I had made since providing outpatient clinics at South West Acute Hospital since January 2013.

611. It was in this context that she appreciated that it was not possible for me to additionally complete the triage of all referrals directed to me. She arranged for Mr Young to undertake the triage of those referrals. Mr Young generously agreed. So far as I can recall, he continued to do so from early 2014 and for a period of six months or more.

612. In a stock take of the Regional Review of Adult Urological Services in Northern Ireland, I emailed Mr Mark Fordham, External Adviser to the Regional Review, on 26 May 2014 [SUP 312-314 and AOB-03808-AOB-03810] and again raised the inadequacy of our job plans in relation to administration. In the subsequent Report of Stock Take of Regional Review of Adult Urological Services in Northern Ireland of May 2014, the following issues were identified as persistent issues for the Southern Trust [see supplemental October bundle pages 454 – 479]:

"Southern Trust

1. *The waiting times particularly outpatient services have very long waiting times.*
2. *Access to operating theatre sessions is limited resulting in waiting lists for operative procedures in particular core urology cases.*
3. *The commissioned service and budget agreement aims are based on the workforce capacity rather than the demand.*
4. *Recruitment of clinical staff [consultants, juniors and specialist nurses] has until very recently been a problem. Recent consultant appointments are hoped will improve clinical services in time. The 3 funded specialty doctors remain vacant.*
5. *Numerous outreach day surgery and clinics involve significant travel times and absence from Craigavon Hospital site*
6. *Engagement between primary and secondary care has been limited. The development of regionally agreed care pathways has not been fully instituted or adopted by referring services in primary care and A&E.*

Stinson, Emma M

From: Reid, Trudy [redacted]
Sent: 13 February 2014 17:41
To: Burns, Deborah; Trouton, Heather
Subject: RE: Triage

Debbie I have escalated to Stephen Boyd last night and in more detail today.
Following discussion with Stephen Boyd ophthalmology clinics were reduced over the last few months (they were reported by Consultant to be too busy and the reduction was to make them more manageable and to allow for admin) I have forward each consultants list to their secretaries for Consultants, so they are individually aware of who needs triaged urgently

Regards,

Trudy

Trudy Reid
Acting Head of Trauma & Orthopaedics and Ophthalmology Southern Health and Social Care Trust
Telephone [redacted]
Mobile [redacted]

From: Burns, Deborah
Sent: 13 February 2014 16:43
To: Reid, Trudy; Trouton, Heather
Subject: RE: Triage

This must be immediately escalated to Belfast asap -today and followed with a phone call D

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: [redacted]
Email: deborah.burns[redacted]

From: Reid, Trudy
Sent: 12 February 2014 15:07
To: Trouton, Heather
Cc: Burns, Deborah
Subject: Triage
Importance: High

Heather Sharon has run a quick report on triage– but Katherine is doing a more in-depth report for tomorrow On Sharons report there are 238 patients currently not triaged of which 153 are over 2 weeks and 85 are waiting less than 2weeks for triage- longest waiter for triage is 20 weeks

Regards,

Trudy

Stinson, Emma M

From: Carroll, Anita [redacted]
Sent: 17 February 2014 16:10
To: Carroll, Anita; Boyce, Tracey; Conway, Barry; Gibson, Simon; McVey, Anne; Carroll, Ronan; Trouton, Heather
Cc: Clayton, Wendy; Glenny, Sharon; McAreavey, Lisa; Richardson, Phyllis; Robinson, Katherine; Burns, Deborah; Stinson, Emma M; Lappin, Aideen; Hewitt, Irenee; Lawson, Pamela; Cunningham, Lucia; Cunningham, Andrea; McCaul, Helen; McGinn, Noreen; Rafferty, Lauri; OHanlon, Carmel; Watters, Kate; Cunningham, Lucia; Loughran, MarieT
Subject: Triage of referrals
Attachments: Triage Process.docx

Dear all

I attach the draft process that we will follow as an interim. I suggested to Heather that we should move to the position of accepting the GP categorisation on referrals if these are not triaged and returned in 1 week then we move to appoint, but I appreciate you would have to discuss with Clinicians. However any comments on process as outlined to be returned to me by Wednesday 19th February otherwise we will ensure this is adhered to by all secretaries and Service Administrators, OSLs and RBC Supervisors and Managers.

Anita

Mrs Anita Carroll
Assistant Director of Acute Services
Functional Support Services
5 Hospital Road
Newry
Co. Down
BT35 8DR

Tel: [redacted]
Fax: [redacted]

INTEGRATED ELECTIVE ACCESS PROTOCOL

EXECUTIVE SUMMARY

APRIL 2008

SECTION 3 - MANAGEMENT OF OUTPATIENT SERVICES

3.1 There will be dedicated Hospital Registration Offices (HROs) within Trusts to receive, register and process all outpatient referrals. The HROs will be required to register and scan referrals (where appropriate) onto ERMS and PAS.

3.2 There will be dedicated booking functions within Trusts, developed in line with the booking principles outlined in Section 1.7. The booking processes for non-routine groups of patients, or those with additional needs should be designed to identify and incorporate the specific pathway requirements of these patients.

3.3 To promote and ensure equity for patients, referrals into Trusts should be pooled where possible within specialties. Referrals to a specific consultant by a GP should only be accepted where there are specific clinical requirements or stated patient preference.

3.4 All referrals should be received at the HRO and registered within 1 working day of receipt and able to be tracked through the system. GP priority must be recorded at registration. All outpatient referrals will be prioritised and returned to the HRO within 3 working days. Following prioritisation, referrals must be actioned on PAS and appropriate correspondence issued to patients within 1 working day.

3.5 Where clinics take place, or referrals can be viewed less frequently than weekly, a process must be put in place and agreed with clinicians whereby GP prioritisation is accepted, in order to proceed with booking urgent patients.

Corrigan, Martina

From: Carroll, Anita [Personal Information redacted by the USI]
Sent: 13 February 2014 10:22
To: Trouton, Heather
Cc: Burns, Deborah; Stinson, Emma M
Subject: FW: Triage Process
Attachments: TRIAGE PROCESS.DOCX

Heather this had been the earlier version but in light of discussion I will amend

From: Carroll, Anita
Sent: 13 September 2013 17:10
To: Hall, Stephen; Hogan, Martina; Mackle, Eamon; McAllister, Charlie; Murphy, Philip; O'Reilly, Seamus; Brown, Robin; Convery, Rory; Hall, Sam; Fawzy, Mohamed; McCaffrey, Patricia; McCusker, Grainne; OBrien, Charles; Sidhu, Harmini; Sim, David; Tariq, S; Boyce, Tracey; Conway, Barry; Carroll, Ronan; Trouton, Heather; McVey, Anne
Cc: Lappin, Aideen; Burns, Deborah; Stinson, Emma M; Beattie, Pauline; Lindsay, Gail; McVeigh, Elizabeth; Renney, Cathy; Slaine, Delma; Smyth, Elizabeth; Anderson, Arlene; Brashaw, Isla; Callan, Susan; Hamilton, Pamela L; Magee, Christine; Travers, Marie; McEneaney, Lorraine; OBrien, Joanne; Robinson, Katherine; Forde, Helen
Subject: Triage Process

Dear all

It is necessary to remind everyone about the IEAP rules for triaging patients which states that all patient referrals should be triaged within 72 hours of receipt.

IEAP 3.4.5
All outpatient referrals letters will be prioritised and returned to the HRO within 3 working days. It will be the responsibility of the Health Records Manager or Departmental Manager to monitor this performance indicator. Monitoring will take place by consultant on a monthly basis. Following prioritisation, referrals must be actioned on PAS and appropriate correspondence issued to patients within 1 working day.

(However, even 1 week turnaround would be an improvement).

At this point I would ask that this is discussed within all Clinical teams and Clinicians are reminded of this protocol.

I also want to bring to your attention the attached process which has been shared with Secretaries, Service Administrators and OSLs to ensure we aim to work to these timescales and escalate issues. In this regard each secretary has been asked to set up a file/area in each office where Untriaged referrals can be stored. It will be the responsibility of the secretary to remind the Consultant if Untriaged referrals have not been actioned.

Anita

Mrs Anita Carroll
Assistant Director of Acute Services
Functional Support Services
5 Hospital Road
Newry
Co. Down
BT35 8DR

Tel: [Personal Information redacted by the USI]
Fax: [Personal Information redacted by the USI]

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

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

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

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

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

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

Southern Health and Social Care Trust

Interview with Martina Corrigan (MC)

PRESENT: Dr J Johnston
Mrs Trudy Reid

Introductions
Dr Johnston explained his clinical history, he retired as an Anaesthetist in 2013, then becoming the Assistant Medical Director in the Belfast Health and Social Care Trust. More recently he is working for the Department of Health developing the Regional Morbidity and Mortality electronic system.

The review of this Serious Adverse Incident (SAI) is not part of his role working for Department of Health, Dr Wright (Medical Director for Southern Health and Social Care Trust (SHSCT)) requested Dr Johnston to lead SAI.

Dr Johnston stated the interview was in relation to the triage aspect within the Trust and more particularly Mr O'Brien. He was aware may be other issues, however was not aware of the specifics, his remit was only to review triage.

Mark Haynes was advising regarding clinical issues and Dr Rankin and Mrs Gishkori had been interviewed.

Mrs Corrigan (MC) stated she was the Head of Service (HoS) for ENT/Urology/Ophthalmology and outpatients. She had been in post approximately nine years; she was in the post from 2009. MC stated from talking with others she was aware this was a long running issue, perhaps ongoing for twenty five years.

Martina Corrigan stated she inherited the problem and highlighted this was an ongoing issue with Mr O'Brien. He was the worst offender for not triaging and took longest to triage.

There were issues with other consultants and specialists but nowhere as problematic as Mr O'Brien.

When waiting times were nine weeks, it was more of an issue if letters were not triaged in 72 hours as per the Integrated Elective Access Protocol (IEAP).

If there were issues, she contacted a consultant and there would be an improvement. Mr O'Brien could have been contacted and letters did not appear.

- Waiting times increased e.g. – urology 92 weeks routine – if letter came in today, the 72-hour triage rule is not as crucial as it was when waiting times were 9 weeks.
- If allocated to Red flag route, the triage is still 24 hours regardless of waiting times 14 days. (this is not problem with other consultants)
- All Red Flag referrals go to the Red Flag cancer team, who bring them to the on-call consultant or via e-triage. The Surgeon of the Week (SOW) has to triage to see if they need to remain Red Flagged. The SOW may order scans etc.

All on the triage list need completed.
If he doesn't triage – the administration team in the past would have escalated to the HoS.

- Escalated letters to the HoS were put on list/appointed to continue the process.
- The Normal & Urgent sat on a list.
- 500 letters were found – (including Red Flag letters; but all the R/F had been appointed)

This is where the problem arose; the letters that sat on the waiting list and were not upgraded.

Dr Johnston stated this had been happening over 25 years,
Mr O'Brien was not only one who, on occasion, did not triage but was the only one, that when asked, didn't do it.
This came to head in 2014.

The informal default process, why was it informal?
Why was Mr O'Brien not told just to do it?
MC stated she raised it; she wrote to Mr O'Brien and then escalated to the Assistant Director and Associate Medical Director.
This was addressed finally with Dr Rankin who with AD, AMD at time of the British Association of Urology Specialists (BAUS conference), and MC remembered that despite triaging the letters at that time, Mr O'Brien did not get the conference due to a volcanic ash cloud.

During Mrs D Burn's time as Interim Director of Acute services, the un-triaged letters built up again. Mrs Burns met with Mr O'Brien and MC and very firmly told him to triage. Note: according to DB interview, she told AO'B to stop triaging.

Mrs A Carroll, Mrs K Robinson and & MC met. Mrs Carroll considered what are we going to do; if Mr O'Brien was not triaging patients then they were not going onto any waiting list (urgent/routine), they were the only people in room.
While the process of putting people on the waiting list without triage meant that people did not get missed which was good to be on a list, it meant that there was no way of picking up who was triaged or what was the extent of non-triage.

Dr Johnston highlighted, if letters were not triaged, patients were not upgraded.
MC stated yes this is a problem. GP's should have same responsibility, but the extent had been known. In the referral default process, there was not a safety net; this took away her safety net of checking triage compliance, as she could not see what was triaged.

Dr Johnston – meetings were held, they were difficult. Processes were put on place. Why it was not escalated earlier?
MC stated process was to put patients on waiting list; this was better than nothing. She didn't know why escalation didn't go higher. Consultants saw some triaged letters – then worked out why it happened and identified the gap. The problem was only found out by looking at on call weeks.

Dr Johnston stated that [redacted] *was the index case. In December 2016 during the SAI Mr T Glackin wrote a letter exposing the problem.*

Mrs Corrigan stated in December 2016 she found the letters in a filing cabinet.

and some email conversations. All of these meetings were informal and no minutes were recorded for them and, from my recollection, Mr O'Brien never attended any of these meetings and I can confirm that I was never at any meeting with any of the above in this time period at which Mr O'Brien was in attendance.

Mr Brown and Mr Young

55.3 Issues relating to triage and notes at home were discussed. Meetings with Mr Young would have normally taken place in his office or via email and with Mr Brown mostly by telephone, as he was based in Daisy Hill Hospital. All of these meetings were informal and no minutes were recorded for them and, from my recollection, Mr O'Brien never attended any of these meetings.

2013 - 2015

Mr Mackle, Mrs Trouton and Mrs Burns

55.4 These meetings were mainly concerning triage, notes at home and review backlogs. They would have taken place in Mrs Burn's office, Mrs Trouton's office or in the Associate Medical Director's office, all on the Admin Floor. All of these meetings were informal and no minutes were recorded for them and, from my recollection for the majority of these meetings, Mr O'Brien was not in attendance. An exception was one meeting that I attended with Mrs Burns and Mr O'Brien in Mrs Burn's office where we discussed triage and what we could do to assist him with his admin work. I can confirm that there were no formal notes of the meeting but Mrs Burns sent an email to Mr Young the next day advising him of the discussions and asking him for his help.

Document is located in Relevant to PIT, Evidence after 4 November 2021 PIT, Reference 77 – Martina Corrigan - 20140224-email yesterday MC

Mrs Burns, Mrs Anita Carroll, Mrs Trouton

55.5 These meetings were informal and they were to discuss how we could ensure that patients whom Mr O'Brien was failing to triage were not

Corrigan, Martina

From: Reddick, Fiona [redacted]
Sent: 02 July 2015 10:54
To: Burns, Deborah
Cc: Carroll, Ronan
Subject: FW: UROLOGY LATE TRIAGE ESCALATION

Importance: High

Debbie,

Just wanted to give you the heads up – I rang Aidan to get an update as to where the below R/F referrals are as some of them are now sitting at D8 and we have no account of what is happening. This is the escalation process within cancer services as the staff are dealing with so many at one point in time and are responsible for keeping all tracked.

Aidan is aware of this from previous conversations. He is dealing with them and processing investigations as he triages but he just needs to let us know and keep informed so that we can track accordingly. He is bringing them in shortly but is very cross at this process and he tells me that he is coming to speak to you. The escalation process works well across all other areas.

Happy to discuss further.

Regards

Fiona

Fiona Reddick
Head of Cancer Services
Southern Health and Social Care Trust
Macmillan Building
Tel: [redacted]
Mobile: [redacted]

From: Carroll, Ronan
Sent: 02 July 2015 10:18
To: Reddick, Fiona
Subject: FW: UROLOGY LATE TRIAGE ESCALATION

Fiona
Martina off can u speak with Aidan pls

Ronan Carroll
Assistant Director Acute Services
Cancer & Clinical Services/ATICs
[redacted]

From: Muldrew, Angela
Sent: 02 July 2015 10:11

From: Muldrew, Angela
Sent: Tuesday, June 30, 2015 10:30 AM
To: Corrigan, Martina
Cc: Davies, Caroline L; Carroll, Ronan; Reddick, Fiona
Subject: FW: UROLOGY LATE TRIAGE ESCALATION

Martina

See below referrals that we are waiting coming back from triage. Would you be able to chase these up with Mr O'Brien?

Thanks

Angela Muldrew
RISOH Implementation Officer
Tel. No. Personal Information redacted by the USI (Mon, Thurs & Fri)
Personal Information redacted by the USI (Tue & Wed)

From: Davies, Caroline L
Sent: 30 June 2015 09:35
To: Muldrew, Angela
Subject: UROLOGY LATE TRIAGE ESCALATION

Hi Angela, the following referrals have still not come back from triage, I have just come back from the Thorndale Unit and there is nothing in my tray:

Surname

Name

Hosp. NO /HCN

Specialty

specific clinic if appropriate

Date Referral Received in Trust

MONTH

Date Referral Received in Cancer Services

Referral received via RF Fax, CCG, RBC, 1 south, Gynae, Secretary

Referrer (GP or OC - if OC put name of referrer)

Date ORE'd

Initial of staff member who Ore'd referral

Date sent to triage

Date received back from triage

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

Corrigan, Martina

From: Burns, Deborah [redacted]
Sent: 13 May 2013 15:09
To: Corrigan, Martina
Subject: RE: Charts being removed from the Trust by consultants

YES PLEASE GO AHEAD AND RAISE ASAP

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: [redacted]
Email: [redacted]

From: Corrigan, Martina
Sent: 12 May 2013 16:28
To: Burns, Deborah
Subject: RE: Charts being removed from the Trust by consultants

Debbie,

This has been an ongoing problem for years. The last time that Helen spoke to me about this I spoke to Aidan and advised him of the issues which he did say he would stop it and it did stop for a while but I had asked Helen if it happened again to raise it with me and also to raise an IR1. Unfortunately there are three charts now in Aidan's house and I am unsure if anyone has spoken to him about it direct (I will check with Helen tomorrow).

I am happy to talk to Aidan again but think we may need to involve Robin as CD as well?

Martina

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

Telephone: [redacted]
Mobile: [redacted]
Email: [redacted]

From: Burns, Deborah
Sent: 10 May 2013 19:17
To: Corrigan, Martina
Subject: FW: Charts being removed from the Trust by consultants

Can you give me background on work to date

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: [redacted]
Email: [redacted]

Corrigan, Martina

From: Burns, Deborah [redacted]
Sent: 10 May 2013 19:59
To: Corrigan, Martina
Subject: FW: Consultants taking charts home

Can you speak to me

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: [redacted]
Email: [redacted]

From: Carroll, Anita
Sent: 10 May 2013 14:01
To: Burns, Deborah
Subject: Fw: Consultants taking charts home

Just fyi

From: Forde, Helen
To: Carroll, Anita
Sent: Fri May 10 13:54:04 2013
Subject: Consultants taking charts home Anita just to let you know that another IR1 has been put in today for 2 charts that Mr O'Brien has at home and that are needed for Monday.

Helen Forde
Head of Health Records
Operations Office, Admin Floor, CAH
Direct Line : [redacted]
Mobile : [redacted]

Corrigan, Martina

From: Burns, Deborah [redacted]
Sent: 03 September 2013 15:11
To: Corrigan, Martina; Mackle, Eamon; Brown, Robin
Subject: FW: CHARTS TO CONSULTANT'S HOME

I know you have tried before – this is a governance issue – Robin can you discuss again with Mr O'Brien - or do we need to escalate?
D

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: [redacted]
Email: [redacted]

From: Carroll, Anita
Sent: 03 September 2013 10:11
To: Burns, Deborah
Cc: Corrigan, Martina; Forde, Helen
Subject: FW: CHARTS TO CONSULTANT'S HOME

Debbie how do you think its best to deal with this , should the HOS discuss with mr o brien can they arrange to get charts back or do we need to discuss at governance as part of the problem is they aren't even tracked out Happy to discuss Anita

From: Forde, Helen
Sent: 27 August 2013 18:15
To: Trouton, Heather; Corrigan, Martina
Cc: Carroll, Anita
Subject: FW: CHARTS TO CONSULTANT'S HOME

Please see below – Mr O'Brien continues to have charts at home. This is causing problems for records as per Pamela's e-mail. What can be done to resolve this?

Helen Forde
Head of Health Records
Operations Office, Admin Floor, CAH
Direct Line : [redacted]
Mobile : [redacted]

From: Lawson, Pamela
Sent: 27 August 2013 11:06
To: Forde, Helen
Subject: CHARTS TO CONSULTANT'S HOME

Helen – can you please raise this issue with the appropriate person? I have been submitting IR1 forms regarding this but the problem is getting worse instead of better.

We are wasting a lot of valuable time searching for charts that are not tracked properly and we are falling behind. Last week was particularly bad and we are short-staffed which doesn't help matters.

Please see list of IR1 forms to date

Corrigan, Martina

From: Carroll, Anita [redacted]
Sent: 12 November 2013 11:58
To: Burns, Deborah; Trouton, Heather; Corrigan, Martina
Subject: RE: Mr O'Brien and charts

I think to escalate to Dr Simpson might be worth a try

From: Burns, Deborah
Sent: 12 November 2013 08:40
To: Trouton, Heather; Carroll, Anita; Corrigan, Martina
Subject: RE: Mr O'Brien and charts

SEE MY EMAIL - VIEW?

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: [redacted]
Email: [redacted]

From: Trouton, Heather
Sent: 12 November 2013 08:37
To: Carroll, Anita; Corrigan, Martina
Cc: Burns, Deborah
Subject: RE: Mr O'Brien and charts

Anita

I have spoken both to Mr O'Brien himself and Mr Young as clinical lead for Urology

Mr O,Brien advised that he would cease this practice.

We could ask Mr Brown to discuss with him but I don't think it would have any effect.

hetaher

From: Carroll, Anita
Sent: 11 November 2013 13:28
To: Trouton, Heather; Corrigan, Martina
Cc: Burns, Deborah
Subject: FW: Mr O'Brien and charts

Dear all I know we have discussed before and heather I know you met him Really don't know what we now do A

From: Forde, Helen
Sent: 11 November 2013 13:07
To: Carroll, Anita
Subject: Mr O'Brien and charts

Just to keep you in the loop as this may be going to Debbie, and I've said to Martina.

Corrigan, Martina

From: Mackle, Eamon [redacted]
Sent: 20 February 2014 11:30
To: Burns, Deborah
Subject: Fw: CHARTS AND aob

From: Carroll, Anita
Sent: Wednesday, February 12, 2014 04:47 PM GMT Standard Time
To: Trouton, Heather; Mackle, Eamon
Cc: Corrigan, Martina
Subject: FW: CHARTS AND aob

Sharing as requested
A

From: Lawson, Pamela
Sent: 12 February 2014 16:46
To: Carroll, Anita
Subject: RE: can i have an update on mr o brien ?

Anita – please see below – these are details of the IR1 forms submitted re charts Mr O'Brien has had to bring in from his home for clinics and admissions.

08/05/13 – 1 chart
20/05/13 – 1 chart
16/05/13 – 1 chart
31/05/13 – 2 charts
14/06/13 – 1 chart
22/08/13 – 3 charts
23/08/13 – 2 charts
27/08/13 – 3 charts
30/08/13 – 2 charts
16/09/13 – 1 chart
18/09/13 – 1 chart
20/09/13 – 1 chart
03/10/13 – 6 charts
14/10/13 – 1 chart
15/10/13 – 1 chart – AOB forgot to bring chart in – pages and labels had to be made up for CDSU procedure
15/10/13 – 1 chart
04/11/13 – 1 chart – chart did not arrive in time for clinic
25/11/13 – 6 charts
11/12/13 – 6 charts
08/01/14 – 2 charts
09/01/14 – 2 charts
21/01/14 – 3 charts – not able to get these charts as AOB was out of the country and his secretary was on leave
24/01/14 – 3 charts
12/02/14 – 3 charts

From: Carroll, Anita
Sent: 12 February 2014 16:38

20.2 If the issue was about staffing I would raise with my own Assistant Director, Anita Carroll, although staffing issues would not have been solely related to urology but would be in general.

20.3 I did escalate issues to Anita Carroll regarding the charts at home and she in turn escalated to the Assistant Director at the time – Heather Trouton. *Please see:*

35. 20150127 Aob and charts at home

44. 20131014 Chart with AOB

21. In what way is your role relevant to the operational, clinical and/or governance aspects of urology services? How are these roles and responsibilities carried out on a day to day basis (or otherwise)?

21.1 Please see 19.1

21.2 On a day to day basis the staff in Health Records would know what charts to get for the urology clinic and they would pull these charts, and prepare them for the clinic or admission in the same ways as they pulled and prepped charts for all clinics and admissions.

21.3 The ward clerk would file charts, update PAS and make follow-up appointments in the same way as they would for every ward and specialty.

22. What is your overall view of the efficiency and effectiveness of governance processes and procedures within urology as relevant to your role?

22.1 Governance processes relevant to my role related to my staff completing a Datix when a chart required for a clinic was found to be in Mr O'Brien's house. From the period 08/05/13 – 1/8/14 there were 29 Datix completed relating to 63 charts. *Please see 43. 20201204 Datix for Missing*

charts. It had not been our practice to complete a Datix when the chart was at Mr O'Brien's home but as the problem continued we started to complete a Datix each time a chart was in Mr O'Brien's house commencing in May 2013, and continuing until we were told not to complete any more Datix by the Director of Acute Services at the time, Debbie Burns. (see 22.3)

22.2 My view regarding the effectiveness of this process would be that it was not effective as no change in working practices were ever made, and I was not made aware of what action was taken in the management of the Datix.

22.3 We were asked to stop completing the Datix related to Mr O'Brien having charts at home by the Director of Acute Services at that time, Debbie Burns. This was a conversation on the corridor. I cannot recall the date of this conversation but our Datix stopped on 1/8/14 (with only one in 2016 an one in 2019) and Debbie Burns moved from Acute in approximately April 2015, so I would put the date in the region of August 2014 – April 2015. Debbie Burns stated that Mr O'Brien was being helpful to her and she did not want him annoyed I had mixed feelings about this as my staff were annoyed about having to search for charts to find that they were not in the office, and therefore their time was wasted in the search by having to chase up to get the chart the next day from Mr O'Brien and the situation did not improve. However, my manager was filling in a Datix each time this occurred but nothing was being achieved, and so her time was being wasted. It felt as if there was no point in us highlighting this concern as nothing was going to be done about it.

23. Through your role, did you inform or engage with performance metrics or have any other patient or system data input within urology? How did those systems help identify concerns, if at all?

6. I am aware that on a regular basis Leanne Brown who is the Supervisor in the RBC and who had responsibility for urology would have raised issues regarding triage within her area which is urology . The issues related specifically to Mr O'Brien. These issues were flagged with the Director, the Assistant Director for surgery and the Head of Service for urology.

7. A triage report went out every Friday and there were regular delay issues with Mr O'Brien's triage.

8. Around December 2015 I sent an e-mail to my Assistant Director colleagues advising that there were delays . I did not specifically name any Consultant but I highlighted that the triage was not being done in line with the IEAP guidance. I sent this to Heather Trouton, Barry Conway Ronan Carroll, Anne Mcvey and Simon Gibson. The purpose of my e-mail was to agree a process whereby if triage was not done and returned the patient would be categorised as per the GP referral. This was agreed at that time.

9. The default process commenced around December 2015. In earlier 2015 referrals were waiting but staff in the booking centre were probably already adding patients to the lists as per the GP category on the referral. In general there wouldn't have been many referrals downgraded or upgraded. The Referral and Booking Centre get around 180,000 referrals every year.

10. Other than there were delays with triage I don't know anything about patient care delay or harm.

11. I know the IEAP was meant to be regional guidance which recommends 72 hours for triage. There would have been delays outside of this across specialities but in the main it was generally done within a week which I feel is reasonable. Some of the other specialties may not have had the same level of referrals as urology.

12. In terms of notes, within PAS and case note tracking, charts are generally tracked out to an address which on the system may just have been 'Aidan O'Brien'. There would be no way of knowing that notes are not in the office or in the secretary's office. The only time an issue regarding charts might be escalated to me is if a chart is to be pulled for a clinic and it can't be found. Generally staff would check with the secretary for the chart if it can't be found. I am aware the secretary may have said Mr O'Brien had that set of notes at home and he would bring them in. There was no specific issue being flagged to me on a regular basis about charts.

13. A few times Mr O'Brien's name would have come up and so I suggested we put a Datix in to alert that a chart was not available for a clinic. I was advised to refer such issues to the Head of Service. Debbie Burns told my head of health records Helen Forde not to put Datix's in the system for charts. Helen shared this information with me and I accepted that maybe this wasn't the right mechanism for flagging the issue.

To: Corrigan, Martina
Subject: Re: Results and Reports of Investigations

Martina,

I write in response to email informing us that there is an expectation that investigative results and reports to be reviewed as soon as they become available, and that one does not wait until patients' review appointments. I presume that this relates to outpatients, and arises as a consequence of patients not being reviewed when intended. I am concerned for several reasons:
• Is the consultant to review all results and reports relating to patients under his / her care, irrespective of who requested the investigation(s), or only those requested by the consultant?
• Are all results or reports to be reviewed, irrespective of their normality or abnormality?
• Are they results or reports to be presented to the reviewer in paper or digital form?
• Who is responsible for presentation of results and reports for review?
• Will reports and results be presented with patients' charts for review?
• How much time will the exercise of presentation take?
• Are there other resource implications to presentation of results and reports for review?
• Is the consultant to report / communicate / inform following review of results and reports?
• What actions are to be taken in cases of abnormality?
• How much time will review take?
• Are there legal implications to this proposed action?
I believe that all of these issues need to be addressed,

Aidan.

-----Original Message-----
From: Corrigan, Martina [redacted]
To: Aidanpobrien [redacted]; [redacted]>; Akhtar, Mehmood [redacted]; O'Brien, Aidan [redacted]; Young, Michael [redacted]
CC: Dignam, Paulette [redacted]; Hanvey, Leanne [redacted]; McCorry, Monica [redacted]; Troughton, Elizabeth [redacted]
Sent: Wed, 27 Jul 2011 5:30
Subject: FW: Results
Dear all

Please see below for your information and action

Thanks

Martina

Martina Corrigan

Head of ENT and Urology

Craigavon Area Hospital

Tel: Personal Information redacted by the USI

Mobile: Personal Information redacted by the USI

Email: Personal Information redacted by the USI

Personal Information redacted by the USI

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 7 of 2023

Date of Notice: 5 May 2023

Note: An addendum amending this statement was received by the Inquiry on 23 June 2023 and can be found at WIT-98544 to WIT-98770. Annotated by the Urology Services Inquiry.

Witness Statement of: Martina Corrigan

I, Martina Corrigan, will say as follows:-

1. **Please consider the following extracts from your "SAI Urology Review Interview", which took place with Dr Dermot Hughes and Patricia Kingsnorth on the 18 January 2021 at 12 Midday via zoom (see WIT 84355 – 84356) and address the questions following each section:**

Extract 1:

…

***Martina advised that she worked in SHSCT for 11 years, and confirmed that during that time Mr O'Brien never recognised the role of the Clinical Nurse Specialists. She confirmed that he never involved them in his oncology clinics. She is aware that some of the Clinical Nurse Specialists would have asked to be at the clinics but Mr O'Brien never included them*. WIT 84355**

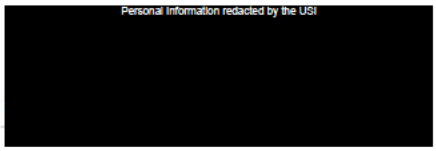
…

(a) Please set out, including names of any relevant individuals, details of anything said and dates (approximate if necessary), the basis on which you state that:

(i) For 11 years, Mr O'Brien never recognised the role of the Clinical Nurse Specialist.

Statement of Truth

I believe that the facts stated in this witness statement are true

Signed: 

Date: 12 May 2023

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Refs: Section 21 Notices Number 24 of 2022 and Number 7 of 2023
Dates of Notices: 29th April 2022 and 5th May 2023

Addendum Witness Statement of: Martina Corrigan

I, Martina Corrigan, will say as follows:-

I wish to make the following amendments and/or additions to my existing responses of 6th July 2022 (to s.21 Notice No.24 of 2022 dated 29th April 2022) and of 12th May 2023 (to s.21 Notice No.7 of 2023 dated 5th May 2023) and, beyond this, to provide some further information regarding the chronology of events surrounding the recruitment of Clinical Nurse Specialists for Urology in the decade from approximately 2010 to 2020 as I have become aware that this is an issue in respect of which the Inquiry would welcome further information:

Section 21 Notice No.24 of 2022 dated 29th April 2022

1. I wish to make the following amendments and/or additions to my existing response dated 6th July 2022:

1.1 WIT-26198 - Para 16.3 (b) v – The existing paragraph below should be replaced by that in red:

Existing para 16.3 (b) v

'The funding for this proposal was going to go 'at risk' but I presented that these were needed to assist in tackling the increasing waiting times for outpatient appointments. Mrs Burns agreed to go 'at risk' for these posts and we temporarily appointed 2 members of staff who were substantive Band 5s to these and then we backfilled their posts in the unit. To note, both of these Band 6s eventually have taken up permanent Band 7 Clinical Nurse Specialist roles

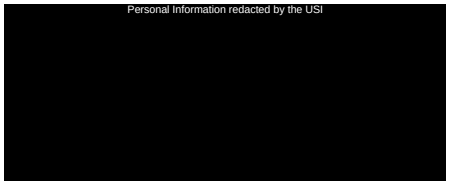
2.5 Where there is any conflict or discrepancy between Patricia's handwritten note of the 18th January 2021 meeting and the final typed note of the meeting (of 25th January 2021), I would place more reliance upon the handwritten note.

Recruitment of Clinical Nurse Specialists for Urology

3. I have become aware, in preparing for my evidence next week, that the Inquiry would welcome further information on the chronology of events surrounding the recruitment of Clinical Nurse Specialists for Urology in the decade from approximately 2010 to approximately 2020 and that it would assist if this were provided ahead of my oral evidence. In the circumstances, I have attempted to provide a summary of my involvement in, and knowledge of, relevant events in chronological form. I have set this out in the table attached to this addendum witness statement and have also provided copies of the documents referenced in the right-hand column of the table and numbered [1] to [26].

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: 

Date: 23rd June 2023

5.3 In June 2016, due to the Head of Service for Trauma and Orthopaedics and Ophthalmology securing a new role (Head of Governance), there was a new appointment to her post, Brigeen Kelly, and when she took up post she clearly stated that she would not be doing ophthalmology as part of her role as she had all the Nursing within Surgery and Elective Care (SEC) reporting through the Lead Nurses to her. When, at a Performance Meeting, the question was asked who the Head of Service was for Ophthalmology, the Assistant Director, Ronan Carroll, advised that I would be taking this on. I spoke to him after the meeting as this had been the first that I had heard of this plan and he advised that, as it was a visiting outpatient service, it was felt that it could be added, and was relevant, to my role as Head of Outpatients.

5.4 I have attached my original Job Description for Head of Urology and ENT and this Job Description describes the role that I held except that it expanded, as explained above, to include the Head of Service for Outpatients and Ophthalmology.

5.5 I have been Assistant Director for Public Inquiry and Trust Liaison (Band 8C) since 7th June 2021. My duties and responsibilities are contained within the *attached document – 2. Public Inquiry AD JD and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments*

Job Description

5.6 After the Public Inquiry was announced the Trust took steps to put a process in place to manage the Public Inquiry responses. Mrs Heather Trouton, Executive Director of Nursing, Midwifery and AHPs, was allocated the role of Director for the Public Inquiry and I applied and was appointed as Assistant Director to the Inquiry. The Trust took cognisance of the perceived conflict of interest for both Mrs Trouton and myself and appointed a Programme Director for the Public Inquiry, Mrs Jane McKimm, who has never had any operational responsibility for Urology services. The Trust then also appointed Mrs Margaret O'Hagan as the Independent Trust Advisor for the Urology Services Inquiry. She is on secondment from the Northern Trust. For the Trust to respond fully

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

JOB TITLE	Assistant Director for Public Inquiry and Trust Liaison
BAND	8C
DIRECTORATE	Executive Director of Nursing and AHPs
INITIAL LOCATION	Trust Headquarters, Craigavon Area Hospital
REPORTS TO	Executive Director of Nursing and AHPs
ACCOUNTABLE TO	Chief Executive

JOB SUMMARY

In the first instance, the post holder will be responsible through the Executive Director of Nursing and Allied Health Professionals for ensuring that the Trust meets the legal requirements of the Inquiries Act 2005 in respect of the Statutory Public Inquiry regarding the Practice of a Southern Trust Consultant Urologist. The post holder will also act as the Trust's Liaison Officer for the Inquiry Panel, the Directorate of Legal Services and other external stakeholders, for example, the Department of Health.

KEY DUTIES / RESPONSIBILITIES

For each of the following, the post holder will;

1. On behalf of the Executive Director of Nursing, lead on the coordination, administration and project management of work streams relating to the Public Inquiry.
2. In conjunction with the Executive Director of Nursing, develop, quality assure and manage processes that ensure information requested by the Public Inquiry is reviewed, accurate, complete prior to issue.

c. **Though MDM and pharmacy involvement to ensure medication advice sheet stays up to-date. Periodic review date set, and awareness of pharmacy to notify of updates.**

7. **Extracorporeal Shockwave Lithotripsy treatment session**

Recommendations were made following the service evaluation, patient and staff interviews, and patient post-treatment questionnaire

Recommendations and outcomes for Craigavon Stone Treatment Centre

1. **Decrease the time for Nurse to check-in patient and consent patient for ESWL treatment on day of treatment**
   Patient information pack and pre-prescription of pain medications. Follow-up time and motion study to be conducted.

2. Have typed discharge for patient ready upon discharge from ESWL treatment day. Have discharge uploaded on day of treatment to Electronic care records so can be viewed at any time by Doctors, especially in the event of an emergency admission to Accident and Emergency.
   Reviewing the data needed for inclusion into a discharge letter, for immediate discharge and follow-up, the letter went through a number of PDSA cycles through the stone MDM and day of treatment.
   We moved from a hand printed discharge letter to an electronic generated letter, allowing a standard letter to be generated, with all necessary information required for completion.
   The letter had to be quick (less than 5 minutes) and easy for the author to complete. Following meetings and successful lobbying of the Electronic Care Records team (Northern Ireland regional Electronic notes) we achieved access and upload of the discharge letter. The letter can now be uploaded to Electronic Care Records straight after its generation, and allows a printed copy to the patient.
   The patients General Practitioner (GP) had previously received a typed discharge letter some 6 weeks following the patient's treatment. The standard electronic uploaded discharge summery immediately following treatment meant the additional letter to the GP was no longer required**.** The electronic generated discharge therefore prevented any further secretarial input, and thus saving money.

3. Review on pain medication given to patients at Southern Trust Stone Treatment Centre, and recommendation for breakthrough medication during ESWL treatment.
   A literature review was conducted on the Stone Treatment Centre long standing use of Piroxicam prior to ESWL treatment. The data suggested that the NSAID diclofenac may provide a more successful pain relief than Piroxicam 20mg.

c. To maintain quality standards and provide high quality standards (In my opinion, the Urology Service did continue to maintain and provide high quality standards to the majority of patients who came under their care);
d. To provide high quality elective and emergency services (In my opinion, whilst the Urology Service provided high quality services to those who came in as an emergency and for those who were admitted electively, due to capacity - which led to delays throughout the patient journey [first appointment/ diagnostics/ admission for procedure to follow-up] - the urology service, through no fault of themselves, could not provide as high a quality of service as they would have liked).

16. Do you think the unit was adequately staffed and properly resourced from its inception? If that is not your view, can you please expand noting the deficiencies as you saw them?

16.1 In my opinion the Urology Unit was not adequately staffed but I can confirm that was not due to funding from the Department of Health to implement the recommendations from the review. I have outlined below the reasons for my above statement.

16.2 When I took up my post in September 2009 the following staff were in post:

a. 3 Consultant Urologists (Mr O'Brien, Mr Young and Mr Akhtar)
b. 2 Registrars (various doctors held this post due to it being a rotational training post)
c. 1 GP with Specialist Interest (7 sessions per week) [redacted]
d. 1 Lecturer Practitioner in Urological Nursing (2 sessions per week) (Jerome Marley)
e. 2 Urology Specialist Nurses (Band 7) (Kate O'Neill and Jenny McMahon).

16.3 The Regional Review recommended that there was an increase in staffing as follows:

a. Consultant Urologists should increase from 3 to 5 consultants - This proved problematic as, although the funding was available, it took some years to get 5 consultants in post and, even when the Trust was successful, some of the consultants only stayed for a short period of time.

   Documents attached namely:

   186. 2009-2022 – Consultants in post

   and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

b. Clinical Nurse Specialist to increase from 2 to 4 clinical nurse specialists. -

   i In 2009 there were two Clinical Nurse Specialists in post, Kate O'Neill and Jenny McMahon. The plan from the Review was to recruit a further 2 nurses who were to be aligned to cancer as per the review.

   ii It was also stated in the Review that this would be taken forward by NICAN during January – March 2011, which meant that the Trust couldn't move to recruit for these two posts until this had been finished.

   iii As Head of Service, I was not involved in this process and this was under the remit of Head of Cancer Services, Alison Porter and then Fiona Reddick, who both reported to Ronan Carroll, Assistant Director from 2009-2016, and then to Heather Trouton from 2016-2018, and then to Barry Conway from 2018-now. So, for this process I had no influence to 'speed it up' which, from a personal perspective, I felt did cause issues for the operational aspect of the service in that, whilst I operationally managed the Clinical Nurse Specialists, I had no influence over how and when they would be appointed.

   iv In October 2014, whilst still waiting on the decision on the Cancer Clinical Nurse Specialists, I prepared and presented a paper to Mrs Burns (Interim Director of Acute Services) in which I requested that we

Corrigan, Martina

From: Corrigan, Martina <[redacted]>
Sent: 06 February 2012 15:01
To: O'Brien, Aidan; [redacted]
Cc: Scott, Jane M; ONeill, Kate
Subject: FW: Day4 outcome escalation

Importance: High

Dear Aidan,

Can you advise?

Many thanks

Martina

Martina Corrigan
Head of ENT and Urology
Craigavon Area Hospital

Tel: [redacted] (Direct Dial)
Mobile: [redacted]
Email: [redacted]

From: Montgomery, Angela
Sent: 06 February 2012 14:33
To: Corrigan, Martina
Cc: Scott, Jane M; Graham, Vicki
Subject: Day4 outcome escalation
Importance: High

HI Martina

Vicki is unable to find the below 2 patients medical notes following a day 4 appointment with Mr O'Brien and can therefore not get a clear outcome. Can you please speak to Mr O'Brien to see where these charts may be as they are still tracked to Thorndale Unit?

[redacted]
Day 4 appointment 06.01.12

[redacted]
Day 4 appointment 06.01.12

Thanks

Angela

Angela Montgomery
Cancer Services Co-Ordinator
Tel. No. [redacted]

Corrigan, Martina

From: Burns, Deborah [redacted]
Sent: 10 May 2013 19:59
To: Corrigan, Martina
Subject: FW: Consultants taking charts home

Can you speak to me

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: [redacted]
Email: [redacted]

From: Carroll, Anita
Sent: 10 May 2013 14:01
To: Burns, Deborah
Subject: Fw: Consultants taking charts home

Just fyi

From: Forde, Helen
To: Carroll, Anita
Sent: Fri May 10 13:54:04 2013
Subject: Consultants taking charts home

Anita just to let you know that another IR1 has been put in today for 2 charts that Mr O'Brien has at home and that are needed for Monday.

Helen Forde
Head of Health Records
Operations Office, Admin Floor, CAH
Direct Line [redacted]
Mobile : [redacted]

Willis, Lisa

From: Corrigan, Martina
Sent: 08 October 2013 09:52
To: Trouton, Heather
Cc: Carroll, Anita
Subject: RE: UPDATE ON CHART WITH AOB

Follow Up Flag: Follow up
Flag Status: Flagged

Heather

Best time is probably is a Thursday between xray meeting over at 9:30ish and grand ward round at 10ish, or else on a Friday in Thorndale, between patients.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Telephone: Personal Information redacted by USI (Direct Dial)
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

From: Trouton, Heather
Sent: 08 October 2013 08:28
To: Corrigan, Martina
Cc: Carroll, Anita
Subject: FW: UPDATE ON CHART WITH AOB

Martina

I need to talk to Aidan re this when would be the best time?

heather

From: Carroll, Anita
Sent: 07 October 2013 10:58
To: Trouton, Heather
Subject: FW: UPDATE ON CHART WITH AOB

Sorry to keep going on re this but is there anything Eamon could do to assist ?
A

From: Forde, Helen
Sent: 04 October 2013 14:24
To: Carroll, Anita
Subject: FW: UPDATE ON CHART WITH AOB

Here's an example of the extra work that is associated with Mr O'Brien having charts at home.

Willis, Lisa

From: Corrigan, Martina
Sent: 26 October 2014 14:51
To: Trouton, Heather
Subject: RE: NOTES WITH AOB

Follow Up Flag: Follow up
Flag Status: Flagged

Heather

It had improved but I feel it may be slipping again and I will talk to Aidan again

Martina

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

Telephone: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Trouton, Heather
Sent: 15 October 2014 15:28
To: Corrigan, Martina
Subject: FW: NOTES WITH AOB
Importance: High

Martina

Are you aware that this is still a problem ? has it improved at all ?

Heather

From: Carroll, Anita
Sent: 14 October 2014 14:40
To: Trouton, Heather
Subject: FW: NOTES WITH AOB
Importance: High

From: Forde, Helen
Sent: 14 October 2014 13:52
To: Carroll, Anita
Subject: FW: NOTES WITH AOB
Importance: High

See below – still a problem

Helen Forde
Head of Health Records
Admin Floor, CAH
DDI [redacted] Ext [redacted]

'You can follow us on Facebook and Twitter'

From: Lawson, Pamela
Sent: 14 October 2014 13:34
To: Forde, Helen
Subject: FW: NOTES WITH AOB
Importance: High

fyi

From: Lawson, Pamela
Sent: 14 October 2014 13:33
To: Troughton, Elizabeth; Corrigan, Martina
Subject: FW: NOTES WITH AOB
Importance: High

Elizabeth – would you please explain to Mr Glackin that these notes will not be present for the appointment tomorrow as Mr O'Brien has them.

Thanks
Pamela

From: Mills, Barbara
Sent: 14 October 2014 10:36
To: Lawson, Pamela
Subject: NOTES WITH AOB
Importance: High

Hi Pamela,
[redacted] chart with AOB. Noleen e-mailed him twice –no response. Needed for CAJGPB 15/10/14.

Many Thanks
Barbara

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 07 November 2014 10:54
To: Trouton, Heather
Subject: FW: CHARTS REQUIRED BY RECORDS PLEASE

Heather

Can we have a chat about this as it is becoming a problem again

Thanks

Martina

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

Telephone: [redacted]
Mobile [redacted]
Email: [redacted]

From: Lawson, Pamela
Sent: 07 November 2014 10:50
To: O'Brien, Aidan
Cc: Forde, Helen; Loughran, MarieT; Corrigan, Martina
Subject: CHARTS REQUIRED BY RECORDS PLEASE

Dear Mr O'Brien

Can I ask you please to bring in the following charts asap?

[redacted] – admission to 2 North 06/11/14

[redacted] – required for your clinic AAOBU1 on Monday 10th November.

Many thanks
Pamela

Pamela Lawson
Health Records Manager
CAH
[redacted]

From: Lawson, Pamela
Sent: 17 October 2016 11:39
To: Forde, Helen
Cc: Corrigan, Martina
Subject: MR O'BRIEN AND CHARTS AT HOME

Hi Helen

I just learnt this morning that Mr O'Brien is going from mid-November possibly until January 2017.

I would like to get any charts back into Records from his home. Martina is on leave until 31 October.

Is there anything we could do in the meantime? I think if he started to bring a few in each day we could cope with it better.

Thanks

Pamela

Pamela Lawson

Health Records Manager

CAH

Personal Information redacted by the USI

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by the USI
Mobile Personal Information redacted by the USI

From: Lawson, Pamela
Sent: 10 November 2016 14:41
To: Corrigan, Martina
Cc: Gibson, Simon
Subject: FW: MR O'BRIEN AND CHARTS AT HOME

Martina – is there any way we can get these charts.

I am looking one at the moment for Personal Information redacted by the USI if you could possibly action??

Thanks very much

Pamela

From: Lawson, Pamela
Sent: 17 October 2016 11:40
To: Nelson, Amie
Cc: Forde, Helen
Subject: FW: MR O'BRIEN AND CHARTS AT HOME

Amie – in Martina's absence.

Pamela

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by USI
Mobile : Personal Information redacted by USI

From: O'Brien, Aidan
Sent: 14 November 2016 16:09
To: Corrigan, Martina
Subject: RE: MR O'BRIEN AND CHARTS AT HOME

Martina,

As I will be having my surgery on Thursday morning, I expect to be home again over the weekend.

I expect that I will be well enough to dictate correspondence concerning patients and have the charts delivered to Noleen's office for typing.

I would greatly appreciate if I could be afforded this opportunity to have all charts returned in this manner.

Thank you,

Aidan.

From: Corrigan, Martina
Sent: 14 November 2016 07:15
To: O'Brien, Aidan
Subject: FW: MR O'BRIEN AND CHARTS AT HOME

Further emails Aidan.

Thanks

Subject: RE: MR O'BRIEN AND CHARTS AT HOME
From: O'Brien, Aidan [redacted]
To: Corrigan, Martina
Sent: 14/11/2016 21:32:12

Martina,

I have already asked Noleen to return [redacted] chart to Pamela Lawson, who has requested it.

Thank you,

Aidan.

From: Corrigan, Martina
Sent: 14 November 2016 17:49
To: O'Brien, Aidan
Subject: RE: MR O'BRIEN AND CHARTS AT HOME

Aidan

I am more than happy with this plan, please let me know if there is anything I can do to assist.

By any chance could [redacted] be left in as I have had governance looking for this chart as well.

Wishing you all the best for Thursday, please take care

Talk soon

Kind regards

with most of the consultants who were on-call and they would do an additional ward round or go and request further tests to assist with the patient flow, or they would attend the Emergency Department to assess urology patients to see if they could be 'turned around' without needing to be admitted. I can confirm that this was the case for all consultants with the exception of Mr O'Brien who, whilst he was pleasant and polite the majority of times, would not have agreed to do an additional ward round as his view would have been that, if they were still in the ward, they needed to remain there. My personal opinion was this was frustrating as the bigger picture (that all of the others understood) was that, if someone could go home from the ward, then this freed up a bed for a patient who was waiting admission from the Emergency Department. So, when he would have been the consultant on-call I would not have approached him for assistance.

c. At any time I could approach any of the Team, apart from Mr O'Brien, to discuss any issues in relation to performance and they would have helped me out if they could, for example, adding an extra patient to a clinic, taking a look at notes to see if a patient needed seen urgently if, for example, there had been an informal query from a patient or via an MLA/MP, etc.

Mr O'Brien

30.4 For the purpose of completeness I would like to clarify my working relationship with Mr O'Brien and then outline examples as to why I felt that he didn't appear to have a good working relationship with medical and professional managers.

30.5 At my first introduction to Mr O'Brien on 28 September 2009, after he had greeted me he asked me *what exactly I would be doing and was I yet another manager/administrator who would be 'chasing' the team for information and how exactly did I propose to head up their urology service?* As I was new, and at that stage unfamiliar with what my role would entail, I wasn't able to

day to day operational running of the service and ensuring that the needs of the patients were met from the perspective of both elective and emergency patients. I also was responsible for working with Mr O'Brien and the others in service development. In my job description it does not state that I was to have operational responsibility for the consultants and I didn't have such responsibility for the other medical staff within my area (except for keeping a record of their leave, which was more for rota purposes that actually managing their leave).

52.2 From February 2017, my role with Mr O'Brien changed in that I had to do a weekly monitoring of his Return to Work Plan and this meant that I spent more time with a focus on the four areas that I had to monitor.

52.3 As Head of Service for Urology the contact with Mr O'Brien was by various methods and for various reasons and therefore the amount of time would have varied. There were times, such as the meetings with the Department of Health when we were working on the Team South Implementation Plan, that I would have contact with Mr O'Brien at least once per week when he attended our weekly Monday meetings and this went on for approximately 15 months (2010-2012). I would also have met with him and the rest of the Team on a Thursday lunchtime when we had our Departmental meeting, although Mr O'Brien didn't always attend. We would also have had regular meetings during the summer and autumn of 2014 when we were planning for the meetings with the Department of Health with the proposal for going forward with the 'blue-sky' thinking for urology services. There would also have been ad hoc meetings when I needed the Team to meet with GPs about pathways, etc.

52.4 I would have had ad hoc, face to face meetings with Mr O'Brien as and when required, for example, to discuss patient flow issues, triage issues, needing a response to complaints, etc. These were not normally planned and were in the nature of the operational management of the service.

Directors and Associate Medical Directors. They were not unique to me. During the Review of (Adult) Urology services I can confirm that the weekly Monday evening meetings could become quite fractious as the Department of Health were trying to get the Trust to agree to clinic activity. Mr O'Brien would not agree to the BAUS guidelines of 20 minutes for a new patient and 10 minutes for a review patient (this had been accepted in the other two Urology 'Teams' in Northern Ireland) and, whilst agreement was eventually reached, Mr O'Brien was in the minority as he wouldn't sign up to this activity and would quote this back to me over the years.

30.10 Mr O'Brien was very aggrieved with the Review of Urology Services (2009), particularly the removal of radical pelvic surgery from Craigavon Hospital and it was his view, and he said it on a few occasions, that patients had died as a result of this decision. Mr O'Brien would have openly said that Mark Fordham (external author of the paper) should never have been allowed to be involved in suggesting this recommendation.

30.11 Mr O'Brien didn't hide the fact that he didn't work well with Dr Rankin and Mr Mackle. Both of these managers tried to manage him through the IV fluids and antibiotic review, through radical pelvic surgery moving to Belfast, and through his continuous non-compliance to triaging the new outpatients. Dr Rankin and Mr Mackle would have persevered in holding Mr O'Brien to account which, in my opinion, Mr O'Brien didn't like as he was used to 'doing it his own way'.

30.12 Mr O'Brien would often mention his legal connections through his brother and his son both being barristers and, in my opinion, made some of the medical and professional managers nervous and I would suggest was a reason for not challenging some of his practices.

30.13 I have an awareness of at least two occasions where managers had been asked to step back from managing Mr O'Brien. In approximately 2011/2012 Mr Mackle had been advised that he was being accused of bullying

b. Sr O'Neill, Clinical Nurse Specialist, came to speak with me and bring me examples of her concerns regarding Personal Information redacted by the USI, locum urologist, which I immediately brought to the attention of Mr Haynes as AMD for Urology.
c. Mr Haynes approached me regarding the team's concerns with respect to Mr Personal Information redacted by the USI and his clinical ability and we raised this with Mr Mackle and a meeting took place.
d. Mr O'Donoghue came to see me to discuss Mr O'Brien's attitude towards him at meetings and said he felt that Mr O'Brien undermined him which made working with him very difficult. I asked him if he needed me to do anything about this but he said at that time he just needed to 'vent' and that he would deal with this himself, however, I did advise him to speak with one of his other consultant colleagues about the issue.
e. During my tenure the ward sisters from Ward 3 South (Sr Magill/Sr Hunter/Charge Nurse Patrick Sheridan/Sr Caddell) would have come to see me in my office regarding their concerns about the levels of staff on the ward and their concern that it wasn't safe. On these occasions, I would have discussed the issue with their Lead Nurse and we would have worked at securing staffing from other areas. If we had been unsuccessful, then we would have spoken with Mr Carroll to assist with a solution.

38.2 During my tenure I would have been involved in responding to patient complaints, patient support queries, MLA and MP enquiries, and so on which meant I was aware of any areas of concern. I also would have attended any meetings with families who had raised a complaint and then I would have fed back any learning to my teams. As I was copied into all IR1s from the Datix system, I would always have read these and, if there were any concerns, acted on them immediately; for example, in the case of a fall of a patient in Ward 3 South who had come to harm, I would have contacted the Ward to find out details; or in the case of a medication incident, again I would have investigated this so that I was appraised of what the problem was.

v. Not conforming to booking of patients – doing his own thing

Mr O'Brien was asked on numerous occasions not to do his own scheduling of patients for theatre lists. However, he continued to do this. This entailed him ringing each patient and detailing what they needed to do or not do. Whilst this practice was good for the individual patient, no other consultant did this and, whilst he was doing this, he wasn't triaging, dictating or looking at results and was therefore doing a task that wasn't necessary. I know that, over the years, clinical managers (especially those doing his job plan/appraisal) asked him to stop this practice and explained to him the reasons why he should stop. This issue arose in this context because I understand that Mr O'Brien always requested more admin time and it was felt that, if he ceased the individual scheduling of patients, then he would have that additional time. This was always Mr O'Brien's practice which led to him not having time to do other admin but also meant that, as he scheduled his own patients, he was not conforming to chronological management and therefore, whilst he insisted it was in the patient's interest that he did the scheduling, other patients were disadvantaged.

Practice of patients receiving regular doses of Intravenous Antibiotics and Fluids

vi. I was made aware of this concern by Mr Mackle in 2010 when I was given a list of patients to arrange case discussions on and then to monitor them to ensure that they didn't come into the ward for any more IV antibiotics and fluids. From my recollection this practice had been on-going for at least 5 years before I took up post.

Benign Cystectomies

Not providing oncology patients with access to a Key Worker (Clinical Nurse Specialist)

x. I became aware that Mr O'Brien did not permit the Clinical Nurse Specialists to provide support as key worker to his oncology patients. I only became aware of this in November 2020 from the outcome of the investigations into the most recent SAI patients. This was never raised with me as a concern and, as the oncology multi-disciplinary meetings are part of the Head of Oncology Services' remit, I was never involved in these.

Not following up upon results

xi. In June 2020 when the Directors Mrs McClements and Dr O'Kane asked me to do an admin look at Mr O'Brien's patients who had gone to theatre both as an emergency and electively, I discovered that some of these patients had had investigations and it appeared that they had not had their results reviewed by Mr O'Brien. It was as a result of this that Professor Sethia (external consultant) was asked to review all the records of patients who had had a test requested by Mr O'Brien and it was apparent that some of these patients had not had follow-up. Some of these patients were part of the recent SAI and some have been subject to a Structured Clinic Record Review (SCRR). The lookback review was from January 2019-June 2020 so this issue goes back to at least January 2019 as far as I am aware.

Prescribing unlicensed drug bicalutamide

xii. I only became aware that Mr O'Brien had been prescribing the unlicensed drug bicalutamide when Mr Haynes brought this to Dr O'Kane's and my attention whilst we were undertaking the clinical aspect of the initial lookback in October 2020. This was never raised with me as a concern and, as the oncology multi-disciplinary meetings are part of the Head of Oncology Services' remit, I was never involved in these and none of the clinical staff

b. Digital dictation – This was the second area of weakness. Whilst this showed electronically how many letters there were, it didn't show if there was a letter for each patient. So, for example, if there were 8 patients who attended the clinic then I would have received a report from the Service Administrator to say there were 8 letters on the G2 system and, as part of my monitoring, I would have had to spot-check these clinics to ensure all 8 patients each had a letter. I did this spot-check every 3 months as I was assured that all patients were having a letter dictated on their attendance. However, in September 2019 I discovered during my spot-check that, whilst there were 8 patients and 8 letters on the G2 system, one patient had 3 letters (one letter to their GP, one letter to the patient with instructions, and one letter to the Clinical Nurse Specialist to review for lower urinary tract symptoms), one patient had 2 letters (one letter to the GP and then a specific one to patient with instructions), 3 patients had 1 letter each, and (unfortunately) 3 patients didn't have any letter dictated. I duly highlighted this to Mr Carroll. My observation on this is that I suspect Mr O'Brien realised this feature of the system, realised that this check was not done for every clinic, and slipped back into his old ways. I had organised a meeting about this on 8 November 2019 with Mr McNaboe and Mr O'Brien. Mr O'Brien sent me a letter dated 7 November 2019 in which he stated, '*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.'* This, in my opinion, amounted to evidence that he had decided that, when he thought he was no longer being monitored, he could start to do his own thing again.

61. Did any such agreements and systems which were put in place operate to remedy the concerns? If yes, please explain. If not, why do you think that was the case? What in your view could have been done differently?

61.1 In my opinion the systems that were in place pre-2017 remedied the concerns in respect to the IV antibiotics and the cystectomies (as described

Documents attached namely;

362. 20220329 - Email Urology Service Development meeting 20180924

363. 20220329 - Email Urology Service Development meeting 20180924 att1

and can be located in folder – Martina Corrigan – no 24 of 2022 – attachments

63. Did you raise any concerns about the conduct/performance of Mr O'Brien. If yes:

(a) outline the nature of concerns you raised, and why it was raised

63.1 During my tenure working with Mr O'Brien the main concerns that I escalated were in respect to his non-triage, patients' notes at his home, and his lack of engagement with respect to performance - both elective and emergency (e.g., not doing a ward round to help with patient flow). I would also have raised concerns regarding Mr O'Brien bringing patients in from home on the week that he was consultant urologist of the week, thereby adding more pressure to an already pressured system.

(b) who did you raise it with and when?

63.2 These concerns were raised throughout my tenure and, in particular, from 2010-2015. I mainly raised these with Mrs Trouton/Mr Mackle and Mr Young.

(c) what action was taken by you and others, if any, after the issue was raised

63.3 With respect to non-triage there was further escalation to the Director of Acute Services (Dr Rankin/Mrs Burns), who both met with and spoke to him about this.

with the lessons highlighted in Dr Dermot Hughes' overarching Serious Adverse Incident report as follows:

a. The Trust must promote and encourage a culture that allows all staff to raise concerns openly and safely.
b. Ensuring a culture primarily focused on patient safety and respect for the opinions of all members in a collaborative and equal culture.
c. The Trust must take action if it thinks that patient safety, dignity or comfort is or may be compromised and mechanisms should be put in place to allow this to happen.
d. The Trust have commenced strengthening its governance structure and there has been a lot of work on improvement being developed and led by our previous Medical Director, Dr O'Kane, and this needs to continue into all Directorates and Divisions within the Trust.

68.2 In my opinion, there has also been the following learning from a governance perspective:

a. A key learning for me is the failure of staff to formally raise concerns that they had about Mr O'Brien's practice. So, whilst we were aware of non-conformance with triage, patient notes at home, IV antibiotics and cystectomies, I think that there were a lot of missed opportunities to become aware of issues such as medication practice (bicalutamide), not having a key worker present with him during oncology consultations, not acting on results, and not being available for the morning ward rounds. Whilst I could monitor the aspects of his job that I was aware of, I do believe that, if others had raised these other concerns, we would have been in a position to address these much sooner than when they came to the fore in 2020.

was, therefore, doing a task that it wasn't necessary for him to do. I know that, over the years, clinical managers (especially those doing his job plan/appraisal) asked him to stop this unnecessary practice and explained the reasons why he should stop as he always requested more admin time and it was felt that, if he ceased the individual scheduling of patients, then he would have that additional time. But he chose to ignore this directive and continued this practice right up until he retired.

70.5 Mr O'Brien always dictated his own workload, right from the time of the Regional Review when he would not agree to the numbers of patients being booked to his clinic. The (then) Director of Acute Services (Dr Rankin) overturned this and asked that we booked the agreed number of 14 patients to his clinics (8 New and 6 Review), which we did and we ended up having to reduce this to 8 patients as Mr O'Brien wasn't finishing his clinics until 8pm at night, which was unfair on patients waiting and on the staff as this was every Tuesday evening. Mr O'Brien, when challenged about this, said he would not rush appointments, yet the rest of his peers were able to see the required number of patients without any complaints from patients that the consultations were rushed. So, once again, Mr O'Brien got to do his own thing and, in my opinion, this was a mistake by his clinical managers as to me it appeared as if he was being rewarded for his bad behaviour.

70.6 I also think that a mistake was made in the first Maintaining High Professional Standards investigation. I do feel that, in February 2017, Mr O'Brien should not have been allowed back to work so soon and particularly he should not have been able to come back until after the investigation was fully completed. There were too many issues and I think that, by allowing him back so soon, there was not a proper plan in place to manage him. For example, I now think it was a mistake that the monitoring only took place for outpatient dictation

The Assistant Director is a temporary post for which I sought and was granted a secondment from my Head of Service role. The Head and Service role has expanded over the years to take on Outpatients and Ophthalmology - this is addressed in more detail in Question 5, which also details the job summary of both posts.

1.3 In the paragraphs below I have provided a chronological list of events of my involvement in and knowledge of all matters falling within the scope of the Urology Services Inquiry Terms of Reference.

2009-2013

1.4 Key events during this time period were:

a. Regional Review of (Adult) Urology Services (2009) and the Implementation of Team South (Nov 2010) – this is addressed in more detail in questions 9, 10, 13, 14, 15.
b. Issues around accommodation in the Thorndale outpatients unit and, during this time, we secured funding and refurbished an area in Main Outpatients and we were able to move the Thorndale unit in October 2013 - this is addressed in more detail in questions 7 and 48.
c. Ongoing recruitment and retention issues – this is addressed in more detail in Questions 16, 17, 18 and 19.
d. Issues raised about staff within the Urology Team – this is addressed in more detail in question 19, 39 and 45.

1.5 Issues raised about Mr O'Brien during this time period were:

a. Administering of regular IV Antibiotics and Fluids – addressed in more detail in Questions 54, 55, 56 and 69.
b. A question was raised on the number of benign cystectomies that had been carried out by Mr O'Brien - addressed in more detail in Questions 54, 55, 56 and 69.

Aimee Crilly

From:
Sent:
To: **Subject:**

-----Original Message-----
From: Corrigan, Martina [redacted]
To: [redacted] [redacted]
Glackin, Anthony [redacted] Haynes, Mark [redacted]
[redacted] [redacted] Young, Michael
[redacted] O'Brien, Aidan [redacted] ODonoghue, JohnF
[redacted] [redacted] Tony Glackin
[redacted]
Sent: Fri, 30 Nov 2018 14:49
Subject: Monday 3 December

Dear all,

Apologies as I had meant to send this email earlier.

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

I have reinstated the PM activity.

Regards

Martina

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

INTERNAL: [redacted]
EXTERNAL : [redacted]
Mobile: [redacted]

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 06 April 2011 18:26
To: Rankin, Gillian; Mackle, Eamon
Cc: Trouton, Heather
Subject: Urology Triage
Attachments: Urology Triage.doc

Dear all,

Further to request for information for meeting with Mr O'Brien tomorrow, please see attached. I have also emailed Wendy to see if it is possible to get information on theatre start and finish times as requested.

Many thanks

Martina

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

Tel: [redacted]
Mobile: [redacted]
Email: [redacted]

Urology Triage

Update Monday 4 April 2011

There were a total of 129 letters for triage from Mr O'Brien's office – longest date was 1 February 2011 and these were a mixture of GP and other Consultant referral letters.

On Friday 1 April - Mr Young triaged 14 letters to allow for patients to be sent for ICATS clinics week beginning 4 April.

On Friday 1 April – Mr Akhtar triaged 53 letters which included 3 red flags sent up from Mandeville. From these three 2 were downgraded.

9 were upgraded to red flag and these have been left with Mandeville for appointments at Mr Akhtar's additional clinics next week. Longest wait in this is 3 February.

13 patients to GPWSI (including 1 of the downgraded red flag)
1 patient to stone service
8 patients to LUTS
1 patient was for an urgent appointment at consultant clinic
18 patients for routine consultant clinic (including 1 of the downgraded patients)
2 need to be brought into the ward
1 needs to be discussed at MDT

There are 62 letters still to be triaged by Mr O'Brien –

30 dated February (longest wait is 1 February)
32 dated March (dated from 1 March onwards)

The above figures include internal referrals – consultant to consultant

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 19 August 2011 16:20
To: michael.young[redacted] 'O'Brien, Aidan' [redacted] mehmood.akhtar[redacted]
Cc: Dignam, Paulette; Hanvey, Leanne; McCorry, Monica; Troughton, Elizabeth
Subject: Triaging

Dear all,

I have just received the bi-weekly report on outpatient activity and note that there are a total of 48 referral letters outstanding for triage these are waiting between 6 and 10 weeks. As per the Integrated Elective Access Protocol (IEAP) these should be turned around within 72 hours which I recognise is not always possible and we are normally allowed one week turnaround time.

I would be grateful if could please check your triage folders and any outstanding letters be triaged as a matter of urgency as Dr Rankin will be looking an update from me at our Tuesday AM performance meeting.

Many thanks

Martina

Martina Corrigan
Head of ENT and Urology
Craigavon Area Hospital

Tel: [redacted]
Mobile: [redacted]
Email: [redacted]

Corrigan, Martina

From: aidanpobrien [redacted]
Sent: 28 February 2012 22:05
To: Corrigan, Martina
Subject: Re: Demand Capacity Analysis surgical division 23 feb 2012
Attachments: Demand_Capacity_Analysis_surgical_division_23_feb_2012.doc

Martina,

Regarding the demand capacity analysis for outpatient, am I correct in understanding that there are 71 new patients to be seen as outpatients during March, and that there is the capacity to provide 79 patients with appointments, and that therefore, there will be no problem?

Secondly, I do hope that I should be up to date with triaging.

Thirdly, I have been concerned to find patients appointed to my clinic at CAH these past 2 weeks, and who were triaged by me and by Michael Young to the Haematuria Clinic in November 2011, and who have not been given an appointment at the Haematuria Clinic, but instead diverted to my consultant-led clinic 3 months later. I have since been advised that only those patients triaged to Haematuria Clinic and designated 'Red Flag' are actually being appointed to the Haematuria Clinic. Both Michael Young and I were off the view that all patients triaged to the Haematuria Clinic were treated effectively as Red Flags and treated equitably. Instead, these patients have not been given an appointment for three months. They have had longer to wait that those with the least important conditions who have had appointments within 2 months. I would be grateful if you would look into this for me. There is something fundamentally wrong here!

Lastly, I will meet with you in coming days to arrange review of the oncology backlog, beginning in April 2012,

Aidan.

-----Original Message-----
From: Corrigan, Martina [redacted]
To: Aidanpobrien [redacted]; Akhtar, Mehmood [redacted]; O'Brien, Aidan [redacted]; Young, Michael [redacted]
CC: Dignam, Paulette [redacted]; Hanvey, Leanne [redacted]; McCorry, Monica [redacted]; Troughton, Elizabeth [redacted]
Sent: Fri, 24 Feb 2012 15:42
Subject: Demand Capacity Analysis surgical division 23 feb 2012

Dear all

Please see attached the demand capacity analysis for urology for outpatients.

There are a few outstanding letters awaiting triage which I would be grateful if you could check and process and send to booking centre for booking.

Also we need to have a plan for the urgent reviews which are the patients waiting past their due review dates that have been deemed urgent.

Happy to discuss and I would be grateful if you could action the outstanding letters for triage.

Corrigan, Martina

From: Trouton, Heather
Sent: 20 February 2013 08:58
To: Corrigan, Martina
Subject: RE: Urology referrals

Can monica take them and give them to another consultant?

I agree they should not have been left and will address on Mr O'Briens return but in the meantime we cant leave them until he comes back from leave

Heater

From: Corrigan, Martina
Sent: 19 February 2013 15:12
To: Trouton, Heather
Subject: FW: Urology referrals

Heather

See below – this is very worrying in that Aidan is in Enniskillen on Monday and therefore will not be back until Tuesday which is another 8 days!

Martina

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

Telephone: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: McCorry, Monica
Sent: 19 February 2013 14:55
To: Corrigan, Martina
Subject: RE: Urology referrals

Thanks Martina – Aidan is on leave this week. I will show this to him on his return.

Thanks Monica

From: Corrigan, Martina
Sent: 19 February 2013 14:19
To: O'Brien, Aidan; McCorry, Monica
Cc: Reddick, Fiona; Carroll, Ronan; Trouton, Heather
Subject: RE: Urology referrals
Importance: High

Dear Aidan

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 06 March 2014 18:04
To: Robinson, Katherine
Cc: Carroll, Anita; Trouton, Heather; Burns, Deborah
Subject: Mr O'Brien triage

Katherine

Debbie and I met with Mr O'Brien and he has agreed that apart from his own named referrals, that on the weeks that he is oncall he will be no longer triaging general urology letters.

Mr Young has asked that during the week of Mr O'Brien's oncall, can the general urology letters that Mr O'Brien would have triaged please be left with him for triaging.

I note that the next weekday that Mr O'Brien is oncall for March is actually 31 March, so this will not happen until then.

Any issues can you please highlight to me in the first instance.

Many thanks

Martina

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

Telephone: [redacted]
Mobile [redacted]
Email: [redacted]

100 Q. So this draft, the 18th January 2016, and the ultimate letter handed on 30th March 2016 have been altered, just in detail, and I want to identify that. But did you do another draft of this letter or is this the last draft that you sent to Mrs. Trouton and Mr. Mackle? 11:02

A. This is the last draft I sent. I did update the figures but I didn't do anything with the draft of the letter. That's this last one.

101 Q. We'll look at that in a second. I think you updated the letters on the day of the 30th March, is that right? 11:03

A. That's right. Yes.

102 Q. Okay. So the first part of this, I just wanted to read some of this out, as I say, because it has just been received by the Panel. The first paragraph in that, you speak to un-triaged outpatient referral letters. And you have said: 11:03

"There are currently 253 un-triaged letters outstanding from the period of time when you were on call. These are dating back to November 2014." 11:03

I just want to ask you about that. Where did you get those figures from for this letter? Where was the source of your hard data, as it were, for this correspondence. 11:03

A. For the un-triaged letters, I would have got that from the Referral and Booking Centre, so most likely through Mrs. Robinson. I would have asked her and she would