Urology Services Inquiry

UROLOGY SERVICES INQUIRY

Note: Two addenda to this statement were received by the Inquiry on 21 September 2023 at WIT-100409 to WIT-100418 and 31 October 2023 at WIT-103533 to WIT-103589. Annotated by the Urology Services Inquiry.

USI Ref: Notice 20 of 2022

Date of Notice: 29 April 2022

Witness Statement of: Mr Robert James Brown (Known as Robin Brown)

I, Robin Brown, will say as follows:-

General

1. Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.

1.1 I was a Clinical Director (CD) for Surgery and Elective care (SEC) in the SHSCT from 02.01.2008 to 31.03.2016. Please see paragraphs 6.2-5 for full details of my changing role. In my role as CD, my responsibilities included operational management, performance, governance, recruitment, job-planning, appraisal, medical education and more – please see **Appendix 2**. In the beginning I was responsible for surgery and all surgical specialties across the Trust but, as I was located in Daisy Hill Hospital (DHH), this proved to be impractical, and my managerial influence on the Craigavon site was very limited. The Trust appointed a second CD, Ms Samantha Sloan, on the Craigavon site, with responsibilities including Urology, on 01.09.2010. I therefore had managerial responsibility for Urology from 01.01.2008 until 01.09.2010. Please see paragraphs 6.2-5 and **Appendices 2-4.**

the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Statement of Truth

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

Signed: _____ Personal Information redacted by the USI [redacted] _____

Date: _____15/06/2022_____

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice Number 20 of 2022
Date of Notice: 29th April 2022

Addendum Witness Statement of: Mr Robert James Brown (Known as Robin Brown)

I, Robin Brown, will say as follows:-

I wish to make the following amendments and additions to my existing response, dated 15th June 2022, to Section 21 Notice number 20 of 2022:

1. Paragraph 1.1 (WIT-17509) should be amended to state the following:

*1.1 I was a Clinical Director (CD) for Surgery and Elective care (SEC) in the SHSCT from its inception on 02.01.2008 to ~~31.03.2016~~ **01.09.10**. Please see paragraphs 6.2-**7** for full details of my changing role. In my role as CD, my responsibilities included operational management, performance, governance, recruitment, job-planning, appraisal, medical education and more – please see Appendix 2. In the beginning I was responsible for surgery and all surgical specialties across the Trust but, as I was located in Daisy Hill Hospital (DHH), this proved to be impractical, and my managerial influence on the Craigavon site was very limited. The Trust appointed a second CD, Ms Samantha Sloan, on the Craigavon site, with responsibilities including Urology, on 01.09.2010. I therefore had managerial responsibility for Urology from 01.01.2008 until 01.09.2010, **and again from 12.12.2011 until my retirement on 31.03.2016.** I have had a short conversation with Sam Hall to identify the period when I was CD for Urology which was between 12.12.11 and 21.03.16. Please see paragraphs 6.2-**7** and Appendices 2-4.*

2a. Paragraph 1.5 (WIT-17510) should be amended to state the following:

1.5 ~~There are no other occasions, that I can recall, when I had significant engagement in the Urology department.~~ I was CD for Urology but this was a difficult role to perform from Daisy Hill Hospital where my job was largely clinical. I had 1 PA (4 hours) allocated for management and, for most of my tenure, I was not supported by a lead clinician. Prior

answer to question 53.' This should state '*I was CD for Urology from 01.01.2008 to 31.08.2010,* ***and again from 12.12.2011 to 31.03.2016****. I assisted with the job-planning process in 2013, as described in my answer to question 53*.'

29. At paragraph 69.3 (WIT-17558), I have stated *'I was CD for the whole of SEC (including Urology), across two hospital sites, from 01.08.2008 to 31.08.2010, and based in DHH.'* I would like to add the following sentence *'I was CD for General Surgery in DHH and for Urology in CAH from 12.12.2011 to 31.03.2016.'*

30. At paragraph 70.3 (WIT-17559), I have stated '*During my tenure as CD for Urology, 01.01.2008 – 31.08.2010, I don't recall any governance issues arising or being brought to my attention.'* This should state *'During my tenure as CD for Urology, ~~01.01.2008 – 31.08.2010,~~ I don't recall any* ***other*** *governance issues arising or being brought to my attention.'*

31. At paragraph 71.1 (WIT-17559), I would like to add the following sentence to the end of the paragraph:

Even after that there were still only 2 CD's for the whole of SEC.

Statement of Truth

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

Signed: Personal Information redacted by the USI [redacted]

Date: 20.09.2023

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice Number 20 of 2022

Date of Notice: 29 April 2022

Further Addendum Witness Statement of: Robin Brown

I, Robin Brown will say as follows:-

1 At paragraph 24.2 (WIT -17526) I have stated, '*The first was in respect of inappropriate disposal of chart material by Mr Aidan O'Brien. I was asked by Zoe Parks (HR) to carry out an investigation. I had training in MHPS investigations delivered by the National Clinical Assessment Service (NCAS) on 27.02.2008'*. On further reading of archived emails, I now know that the Investigation into the disposal of chart material in a bin was carried out using the Trust Disciplinary Policy rather than MHPS as stated in paragraph 24.2 of my Section 21 response. From a practical point of view the process, for me, was identical no matter which protocol was in place. It involved interviewing witnesses, preparing statements, writing a report and issuing a warning. The final report was sent by Zoe Parks to Eamon Mackle and Heather Trouton for approval prior to issue of an informal warning. I was not copied into their responses *(see 1. FW Disciplinary Investigation - STRICTLY PRIVATE AND CONFIDENTIAL FOR ADDRESSEE EYES ONLY, A1-A3*).

2 **Outstanding Triage - September 2011** Heather Trouton asked me to speak to a Consultant in another specialty (not Urology) in September 2011 regarding outstanding triage. He had 141 letters stretching back 27 weeks. This practitioner was an employee of the Belfast HSC Trust who had an outreach clinic in DHH where he saw patients from the Southern Trust (*see 5.-6. FW demandcapacity, A1*). I have extracted the information relating to outstanding triage and numbers of patients waiting for new and review appointments (*see 7. Appendix 3. Extract - Outstanding Triage and numbers of patients awaiting new and review outpatient*

to the formation of the SHSCT I had been a CD in Daisy Hill Hospital alone and had responsibility for Surgery and Anaesthetics. I was able to manage that role effectively: I had agreed job plans with all my consultants and had time to design some important innovations. I was close to my team on a daily basis and had ready access to the soft intelligence that is so important to managing a department. I also had the adjacency and availability of all the managers that facilitated the exchange of information and advice and it worked well.

2b. I would like to add the following paragraphs after paragraph 1.5 (WIT-17510):

1.6 Things changed with the inception of the new Trust. The management systems in DHH were largely moved to CAH. All of the AMDs for acute services were then in CAH and I was remote for the 'nerve centre' of the Trust. My information came through official channels but even that was not all that effective given the communication difficulties relating to travel between sites, videoconferencing and simply my availability for meetings. The biggest problem was the lack of opportunity for acquiring soft intelligence or the ability to pop into a manager's office for a quick chat which makes for effective management. I knew a lot about my team in Daisy Hill Hospital but had little knowledge of the teams in CAH.

1.7 Videoconferencing (VC) was meant to address the problem of communication between the two sites but it was ineffective in my view for the following reasons:

(i) In most cases I was the only participant from DHH. If the link did not work meetings often simply proceeded at the CAH side;

(ii) Efforts were made to schedule meetings to suit my availability but all managers and most other participants were on the CAH side and it was often not practical to schedule a meeting around my availability;

(iii) The meeting room was in CAH and I was the person on the screen in the corner which did not make for good interaction. It was not like Zoom or Teams. The microphone was placed in the middle of the table and all conversations were picked up and superimposed. There were attempts to introduce protocols so that only one person spoke at a time but this never worked. I do recall that the only VC that

Stinson, Emma M

From: Brown, Robin <[redacted]>
Sent: 19 February 2013 19:00
To: Mackle, Eamon; Hall, Sam
Cc: Trouton, Heather; Rankin, Gillian
Subject: RE: Job Plans
Attachments: JOB-PLANNING CHART Mr B.docx

The attached chart show where we are with the job plans at present.
I am struggling to find the time to progress so many job-plans at the same time and so some assistance would be appreciated.

Robin

-----Original Message-----
From: Mackle, Eamon
Sent: 19 February 2013 17:59
To: Brown, Robin; Hall, Sam
Cc: Trouton, Heather; Rankin, Gillian
Subject: Job Plans

Hi Robin

I have been talking to Gillian about Job Plans and she needs them finished in the next month. I appreciate your workload so we need to split them up. Therefore can you do Adrian's and Damian's. Also have you done the two Assoc Specs and the permanent staff grades?

Sam Hall has agreed to do 4 of the CAH cons (Gareth, Manos, Muhammed and Alastair) and I will do the remainder.

Also when can I see the new urology Job Plans to check if they match the principles agreed with Gillian at the monday evening meetings?

Eamon

has increased to six or seven (I'm not sure exactly) since then and there are many more middle grade and junior staff. The Trust would have information on the dates of appointment of new staff and dates when others left. I do know, from my own personal experience of referring patients to the unit, and later in 2016/7 of working in the unit, that all the consultants had long waiting lists for outpatient appointments and elective surgery. I do not know if these waiting lists were longer than waiting lists in other urology units across the province. I would not have sufficient knowledge of the staffing and throughput of the Urology department to say whether the long waiting lists were due to inadequate staffing or not.

17. Were you aware of any staffing problems within the unit since its inception? If so, please set out the times when you were made aware of such problems, how and by whom.

17.1. From about 1995 I became aware that the Urology service had long waiting times for outpatient and inpatient services. I knew about the long waiting times because I referred patients to the service. I do not know if this was due to staffing or demand. I do not know how, or if, this changed over time as more staff were recruited or if waiting times were significantly different to other urological units in the region. I was not involved in the recruitment process in the Urology department. I think Michael Young or Heather Trouton would be able to answer this question.

18. Were there periods of time when any posts within the unit remained vacant for a period of time? If yes, please identify the post(s) and provide your opinion of how this impacted on the unit. How were staffing challenges and vacancies within the unit managed and remedied?

18.1. The Trust would have records of the appointments, resignations and retirements of staff in the unit. I do not know if there were posts that were vacant for significant periods. Michael Young, Heather Trouton and Simon Gibson would have this knowledge.

19. In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of urology services?

hospital, I had only very limited understanding of the changing staffing arrangements in in the Urology.'

9. I would like to amend paragraph 20.1 (WIT-17524) to the following:

20.1. I had clinical engagement with the Urology service from 1993 to 2017. I provided a basic, and mainly diagnostic, urological service in DHH and I referred a lot of patients to the CAH Urology department. I observed the department develop from a single-handed consultant (Aidan O'Brien) to a team of six or seven consultants (I'm not sure exactly) and a complement of junior staff and trainees. During the **first** period from 2008-2010 when I was CD, I think that the number of consultants increased to three. I know that there was Aidan O'Brien and Michael Young, but I am not completely sure if there was a third or of the name. **During the second period from 2011-2016 there were several consultant appointments, several resignations and a number of temporary locums. There was also an expansion of the middle tier.** ~~There may have been other staff who were appointed resigned or replaced during my tenure, but~~ I have no accurate recollection of precisely when staff came or left. The Trust could provide information on dates of appointments and resignations. Again I think Michael Young (Lead Urologist), Martina Corrigan (HOS) or Heather Trouton (AD) would be able to provide information on staffing.

10. At paragraph 21.1 (WIT-17525), I have stated '*I was CD for SEC (Including Urology) for 2 years and 9 months from 01.01.2008 to 31.08.2010 and CD for DHH (not including Urology) from 01.09.1010 to 31/03/2016.*' This should state '*I was CD for SEC (Including Urology) for 2 years and 9 months from 01.01.2008 to 31.08.2010 and* ***subsequently CD for DHH and Urology from November 2011 to March 2016.'***

11. At paragraph 24.1 (WIT-17526), I have stated '*There were two occasions when concerns were raised with me. On both of these occasions I wasn't CD for Urology, though I think that we probably all worked together and didn't apply rigid boundaries. In the first instance, as set out in paragraph 24.2, the CD was Ms Samantha Sloan. In the second instance, as set out in paragraph 24.3, the CD was Mr Sam Hall.'* This should state '*There were two occasions when concerns were raised with me. In the first instance, as set out in paragraph 24.2, the CD was Ms Samantha Sloan. In the second instance, as set out in paragraph 24,* ***I was CD for Urology.'***

19.1. In my view, practically every department in the HSC is under-resourced and understaffed. I do not know if the stresses felt in Urology were greater than other specialties. I do not know if there were staffing problems and, if there were, whether they impacted upon management and governance. I have had minimal, managerial involvement in the Urology unit for nearly 12 years, so I am not very familiar with these issues.

20. Did staffing posts, roles, duties and responsibilities change in the unit during your tenure? If so, how and why?

20.1. I had clinical engagement with the Urology service from 1993 to 2017. I provided a basic, and mainly diagnostic, urological service in DHH and I referred a lot of patients to the CAH Urology department. I observed the department develop from a single-handed consultant (Aidan O'Brien) to a team of six or seven consultants (I'm not sure exactly) and a complement of junior staff and trainees. During the period from 2008-2010 when I was CD, I think that the number of consultants increased to three. I know that there was Aidan O'Brien and Michael Young, but I am not completely sure if there was a third or of the name. There may have been other staff who were appointed resigned or replaced during my tenure, but I have no accurate recollection of precisely when staff came or left. The Trust could provide information on dates of appointments and resignations. Again I think Michael Young (Lead Urologist), Martina Corrigan (HOS) or Heather Trouton (AD) would be able to provide information on staffing.

21. Has your role changed in terms of governance during your tenure? If so, explain how it has changed with particular reference to urology services, as relevant?

21.1. Governance is part of the role of any clinical manager. Clinical managers include the Clinical Director, Associate Medical Director, Medical Director and Director of Acute Services. The CD's role was mainly dealing with high, and often immediate priority, issues such as staffing, recruitment, rotas, timetables etc. Governance was part of it, but I would not have had in-depth knowledge, or total overview, of all the governance arrangements and issues in all of the six departments for which I had responsibility. These six

departments were General Surgery in DHH, General Surgery CAH, Urology CAH, ENT CAH, Orthopaedics CAH and Ophthalmology CAH. Please see paragraph 1.2. I was CD for SEC (Including Urology) for 2 years and 9 months from 01.01.2008 to 31.08.2010 and CD for DHH (not including Urology) from 01.09.1010 to 31/03/2016. During that time my contribution to governance in Urology was mostly reactive, in that I addressed issues brought to my attention. Please see paragraphs 24.2 and 24.3.

22. Explain your understanding as to how the urology unit and urology services were supported by non-medical staff. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to the medical and nursing staff. If you not have sufficient understanding to address this question, please identify those individuals you say would know.

22.1 The Urology Service was supported by the Head of Service, Martina Corrigan who reported to Simon Gibson (AD) followed by Heather Trouton (AD).There were many other non-clinical staff who worked with Martina, Simon and Heather but I am not able to accurately recall names and titles. I think that Martina Corrigan, Simon Gibson and Heather Trouton would be able to supply this information. There were, for example, operational support leads, cancer trackers and booking centre staff. I was based in DHH and virtually all the support services and non-clinical managers were located in CAH.

23. Do you know if there was an expectation that administration staff would work collectively within the unit or were particular administration staff allocated to particular consultants? How was the administrative workload monitored?

23.1 To my knowledge each consultant had their own secretary. The Head of Service would have worked with the team and was not allocated to a particular consultant. I do not know how administrative workload was monitored. I would suggest that Martina Corrigan (HOS) or Heather Trouton (AD) could answer this question.

24. Were the concerns of administrative support staff, if any, ever raised with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what, if anything, you did in response.

Service Based Agreements agreed with the Department of Health (DoH) related to quantities and access times for new outpatients and elective access. There were no access targets for outpatient review patients. I was not party to any of the negotiations with the DoH or subsequently with the Urology team. I do not know if it was one of these two issues or something else which led to disagreement between Mr Mackle and Mr O'Brien. I only recall that Mr Mackle did stop engaging directly with Mr O'Brien but I do nor recollect that he had any issues with anyone else in Urology.

15. Paragraph 31.2 (WIT-17530) should be amended to the following:

31.2 ~~I was CD for Urology from 01.01.2008 to 31.08.2010. My~~ ***As CD my*** *responsibilities included operational management, performance, recruitment, governance, job-planning appraisal and medical education. As outlined in paragraph 1.2, I was unable to have complete managerial oversight of all of these responsibilities* ***in Urology in*** *CAH. Apart from the issues already outlined in my answers to question 24, I do not recall any other issues relating to governance in the Urology service.*

16. Paragraph 33.1 (WIT-17531) should be amended to the following:

33.1. Governance was part of the role of all the clinical and non-clinical managers supported by the Medical Director, the Director of Acute Services and a number of departments in the Trust. Given my remote location, I had very little day to day oversight of governance in the Urology service. ~~, when I was CD from 01.01.2008 – 31.08.2010.~~ I was aware that the consultants engaged in the Morbidity and Mortality (M&M) meetings and were subject to yearly appraisal. Other governance processes such as Incident reporting, MDMs and mandatory training were ~~just being~~ developed during my tenure. Governance arrangements have developed considerably since ~~2010~~ ***inception of the Trust*** *and continue ~~involved in reviewing IR1s (Incident Reports). I was never involved in reviewing complaints. Urology MDM's started on 01.04.2010. Mandatory training was introduced on 24/11/2009. Appendix 25. Mandatory training modules are added from time to time. I have appended my most recent training passport as an example, Appendix 26.~~ to do so. Morbidity and mortality processes were in place at inception of the Trust. Incident reporting was introduced in January 2009 Appendix 18. I was never involved in reviewing IR1s (Incident Reports).* ***I was never involved in reviewing complaints.*** *Urology MDM's started*

24.1. There were two occasions when concerns were raised with me. On both of these occasions I wasn't CD for Urology, though I think that we probably all worked together and didn't apply rigid boundaries. In the first instance, as set out in paragraph 24.2, the CD was Ms Samantha Sloan. In the second instance, as set out in paragraph 24.3, the CD was Mr Sam Hall.

24.2. The first was in respect of inappropriate disposal of chart material by Mr Aidan O'Brien. I was asked by Zoe Parks (HR) to carry out an investigation. I had training in MHPS investigations delivered by the National Clinical Assessment Service (NCAS) on 27.02.2008. I had carried out one previous investigation and assisted in a second. The role of the case investigator is to investigate the concern, produce a report, and forward it to the case manager. The role of the case investigator does not include deciding when to initiate an investigation or to decide what action should be taken as a result of the investigation. The report would have been forwarded to the case manager, Eamon Mackle, for information/action. **Appendix 12**. The case investigator takes no further part in the process. The case manager determines the outcome, and in this case I understand that it was an informal warning as I had suggested at the end of my report.

24.3 On a second occasion, in June or July 2013, Heather Trouton (AD) asked me to speak to Mr O'Brien regarding his practice of taking patient's charts home. I met him informally at the end of a clinic in the Outpatient department of CAH in June or July. I advised him that the practice was inappropriate as charts may be needed for other services. This was a verbal exchange, there is no written record. To my recollection he accepted that the practice was not appropriate. I spoke with him again in November 2013, by telephone, in relation to the same issue and also regarding missing triage. Again this was a verbal exchange, and whist there is no written record, it is mentioned in the email trail, **Appendix 13.** This email trail documents the efforts of Heather Trouton, Martina Corrigan, Michael Young, myself and others to address the issue of missing triage. I have removed the list of patients' names from the original email. The outcome of that exchange of emails was that Aidan O'Brien advised that he would catch up. *"I can assure you that I will catch up, but am determined to do so in a chronologically ordered fashion."* Michael Young also agreed that he and his colleagues in the Urology Unit would assist with the backlog.

Strictly Private and Confidential

Report of Disciplinary Investigation

Mr Aidan O'Brien, Consultant Urologist,
Craigavon Area Hospital

Investigation Team:
Mr Robin Brown, Clinical Director, General Surgery
Mrs Zoe Parks, Human Resources Manager

Date:
June 2011

5.0 CONCLUSION

The investigating team took into account the information provided by Mr O'Brien in relation to this matter and would conclude that the following allegation is proven.

That on 15 June 2011, Mr O'Brien disposed in the confidential waste a section of filing from a patient's chart. This consisted of fluid balance charts, mews charts, TPN prescription forms, Aminoglycosides prescription form and a prescription kardexes.

Mr O'Brien readily admits that he inappropriately disposed of patient information in the confidential waste. He readily admits that this was in error, that he should not have done it and will not do it again. I think that it is also important to note that Mr O'Brien says that he spends more time writing in and filing in charts than probably any other Consultant and from my own personal experience I can confirm that that is the case. Mr O'Brien has the utmost respect for patients, for their information and for the storage of records. This was an unusual behaviour which was the result of frustration from dealing with a large unwieldy chart, difficulties retrieving important information from the chart, and from the difficulty finding anywhere suitable to make good quality records.

The motivation for the incident was honourable in that Mr O'Brien was trying to make an entry in the chart, though the solution to the problem was clearly wrong. I am satisfied that Mr O'Brien has accepted his error and agreed that it will not happen again. I do not think that a formal warning is appropriate to the scale of the case and I would recommend an informal warning, this has effectively already taken place as part of the process.

Mr Robin Brown
Clinical Director
General Surgery

Mrs Zoe Parks
Medical Staffing Manager

Corrigan, Martina

From: Trouton, Heather <[redacted]>
Sent: 26 November 2013 11:40
To: Young, Michael; Brown, Robin
Cc: Corrigan, Martina; Carroll, Anita
Subject: FW: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Follow Up Flag: Follow up
Flag Status: Flagged

Dear Both

In confidence please see below.

I personally have spoken to Mr O'Brien about this practice on various occasions and Martina has also much more often. While we very much appreciate Aidan's response, I suspect that without further intervention by his senior colleagues it will happen again.

I also spoke to him not more than 4 weeks ago both about timely triage and having charts at home and he promised me he would deal with both, however we find today that patients are still with him not triaged from August , he would have known that at the time of our conversation yet no action was taken. I am also advised today that a further IR1 form has been lodged by health records as 6 charts cannot be found.

As stated by Aidan we have been very patient and have offered any help in the past with regard to systems and processes to assist Aidan with this task but it has not been taken up and the delays continue.

Despite the fact that patients sitting not triaged from August mean that we have breached the access standard before we even start to look for appointments I am more concerned about the clinical implications for patients who need seen urgently and possibly even needing upgraded to a red flag status.

We really need you to speak with Mr O'Brien both in the capacity of a colleague but also in your capacity of Clinical lead and Clinical Director for Urology as well of course as patient advocates.

I also really need a response within 1 week on how this is being addressed for now and the future or I will be forced to escalate to Debbie and Mr Mackle as Director and AMD for this service. It has already been suggested that Dr Simpson be involved which I have not progressed to date but it may have to come to that unless a sustainable solution can be found.

Thank you for your assistance

Heather

From: Corrigan, Martina
Sent: 26 November 2013 08:02
To: Robinson, Katherine; Glenny, Sharon
Cc: Trouton, Heather
Subject: FW: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Dear both

Please see below – Katherine can you advise if you receive these?

We really need you to speak with Mr O'Brien both in the capacity of a colleague but also in your capacity of Clinical lead and Clinical Director for Urology as well of course as patient advocates.

I also really need a response within 1 week on how this is being addressed for now and the future or I will be forced to escalate to Debbie and Mr Mackle as Director and AMD for this service. It has already been suggested that Dr Simpson be involved which I have not progressed to date but it may have to come to that unless a sustainable solution can be found.

Thank you for your assistance

Heather

From: Corrigan, Martina
Sent: 26 November 2013 08:02
To: Robinson, Katherine; Glenny, Sharon
Cc: Trouton, Heather
Subject: FW: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Dear both

Please see below – Katherine can you advise if you receive these?

Thanks

Martina

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

Telephone: Personal Information redacted by the USI (Direct Dial)
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: O'Brien, Aidan
Sent: 26 November 2013 02:08
To: Corrigan, Martina
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Martina,
I really am so sorry that I have fallen so behind in triaging.
However, whilst on leave, I have arranged all outstanding letters of referral in chronological order, so that I can passed them to CAO via Monica in that order, beginning tomorrow.
I know that I have fallen behind particularly badly (except for red flag referrals which are up to date) and I do appreciate that this causes many staff inconvenience and frustration, and that all have been patient with me!
I can assure you that I will catch up, but am determined to do so in a chronologically ordered fashion,

Aidan

From: Corrigan, Martina
Sent: 24 November 2013 17:28
To: O'Brien, Aidan
Cc: McCorry, Monica; Robinson, Katherine; Glenny, Sharon
Subject: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE
Importance: High

Corrigan, Martina

From: Trouton, Heather <[redacted]>
Sent: 04 December 2013 18:40
To: Young, Michael; Brown, Robin
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE
Attachments: image001.png

Michael

I certainly didn't expect it to be sorted within a few days , and to be honest was surprised to be advised that triage was being taken over as I agree it is not fair to ask the other three surgeons to bear this workload. Robin and I had discussed just yesterday and were planning to meet with Aidan next week to fully discuss this issue. I'm sorry that I was given not totally correct information.

Thankyou for helping with the backlog. Happy to discuss further next week to try to come up with a sustainable solution.

Heather

From: Young, Michael
Sent: 03 December 2013 18:57
To: Trouton, Heather; Brown, Robin
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Not sure if the messages have transposed well Also not sure 'if it is unlikely that Aidan will change' is correct. I do agree however with the chart issue.
I have offered to help out to get the backlog sorted. This should not have been interpreted as a complete take over of the triage. I do not think it acceptable to ask the other consultants to take up this task – this has not been talked about / discussed etc, yet decisions are being made. I do not find this acceptable. You have expected this issue to have been completely sorted within a matter of a few days. I said I would help sort this out and am doing so.

MY

From: Trouton, Heather
Sent: 03 December 2013 17:28
To: Young, Michael; Brown, Robin
Cc: Corrigan, Martina; Carroll, Anita
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Dear Both

Michael, thank you for speaking with Aidan again.

Robin and I had a conversation about this this morning and the only solution we see if it is unlikely that Aidan will change practice is for triage to no longer go to him. I appreciate this will put an increased burden on yourself, Tony and Mr Surresh but it is just too critical to leave as it is.

I believe you have already agreed to do this for the general triage (Martina informs me) which is great and much appreciated.

We will have to closely monitor the returns of the named referrals though and Anita can you please ask Katherine to let us know early if there are any problems arising?

Learning

66. Are you now aware of governance concerns arising out of the provision of urology services, which you were not aware of during your tenure? Identify any governance concerns which fall into this category and state whether you could and should have been made aware and why.

66.1. I retired from clinical practice on 31.03.2016. I continued to provide clinical services on a temporary contract until 31.03.2017 as set out at paragraph 5.1. Whist I still work part-time for the Trust, virtually all my work is done from home, (please see paragraph 5.3). I was told by Mr Haynes, on 14.10.2020, that there was a plan to review some of Mr O'Brien's patients, because his treatments of cancer patients was not consistent with guidelines as set out at paragraph 54.3. I understand from the media that a look-back exercise was undertaken. During the time when I was engaged in clinical practice, and particularly when I attended Urology MDMs, I was not aware of any variance in cancer management. I understand that this issue came to light after I ceased clinical practice.

66.2. In relation to the missing triage and charts at home as referred to at paragraphs 24.3 and 55.3, I understood that agreement had been reached then to address the issue. If there was an on-going issue with triage I would expect that it would have been drawn to the attention of one of the clinical or non-clinical managers on the CAH site. I was not aware on an on-going issue with triage.

67. Having had the opportunity to reflect, do you have an explanation as to what went wrong within urology services and why?

67.1. I never knew that Mr O'Brien's treatment of cancer patients was different to anyone else's. The principle of MDMs is that treatment plans are agreed by the team based upon guidelines and best practice. I don't know why he chose to treat his patients differently to guidelines or how this came to light. I don't know the reason why he did not apply the treatment plans agreed at MDM.

67.2. I also understand from the media that Mr O'Brien had fallen behind with triage again. I do not know if the problem persisted or recurred. If it was a persistent problem, then I think that information would have been known to the non-clinical managers, Martina

54.3. I first became aware of the more recent issues of concern about three and a half years after I retired on 31.03.2016. Mr Mark Haynes texted on 14.10.2020 requesting a Zoom meeting, which we had immediately. He advised me that issues had been raised about Mr O'Brien's management of some cancer patients and asked me if I could assist with a look-back exercise of patients' charts. I can't exactly remember what the issues were, but I think it was something about differences between his treatment of some cancer patients and guidelines. I advised him that I had a long and good professional relationship with Mr O'Brien and that I might not be considered sufficiently impartial. Mr Haynes advised me that my basic knowledge of urology placed me in an ideal position to do the exercise. I reluctantly agreed, but I did not hear from Mr Haynes again. I did not assist with the look-back exercise. I had no idea, until that telephone contact that there were any issues with Mr O'Brien's management of cancer patients.

55. Please detail all discussions (including meetings) in which you were involved which considered concerns about Mr. O'Brien, whether with Mr. O'Brien or with others (please name). You should set out in detail the content and nature of those discussions, when those discussions were held, and who else was involved in those discussions at any stage.

55.1. There were three occasions when I was involved in discussions about concerns in relation to Mr O'Brien – please see paragraphs 24.1-3 and **Appendices 12 & 13,** and paragraph 54.3.

55.2. The first issue of concern was in respect of inappropriate disposal of chart material by Mr Aidan O'Brien in June 2011.

- I was asked by Zoe Parks (HR) to carry out an investigation. I do not know if this was in person or by telephone call. I can't find an email relating to this.
- 22.6.2011. I wrote to Mr O'Brien inviting him to attend for interview on 23.06.2011 at 4pm. **Appendix 12**, "*Report of Disciplinary Investigation, appendix 1".*
- 23.06.2011. Zoe Parks and I Interviewed Aidan O'Brien in relation to the inappropriate disposal of chart material. "*Report of Disciplinary Investigation, appendix 3".*
- 24.06.2011, Zoe Parks and I Interviewed Shirley Tedford, (Urology Ward Sister) and, later in the same meeting, Sharon McDermott (Urology Ward Clerk), "*Report of Disciplinary Investigation, appendix 4".*

appointments - 15 Sept 2011). Initially I had difficulty contacting him as his single clinic clashed with my operating list. I did speak to him, and whilst it was 12 years ago, to the best of my recollection, he did complete his outstanding triage. Of note, at that time Aidan O'Brien had 2 patients awaiting triage. I do not recall being informed about Mr.O'Brien having an issue keeping up with triage before 2013. Therefore, when Mr.O'Brien assured me in November 2013 that he would catch up with his triage I accepted that assurance and believed that he would keep it under control.

3 **Triage in Daisy Hill** Triage was an issue in other parts of the Trust. In particular, it was an ongoing issue in Daisy Hill in 2013 and 2014 (*see 8.-9. FW DHH Triage issues, A1 and 10.-11. FW Triage of elective referrals, A1*). The problems there related to new staff appointments and their preferences, i.e. what they wished to undertake in triage and what they did not want to be triaged by others on their behalf. Negotiations were complicated and protracted and I have included two emails referring to the issues.

Statement of Truth

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

Signed: Personal Information redacted by the USI [redacted]

Date: 30/10/2023

UROLOGY SPECIALTY

UROLOGY	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
			Sept			+5			+5	
	109		Oct							Cannot give figures, rejigging of job plans
Total										

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS – Aug/Sept 2011

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Mr O'Brien	Urology	CAH	2 (9/8/11)	5 (15/8/11)	57 (Aug 2011)
Mr Young		CAH	4 (11/8/11)	3 (22/8/11)	52 (Aug 2011)
Mr Akhtar		CAH	1 (10/8/11)	7 (22/8/11)	0
Mr O'Brien		BBPC			26 (May 2011)
Mr O'Brien		ACH			9 (June 2011)
Mr Young		BBPC			3 (July 2011)
Mr Young		ACH			4 (June 2011)
Mr Akhtar		STH			
Dr Rogers		CAH			
GURO		CAH			

Received from Robin Brown on 31/10/2023. Annotated by the Urology Services Inquiry.

91. As detailed in Questions 16-18 above, Consultant numbers varied until 2014 and this had an effect on the percentage of emergency work for each individual surgeon to the detriment of their elective work.

[21] Did your role change in terms of governance during your tenure? If so, how?

92. In 2012 (I am unsure of the exact date) I was informed that that the Chair of the Trust (Mrs Roberta Brownlee) reported to Senior Management that Aidan O'Brien had made a complaint to her that I had been bullying and harassing him. I was called into an office on the Administration floor of the hospital to inform me of the accusation. I was advised that I needed to be very careful where he was concerned from then on. I recall being absolutely gutted by the accusation and I left and went down the corridor to Martina Corrigan's office. Martina immediately asked me what was wrong, and I told her of what I had just been informed. In approximately 2020, I truthfully had difficulty recalling who informed me. Martina Corrigan said I told her at the time that it was Helen Walker, AD for H.R. I now have a memory of same but can't be 100 percent sure that it is correct. I recall having a conversation with Dr Rankin who advised that, for my sake, I should step back from overseeing Urology and I was advised that Robin Brown should assume direct responsibility. I was also advised to avoid any further meetings with Aidan O'Brien unless I was accompanied by the Head of Service or the Assistant Director. As a result, I instructed Robin Brown to act on all Governance issues regarding Urology and in particular any issue concerning Aidan O'Brien. At my next meeting with John Simpson, I advised him of the issue and the change in governance structure in Urology. There was no formal investigation of the complaint, and I have checked with Zoe Parks (Head of Medical HR) and she says that there is no record on my file of the accusation.

12. At paragraph 24.3 (WIT-17526), I have stated '*On a second occasion, in June or July 2013, Heather Trouton (AD) asked me to speak to Mr O'Brien regarding his practice of taking patient's charts home.*' This should state '*On a second occasion, in June or July 2013,* ***Deborah Burns (DAS) or*** *Heather Trouton (AD) asked me to speak to Mr O'Brien regarding his practice of taking patient's charts home.'*

13. Paragraph 30.1 (WIT-1729-17530), should be amended to the following:

30.1. During my tenure the AMD was Eamon Mackle, the Head of Service was Martina Corrigan and the Assistant directors were Simon Gibson followed by Heather Trouton. ~~I don't know exactly when Heather Trouton replaced Simon Gibson, as set out in paragraph 6.4.~~ It was my experience that the urologists worked very well together and with me. I was not aware of any difficulties interacting with me or any of the clinical or non-clinical managers, ***apart from Mr Mackle. See additional paragraph 30.2.*** *Any management interaction I had with the Urologists, and for which I have some recollection, was always very professional – please see paragraphs, 24.2, 24.3 and 53.1. I do clearly recall a lot of interaction with the urologists when I was employed as a locum in the urology department from 01.09.2016 to 31.03.2017 and it was always amicable. I saw the urologists interact with each other and with Martina Corrigan, Head of Service, and on all occasions the conversations were very professional.*

14. I would like to add the following paragraph after 30.1 (WIT-17530):

30.2. Mr Mackle stated in his evidence that he was accused of bullying and harassment by Mr O'Brien. Whilst I would not question the factual accuracy of his evidence, I cannot recall ever knowing about it. I do now recall that there was a period of time when Mr Mackle was not on good terms with Mr O'Brien. I think this was around 2012 but I have nothing on record to confirm. I know that Mr Mackle and Mr O'Brien had been engaged in some difficult negotiations. The two things that I recall related to his job-plan and his outpatient New/Review ratio. I recall that Mr O'Brien had a job-plan for more than 15 PAs. There was a push at that time to get all job-plans down to 12 PAs or less in keeping with European Working Time Regulations (EWTR). I remember being impressed by Mr Mackle's achievement, as a similar situation with one of my consultants in the legacy DHH Trust proved much more difficult to resolve. I was previously unaware of the facilitation carried out by Dr Murphy. I do remember Mr Mackle telling me that Mr O'Brien had so many review patients at his clinics that there were very few remaining slots for new patients. The

Service Based Agreements agreed with the Department of Health (DoH) related to quantities and access times for new outpatients and elective access. There were no access targets for outpatient review patients. I was not party to any of the negotiations with the DoH or subsequently with the Urology team. I do not know if it was one of these two issues or something else which led to disagreement between Mr Mackle and Mr O'Brien. I only recall that Mr Mackle did stop engaging directly with Mr O'Brien but I do nor recollect that he had any issues with anyone else in Urology.

15. Paragraph 31.2 (WIT-17530) should be amended to the following:

31.2 ~~I was CD for Urology from 01.01.2008 to 31.08.2010. My~~ ***As CD my*** *responsibilities included operational management, performance, recruitment, governance, job-planning appraisal and medical education. As outlined in paragraph 1.2, I was unable to have complete managerial oversight of all of these responsibilities* ***in Urology in*** *CAH. Apart from the issues already outlined in my answers to question 24, I do not recall any other issues relating to governance in the Urology service.*

16. Paragraph 33.1 (WIT-17531) should be amended to the following:

33.1. Governance was part of the role of all the clinical and non-clinical managers supported by the Medical Director, the Director of Acute Services and a number of departments in the Trust. Given my remote location, I had very little day to day oversight of governance in the Urology service. ~~, when I was CD from 01.01.2008 – 31.08.2010.~~ I was aware that the consultants engaged in the Morbidity and Mortality (M&M) meetings and were subject to yearly appraisal. Other governance processes such as Incident reporting, MDMs and mandatory training were ~~just being~~ developed during my tenure. Governance arrangements have developed considerably since ~~2010~~ ***inception of the Trust*** *and continue ~~involved in reviewing IR1s (Incident Reports). I was never involved in reviewing complaints. Urology MDM's started on 01.04.2010. Mandatory training was introduced on 24/11/2009. Appendix 25. Mandatory training modules are added from time to time. I have appended my most recent training passport as an example, Appendix 26.~~ to do so. Morbidity and mortality processes were in place at inception of the Trust. Incident reporting was introduced in January 2009 Appendix 18. I was never involved in reviewing IR1s (Incident Reports).* ***I was never involved in reviewing complaints.*** *Urology MDM's started*

156. Stephen Hall and Charlie McAllister attended the Acute Clinical Governance meetings as well as the Medical Directors Governance meeting. When we were expanding urology from a 3 to a 5-person team there was a shortage of available theatre space. Charlie McAllister was involved in helping to arrange a three-session day for urology. At one stage there was an issue of timely access to radiology for urology service patients and Stephen Hall helped solve that issue. Both Stephen and Charlie were aware of Aidan O'Brien's foibles but I am unaware of them having serious governance concerns. Mark Haynes and Damian Scullion were made AMDs after my tenure.

[vi] The Clinical Director(s) (the inquiry understand these to have been Robin Brown, Sam Hall, Colin Weir and Ted McNaboe)

157. Robin Brown, upon appointment, was given responsibility for Daisy Hill and for Urology. Robin did not take part in the Monday evening meetings held by Gillian Rankin regarding implementation of the urology review. Robin did, however, attend the monthly governance meeting chaired by Heather Trouton and myself and would bring the perspective of a general surgeon with an interest in urology. Following the false 2012 accusation that I bullied and harassed Aidan O'Brien, any issues requiring direct intervention with Aidan O'Brien were dealt with by Robin Brown. Ms Sam Sloan was appointed Clinical Director in approximately 2010 to help look after General Surgery, ENT and T&O. If Aidan O'Brien was considering admitting a patient for IV fluids & IV antibiotics he had to present the case to Sam Sloan and Dr Damani for approval or other microbiological instructions regarding management. When Sam Sloan left in December 2011, Sam Hall took on this role. Other than IV fluids and IV Antibiotics, I cannot recall either Sam Sloan or Sam Hall raising a governance issue regarding urology.

158. Colin Weir and Ted McNaboe each took up post after my term.

[vii] The Head of Service, namely Martina Corrigan, and

159. I met with Martina Corrigan at least weekly on an informal basis and she also attended the Weekly Governance Meeting chaired by Heather

the practice stopped, that was considered by his colleagues to be a compassionate response to patients who were suffering from recurrent infections

75. There is no doubt that, while not overtly clinical, managers were very aware of the patient safety risks associated with his admin practices. These concerns were highlighted, articulated, and escalated to all Directors of Acute Services and Medical Directors. Mr O'Brien was engaged with and supported with his practice and Mrs Corrigan in particular spent many hours trying to manage around his preferred practice to ensure that patients had access to care. I was also assured by the Clinical Director, Mr Robin Brown, as to the clinical excellence of Mr O'Brien and advised to support rather than challenge his administrative practices.

76. There were no concerns that I was ever aware of regarding Mr O'Brien's clinical ability and patient feedback on care and treatment provided by Mr O'Brien was generally very good

77. On reflection, and knowing what we know now, the issues were greater than admin processes, although we were not aware of that at the time.

78. On further reflection, I consider that Mr O'Brien found it difficult to adjust to the expectations of the Commissioner with regard to activity and practice and he found the expectations of the British Association of Urology difficult to agree with and accept. I think he also found it difficult to adjust to the use of digital technology to support clinical practice and I also think he found it difficult to embrace the full multidisciplinary team and the collective roles that each played to support him and the service. On reflection, I think that Mr O'Brien found it difficult to adjust to the expectations of modern medical practice with regard to standardized pathways and practices.

79. However we now know that despite his portrayal of confidence in his practice and the confidence he enjoyed from his colleagues, the extent of the gaps in patient care escalated throughout his years of practice.

80. I consider this collectively led to a picture of holes in clinical care for a number of patients that remained undetected until a new, bigger consultant team in place were able and willing to identify and share their clinical concerns.

long waiting lists, inadequate job plans and so on. I set my personal development needs to include addressing the long waiting lists, attending urology courses, to continue triaging and dictations, resolving the concerns raised in March 2016, to attend conferences, all of which are detailed in my appraisal folders as referenced above.

336. Mr Robin Brown was scheduled to carry out an assessment of my appraisal documents to ensure that they complied with and satisfied the requirements of revalidation in 2019. Mr Brown did so, finding my documentation to be entirely satisfactory and complimenting me on its quality. I was scheduled to meet with Dr Scullion on Friday 5 April 2019 for revalidation. However, it was requested that I attend a meeting on 4 April 2019 with Dr Khan [see AOB-08172], who had been the Case Manager of the formal investigation conducted during 2017 and 2018. At this meeting, I was advised that Dr O'Kane, the Medical Director, was referring me to the General Medical Council (GMC) [see AOB-56494 – AOB-56496]. On Friday 5 April 2019, Dr Scullion informed me that Dr O'Kane had contacted him earlier that day to advise him that she was referring me to the GMC, as I allegedly lacked insight, and that I was to be advised by him that my revalidation was to be deferred. Dr Scullion had the unenviable task of doing this when I met him for revalidation as scheduled.

337. My role was also subject to a "GMC Colleague Feedback Report", which surveyed the feedback received by my colleagues in relation to me, a "Patient Feedback Questionnaire Report", which surveyed feedback received by my patients, and CHKS Consultant Level Indicator Programme reports, which surveyed data in relation to the number of patients seen, workloads and so on. All these reports are included in my appraisal folders.

(Q 47)

338. I did not carry out reviews or appraisals of others. The only issue which I had with appraisals was to find the time to prepare the documentation for them

a period of two months, to the physical impossibility of earlier job plans offered, a possible (whether acceptable) job plan was submitted for the first time on 31 October 2011. If acceptable, it was to further defy all possibility by being effective retroactively from 1 September 2011. Upon query, now it is to be effective from 1 October 2011, a month before it was offered, and on the grounds that another consultant's job plan, presumably both possible and acceptable, had become effective from that date. Surreal relativism comes to mind!

By now, I feel compelled to accept the Amended Job Plan effective rom 01/10/2011, even though I neither agree with it or find it acceptable. I have endeavoured to ensure that management is fully aware of the time which I believe was required to undertake the clinical duties and responsibilities included in the job plan, to completion and with safety. Particularly during the coming months leading to the further reduction in allocated time, I will make every effort to ensure that I will spend only that time allocated, whilst believing that it will be inadequate".

357. I received a new job plan on 1 April 2012 which was in discussion [see AOB-00361 – AOB-00371] with an allocation of 11.28 total PAs, 9.80 PAs for direct clinical care and 0.80 PA for administration time. I did not accept this job plan as I felt it wholly inadequate. I received a further proposed job plan in February 2013 that proposed an 11PA job which, again, was never agreed [see AOB-06516]. By April 2013, there was a further proposed job plan which allocated 11.275 total PA, 9.80 PAs for direct clinical care and 0.80PA administration time [see AOB-00431 – AOB-00436];s this job plan was also never agreed. It was noted during this time that Dr Rankin and Mr Brown were keen on having 11 PA job plans [see AOB-06516]. It is my belief that the idea of having an 11PA job plan is directly related to the salaries of the consultant urologists as opposed to making an allowance for patient safety and care.

358. During my 2012/2013 appraisal [see AOB-22325] following the above number of proposed job plans, I raised the issue that the job plans were not being

"*The main issues compromising the care of my patients are my personal workload and priority given to new patients at the expense of previous patients. With regard to workload, I provide at least 9 clinical sessions per week, Monday to Friday. Almost all inpatient care and administrative work, arising from those sessions, has to be conducted outside of those sessions. Secondly, the increasing backlog of patients awaiting review, particularly those with cancer, is on ongoing cause for concern." [see AOB-22325]*

606. Whilst I highlighted matters in my appraisal, no-one ever came back to discuss with me how those issues would be addressed.

607. We often met as a team to agree strategies to address the ongoing difficulty the Urology Department had in providing an adequate, safe service. Following those meetings, it was often difficult or impossible to follow through with plans. Surely management should have been providing support and structure? This appears to be acknowledged in an email from Ms Trouton of 18 July 2013 when she referred to that issue in the following terms:

"I thought it might be good to take a moment to summarise the few actions that were agreed and discussed this afternoon as, as Aidan quite rightly states we often agree actions but often never get to implement due to many competing demands on our time." [AOB-06748]

608. As is apparent from elsewhere in this statement there was an ongoing issue in relation to triage. I had a particular view of how triage was best carried out for patients (advanced triage), against a background of increasing numbers of referred patients waiting increasingly long periods of time for first outpatient appointments without any diagnostic or therapeutic measures being taken while waiting. In the context of triage and issues in relation to health records not being found, there was an email exchange in late November / early December 2013 when Mr Brown made the following comments:

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.*

Corrigan (HOS) and Heather Trouton (AD). I don't know how Mr O'Brien's triage was managed after 2013.

68. What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and the unit, and regarding the concerns involving Mr. O'Brien in particular?

68.1. The principle of MDMs is that treatment plans are agreed by the team based upon guidelines and best practice. This is meant to ensure consistent practice between consultants. I don't know why he then chose to treat his cancer patients differently to guidelines. I don't know how you would find out if this was happening, but once it is known then it is appropriate to look back at his practice and investigate any variance. I understand that the GMC have been informed and that Mr O'Brien is under investigation. It is my impression that appropriate action was taken. I don't know what could have been done differently.

68.2. I do not know if the problem with triage persisted or recurred. If it was persistent, I don't know who knew about it or who was dealing with the issue. In terms of learning then maybe a more robust approach to Mr O'Brien's triage may have been appropriate.

68.2. I am not aware of issues relating to the Urology unit as a whole but only to Mr O'Brien specifically.

69. Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

69.1. I know about my own engagement, which was reactive rather than proactive, as referred to in paragraph 69.3 below. I was CD for Urology from 01.01.2008 to 31.08.2010, and I assisted with the job-planning process in 2013, as described in my answer to question 53. I also addressed issues relating to Aidan O'Brien in 2011 and 2013, as set out in paragraphs 24.2, 24.2, 55.2 and 55.3. Even in retrospect, I don't think I could have done much more**.**