the report makes reference to an administrative review (below).

- *I recommend the Trust to carry out an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. The review should look at the full system wide problems to understand and learn from the findings.*

Below you will see are a draft terms of reference regarding this, can you confirm if these terms of reference encapsulate the requirements of the recommendation?

Thanks
Stephen

Purpose

The purpose of the review, is to review the Trust urology administrative processes for management of patients referred to the service.

Objectives

The review will consider the present Trust urology administrative processes regarding referrals to the service and recommendations for the future, rather than past and pre-existing processes. The review in particular will consider the following:

- The administration processes regarding the receipt of and triage of patients referred to the urology service from all sources
- The effectiveness of monitoring of the administration processes including how and where this is information is reviewed
- The roles and responsibilities of operational management and clinical staff in providing oversight of the administrative processes
- The effectiveness of the triggers and escalation processes regarding non-compliance with administration processes
- To identify any potential gaps in the system where processes can be strengthened

Outputs

The Reviewer should provide a report which seeks to address the issues listed above. The report should provide recommendations on improvements to Trust urology administrative processes. Any recommendations should be evidence-based and proportionate, with consideration given to their implementation.

Scope

The review should consider current Trust urology administrative processes for the management of referrals to the service. This is a forward-looking review and, as such, will not consider past decisions.

Timing

The report, including any recommendations of the review, must be submitted to the Trust Acute Director by end September 2020.

Governance and Methodology

The Reviewer will be appointed by, and accountable to, the Trust Acute Director for delivery of the review. Details of the governance which achieves this accountability and the methodology for the review - including evidence gathering, consultation with operational and clinical staff - will be agreed between the Reviewer and the Trust Acute Director by 5th August 2020.

Hynds, Siobhan

From: Corrigan, Martina [redacted] >
Sent: 31 July 2020 12:35
To: Wallace, Stephen; OKane, Maria; Haynes, Mark; McClements, Melanie; Hynds, Siobhan; Toal, Vivienne
Subject: RE: Terms of Reference - Review of Administrative Processes

Follow Up Flag: Follow up
Flag Status: Flagged

Thanks Stephen and just to confirm that Rose and Mary are meeting with me next Thursday afternoon to commence

Regards

Martina

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

Telephone:
EXT [redacted]
[redacted] (External)
[redacted] (Mobile)

From: Wallace, Stephen
Sent: 31 July 2020 12:33
To: OKane, Maria; Haynes, Mark; Corrigan, Martina; McClements, Melanie; Hynds, Siobhan; Toal, Vivienne
Subject: Terms of Reference - Review of Administrative Processes

Dear all,

Please see below terms of reference for the review of administration processes as per MHPS recommendation, these have been reviewed by Dr Khan. Dr's Rose McCullagh and Mary Donnelly have agreed to conduct this work and will commence next week.

Regards
Stephen

Purpose

The purpose of the review, is to review the Trust urology administrative processes for management of patients referred to the service.

Objectives

Stinson, Emma M

From: OKane, Maria [redacted]
Sent: 29 July 2020 12:52
To: Wallace, Stephen; Khan, Ahmed
Subject: RE: MHPS Case Manager Determination

Thank you. For the purposes of what I require currently for the GMC please , Stephen please ask Mary and Rose to review the new patient referral to urology process only and the remainder then sits with acute services. Regards, Maria

From: Wallace, Stephen
Sent: 29 July 2020 12:41
To: OKane, Maria
Subject: FW: MHPS Case Manager Determination

From: Wallace, Stephen
Sent: 29 July 2020 12:40
To: Khan, Ahmed
Subject: FW: MHPS Case Manager Determination

From: Khan, Ahmed
Sent: 29 July 2020 12:33
To: Wallace, Stephen
Cc: Hynds, Siobhan
Subject: RE: MHPS Case Manager Determination

Stephen, thanks. It was clear during this investigations; system wide failure happed at many levels within Acute directorate therefore my recommendation was to provide recommendation for system wide problems in acute Directorate & not to just only focus on urology department. Happy to discuss further.

Regards,
Ahmed

From: Wallace, Stephen
Sent: 27 July 2020 13:47
To: Khan, Ahmed
Cc: Hynds, Siobhan
Subject: MHPS Case Manager Determination

Ahmed,

Further to the AOB investigation conducted in 2018 under MHPS framework the report makes reference to an administrative review (below).

- *I recommend the Trust to carry out an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. The review*

From: Hynds, Siobhan
Sent: 05 October 2020 12:45
To: Khan, Ahmed
Cc: Kingsnorth, Patricia
Subject: URGENT FOR DISCUSSION AT 1.30PM
Attachments: Document2 (2).docx

Hi Dr Khan

Please find attached document setting out draft findings from the initial look at the administrative review. It is only 2 pages – if you get a chance could you take a quick read for discussion at 1.30pm.

Many thanks

Siobhan

Findings

1. **The administration processes regarding the receipt of and triage of patients referred to the urology service from all sources**

Current process – *Referrals to Southern Trust Urology come from a number of different sources within Primary and Secondary Care and also include referrals from the private sector. Referrals are made mainly via CCG (Clinical Communications Gateway) from Primary care (although not exclusively) and in paper format from other sources.*

All referrals are triaged by the Consultant of the week, for the CCG referrals this involves working through a digital list and paper referrals are viewed physically by the Consultant after they have been scanned and dated.

Recommendation –*We recommend moving to an amalgamated electronic list which would incorporate all CCG referrals and also all paper referrals, this list would be locked at an agreed time each week to ensure no patient could be added after the list had been triaged. This process would provide an additional layer of assurance regarding the avoidance of referrals becoming mislead and also to ensure chronicity of referrals in terms of triage was adhered to.*

2. **The effectiveness of monitoring of the administration processes including how and where this is information is reviewed**

Current process- *The monitoring of this service is carried out by the Administration team with cross cover arrangements in place*. There is also a level of oversight by the booking centre.

Recommendation-*We recommend that this process in terms of the administration team and booking centre is formalised and an effective Standard Operating Procedure is put in place with regular review*.

3. **The roles and responsibilities of operational management and clinical staff in providing oversight of the administrative processes**

Current process – *The role of the Consultant of the week and the checking mechanism by the member of the administration team are clear.*

Recommendation – *Again we recommend an effective SOP for the administration processes but also feel that increased communication between clinical teams regarding roles may be helpful and may prevent*

Practitioner Performance Advice (formerly NCAS)
2nd Floor, 151 Buckingham Palace Road
London
SW1W 9SZ
Advice line: 020 7811 2600
Fax: 020 7931 7571
www.resolution.nhs.uk
Personal Information redacted by the USI

6 November 2018

PRIVATE AND CONFIDENTIAL

Dr Ahmed Khan
Medical Director
Southern Health and Social Care Trust
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ

Ref: 18665 (Please quote in all correspondence)

Dear Dr Khan,

Further to our follow up telephone conversation of 31 October 2018 in which Ms Siobhan Hynds and Mr Simon Gibson also participated, and your email of 5 November 2018 to me, I am writing to summarise the issues we discussed and my understanding of the position for all of our records. Please let me know if any of the information is incorrect.

I rang to apprise you of conversations which I had over a period of time with Dr 18665 Personal Information redacted by USI, and to ascertain whether you felt that a meeting would be helpful. Dr 18665 had consented that I would share details of our conversations.

I told you that Dr 18665 has recently become aware of correspondence between what was then NCAS – now Practitioner Performance Advice – and the Trust in September 2016. Dr 18665 felt that between September 2016 and December 2016, he was not afforded an opportunity to address the concerns which had been raised, and this may have avoided the need for a formal investigation. Dr 18665 also told me that he was never supported to address the concerns, and that whilst he accepts some of the criticism in the investigative report, he also considers that the management failure identified should be scrutinised before he is subject to a conduct hearing.

You explained that prior to the September 2016 telephone call, Dr 18665 had been made aware of the concerns, and that the situation had not improved. Ms Hynes also queried whether there was always a requirement under MHPS to manage issues first under local informal processes, or whether there were occasions when a matter was so significant that it would proceed directly to formal investigation. I advised that there is scope to move directly to formal processes, if the matter is deemed sufficiently serious, but that this is a judgement call for an employer. In this case, you considered that the threshold had been passed. As Dr 18665 was a consultant, it was considered that he should have been more proactive in raising issues. It was also reported that since February 2017 Dr 18665 has been able to undertake his work satisfactorily without additional support.

The investigative report has upheld concerns about Dr 18665's practice. Whilst it is accepted that there were management failings, the findings are such that the Trust believes the threshold for putting the matter to a hearing has been reached. You pointed to the negative effects of the situation on patients noted in the report, and did not consider it would be appropriate to manage the matter informally. The Trust considered that it would be for any hearing to consider the evidence and the mitigation put forward by Dr 18665.

We discussed whether a meeting with all parties should be convened, and you took some time to think about the issues which I had raised to consider the case again and to think about whether a meeting would be useful. Having reviewed the situation, the Trust considered that the points raised with me by Dr 18665 had already been comprehensively managed, that there were grounds for a formal investigation and for putting the matter to a hearing (notwithstanding some of the criticism made of how the case had been managed). You were unsure of the purpose therefore of any meeting. In these circumstances, I agreed that it was difficult to see what a meeting would add and I will inform Dr 18665 of this.

Dr 18665 should continue to be offered support from the Trust (such as from OH, staff counselling, mentoring) at what is likely to continue to be a stressful time for him.

I will review the case with you again in approximately 6-8 weeks.

Relevant regulations/guidance:

- Local procedures
- General Medical Council Guide to Good Medical Practice
- Maintaining High Professional Standards in the Modern NHS (MHPS)
- The Medical Profession (Responsible Officer) Regulations 2010 and Amendment 2013

Cc: Hynds, Siobhan
Subject: Re: MHPS investigation

Dear Mr O'Brien

It has been brought to my attention that members of your family have been in contact with Trust employees to discuss the ongoing case you are involved in.

This is entirely inappropriate and must cease immediately.

I have informed staff not to engage with your family members if approached in such a way.

I would be grateful for your acknowledgement of this e-mail.

Yours sincerely,

Dr Ahmed Khan

Case Manager- MHPS
Medical Director (Interim)

Sent from my Samsung Galaxy smartphone.

22.1 I had no interaction with the GMC with regard to Mr. Aidan O'Brien in my capacity as Case Manager.

22.2 I attended, along with Assistant Director Simon Gibson a number of GMC Liaison meetings with Employer Liaison Adviser in my capacity as Acting Medical Director. The first one was on 6th June 2018 and the second one was on 2nd October 2018. This meeting have a set agenda including MHPS case updates and therefore I updated her on Mr O'Brien's case. This case was already known to the GMC ELA from discussions with the previous Medical Director (Dr Wright).

Evidence: See attached GMC Liaison meeting email for June 2018. This can be located at Relevant to MDO/Evidence after 4 November MDO/Reference no 77/no 77 Dr Khan and Dr Wright emails/20180608 Email SHSCT ELA-RO Meeting 6.6.18 - Urology consultant.pdf

Implementation and Effectiveness of MHPS

23. Having regard to your experience as Case Manager in relation to the investigation into the performance of Mr. Aidan O'Brien, what impression have you formed of the implementation and effectiveness of MHPS and the Trust Guidelines both generally, and specifically as regard the case of Mr. O'Brien?

23.1 On reflection, in my view the MHPS process could have been more proactive. However, the dedicated resources were not sufficient. In this regard, I am not aware of the position for others involved in this process but my Case Manager role was an 'add on' to my other roles and responsibilities with no additional or dedicated time allocation.

23.2 I believe that the whole MHPS process requires review and improvements with dedicated resources and training and capacity-building. I believe that there is lot to learn from this case going forward.

24. To what extent were you able to effectively discharge your role as Case Manager under MHPS and the Trust Guidelines in the extant systems within the Trust? What obstacles did you encounter when performing this role and what, if anything, could be done to strengthen or enhance that role?

24.1 I tried my best to fulfil my duties as a Case Manager as best I could do.

Gibson, Simon

From: Khan, Ahmed [redacted]
Sent: 05 November 2018 11:50
To: [redacted]
Cc: Hynds, Siobhan; Gibson, Simon
Subject: FW: MHPS Investigation

Importance: High

Dear Grainne

Further to our telephone conversation on Wednesday 31 October.

Thank you for advising of your recent telephone conversation/s with Mr A O'Brien and his son regarding the on-going process under MHPS within the Trust. My understanding of the main issue raised by Mr O'Brien and relayed by you, is respect of the commencement of the investigation and the decision to move to a formal investigation process rather than manage the concerns informally. Mr O'Brien has outlined that his workload was significantly impacting on his ability to undertake all required work.

As discussed, this is a concern Mr O'Brien raised at the outset of the investigation process. A full and detailed response was provided to Mr O'Brien by letter on 30 March 2017 addressing this issue and setting out the reasons for the decision to manage the concerns through a formal investigation process. As I understand it, this is a judgement for the employer to make under MHPS. Given the serious nature of the concerns, it was considered to be the appropriate course of action. We are now a significant period of time on and have completed a formal investigation, with Mr O'Brien's participation.

I was encouraged to hear from you that Mr O'Brien and his son are not in dispute of the issues of concern. The findings from the formal investigation further outline that the concerns under investigation, and which are now founded, are very serious in nature. After taking further advise, as a Case Manager I remain satisfied that a formal investigation was and is the appropriate course of action in the circumstances. As previously discussed and agreed with you, the next step in the process is to hold a conduct hearing following conclusion of the formal investigation.

I appreciate your offer of a meeting between the trust and Mr O'Brien with you in attendance. Having considered this, we remain unclear as to the purpose of this meeting at this stage. As always we are very happy to be guided by NCAS and if you feel it is useful to meet, we are happy to do so.

We would be very grateful for your advice on the best course of action in this regard and what you feel could be achieved by such a meeting? Please don't hesitate to contact me if required.

Kind Regards,
Ahmed

Dr Ahmed Khan
MHPS Case Manager
Medical Director (Interim)