



UROLOGY SERVICES INQUIRY

USI Ref: Notice 28 of 2023

Date of Notice: 13th December 2023

Witness Statement of: Meadhbha Monaghan

I, Meadhbha Monaghan, will say as follows: -

1. I have been the Chief Executive Officer of the Patient and Client Council ('the PCC') since 13 March 2023. Prior to my appointment as Chief Executive Officer, I was the Head of Operations in the PCC from 15 May 2020 to 13 March 2023.
2. This statement is made on behalf of the PCC in response to the Section 21 Notice and related Schedule received from the Inquiry Team.
3. This is my first statement to the inquiry.
4. In exhibiting documents to this witness statement, I will use my initials "MM" so my first document will be "MM/1".

Patient and Client Council ("PCC") – Roles, Duties and Responsibilities

5. The PCC was established as an Arms Length Body (ALB) of the Department of Health (hereafter 'the Department') on 1st April 2009. The creation of the PCC was part of a major reform of health and social care in Northern Ireland, provided for by the Health and Social Care (Reform) Act (Northern Ireland) 2009 (hereafter 'the 2009 Act'). The functions of the PCC are described in the 2009 Act and have remained unaltered since 2009. Please see exhibit **MM/1**.



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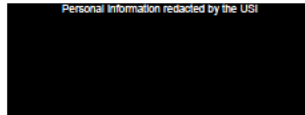
225. The PCC would welcome an amendment to the Departmental Direction and update to the Guidance to require Trust Boards to report on how they have met the specific requirements in the Complaints Direction, Standards and Guidance.

226. The PCC would need additional resource as set out in paragraphs 15-21 in order to maximise its statutory functions in relation to this learning.

Statement of Truth

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

Signed: _____



Date: _____ 17th January 2024 _____



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officer for their respective Health and Social Services Councils ultimately responsible for the proper use of resources by the Council for which they discharged this Accounting officer role. Health and Social Services Council employees were recruited, paid and performance managed through the systems established by their host HSS Board.

23. The 2009 Act refers to a 'scheme of transfer' which governed the transfer of staff and assets from the legacy councils to the PCC. Under this arrangement a number of staff from the four Health and Social Services Councils were appointed to positions within the PCC on 'protected' Terms and Conditions. However, unlike the four HSS Councils the PCC was established as an Arms Length Body in its own right and the functions of the PCC were wider ranging than those of the Health and Social Services Councils. The PCC therefore succeeded rather than replaced the four Health and Social Services Councils (HSSCs).
24. As part of the transfer arrangements from the four HSS Councils to the PCC it was left to each of the four individual Health and Social Services Councils to determine what records and documents they should transfer to the newly established PCC. This accounts for disparities in what records the PCC inherited from each of the Health and Social Services Councils. Having reviewed all hard copy records which were transferred by the HSS Councils to the PCC in 2009, 4 cases relate to the TOR of the Urology Inquiry.
25. The PCC is a regional body which means that its' remit with regard to its statutory functions is Northern Ireland-wide. The PCC has local offices in Belfast, Lurgan, Omagh and Ballymena and its statutory functions under the 2009 reform Act are set out as follows (see exhibit **MM/1**):

Functions of the Patient and Client Council

17—(1) The Patient and Client Council has the following functions as respects the provision of health and social care in Northern Ireland—

(a) representing the interests of the public;



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(b) promoting involvement of the public;

(c) providing assistance (by way of representation or otherwise) to individuals making or intending to make a complaint relating to health and social care for which a body to which this section applies is responsible;

(d) promoting the provision by bodies to which this section applies of advice and information to the public about the design, commissioning and delivery of health and social care;

(e) such other functions as may be prescribed.

(2) In exercising its functions under subsection (1)(a), the Patient and Client Council must—

(a) consult the public about matters relating to health and social care; and

(b) report the views of those consulted to the Department (where it appears to the Council appropriate to do so) and to any other body to which this section applies appearing to have an interest in the subject matter of the consultation.

26. The Patient and Client Council (Membership and Procedure) Regulations (Northern Ireland) 2009² made under the Act make provisions concerning the membership of the PCC Council (Board). Amongst other corporate matters they prescribe that 16 persons shall be appointed to the PCC Council (Board) by the Department and that these persons shall include 5 members of district councils, 5 persons representing voluntary organisations with an interest in health and social care and one person representing a trade union. Two papers saved with PCC Council (Board) papers for a meeting on 9th March 2015 summarise a) the functions of the PCC (exhibit **MM/3**) and b) how the functions of the PCC compare with the functions of equivalent bodies in other UK Jurisdictions and in the Republic of Ireland (exhibit **MM/4**). The functions and role of the PCC are also described in management statements/the Partnership Agreement and in PCC Annual reports.

² [The Patient and Client Council \(Membership and Procedure\) Regulations \(Northern Ireland\) 2009 \(legislation.gov.uk\)](https://www.legislation.gov.uk)



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115. Article 18 requires these bodies to co-operate with the PCC in the discharge of its functions. Whilst this article requires these bodies to consult the PCC, this is only in respect of matters and on such occasions as these bodies '**consider appropriate**'. Similarly, whilst the PCC can essentially require these bodies to provide the PCC with information which the PCC requires in line with the PCC's functions, the information provided is subject to whatever conditions the **providing body decides upon**. This Article also gives the PCC Council a power of entry to premises controlled by any of these bodies. However, this power applies to members of the Council i.e. the PCC Board and does not extend to PCC staff and can only be exercised in connection with the PCC's functions. Finally, under Article 18 these bodies must pay 'due regard' to the views of the PCC but are **essentially free to ignore those views** if they so wish.
116. Article 19 places requirements on these bodies to take steps with regard to public involvement and consultation but it is for the bodies themselves to decide what steps are appropriate. The same article required these bodies to prepare a consultation scheme for the Department to approve. Although this would be after consultation by the Department with the PCC it does not require that the PCC's views must be taken account of.
117. Article 20 requires that the consultation scheme must make it clear how it will involve and consult the PCC (amongst others) in regard to planning services etc. and must pay due regard to the views of the PCC (amongst others).

Organisational development

118. The PCC is a small organisation which currently employs less than 35 whole time equivalent staff (when all posts are filled). The structures and development of the PCC in the period 2012/13 until 2019/20 were undoubtedly affected by financial constraints which applied to the entire health and social care system. As described in paragraphs 15 to 21. In maximising the limited powers of the PCC, we can engage with and work with other statutory bodies which do have a wider range of powers to investigate, inspect, review and regulate health and social care services and the workforce employed in the sector. In the last four



Ensuring independence

67. The PCC does not join such groups as a member, where membership includes having a decision-making role or function in relation to the planning, commissioning and delivery of health and social care services and is not party to decisions made by such groups reserving the right to highlight any concerns regarding decisions made. The PCC believes that it has to remain separate from and independent of the HSC system if it is to then represent the interests of service users or families etc. who may be adversely affected by services and policies developed by such Departmental or HSC groups or bodies.

Access to PCC Services

68. The PCC provides an advocacy and support service to members of the public who wish to make a complaint about health and social care services as set out above in paragraphs 46-54. These complaints mostly arise through direct contact being made by an individual or their representative with the PCC. In some cases the individual will have been referred to the PCC by a member of HSC staff, a third sector organisation or by word of mouth from someone who has experienced PCC's services. The PCC are named within the HSCNI Complaints Procedure under which all of the HSC Trusts operate, and often within complaints literature shared by each of the HSC Trusts who signpost complainants to PCC for independent support. The HSC complaints process is described in more detail below (Para 84-94). Under the process HSC Trusts are expected to advise complainants on the types of help available to them including through the Patient and Client Council (PCC).

69. In some cases an individual will raise an issue in the course of engagement work organised or facilitated by the PCC across the range of engagement structures set out at paragraphs 55-64 e.g. during an Engagement Platform. This may be in the course of the event itself and as part of group discussions. This can also happen after the session or event has concluded when PCC staff are



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improving the safety and quality of services. Dealing with those who have made complaints delivers an opportunity to re-establish a positive relationship with the complainant and to develop an understanding of their concerns and needs.”

91. Consistent with the requirements imposed by the statutory duty of quality the guidance and standards issued by the Department places the responsibility for establishing and operating this complaints procedure on the organisations providing the service. In the case of HSC Trusts, the Chief Executive is accountable for the handling of consideration of complaints. It is the responsibility of the organisation providing the service to ensure that all of their staff are familiar with the HSC complaints process.

92. The Department guidance and standards place the onus on the organisation providing services to provide support to the complainant during the complaints process. It is not expected within the complaints process that all complaints will need or want to enlist the support of the PCC to fairly resolve their complaint. If that was to happen it would most likely indicate one or more of - a failure to operate an effective complaints procedure; a significant failure of internal control divergences and risk management within the organisations system of governance; a failure to comply with the Department’s Direction and guidance on complaints; a failure to meet the requirements of the statutory duty of quality.

93. On the basis of the Department’s Direction, standards and guidance the PCC does not have any power to require HSC Trusts to provide the PCC with the information set out at section 18(1) of the Direction. The PCC has no power to compel or require Trusts to adopt specific content when referring to the PCC and its role and there is no requirement for Trusts to seek PCC agreement as to the content of references to PCC in Trust correspondence, Trust resources e.g. pamphlets or on Trust digital media. It would however be challenging for the PCC within current funding levels to review such Trust material etc. on an ongoing basis.



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94. The Department of Health publishes data on the numbers of HSC complaints each year. The most recent data is for the year 2022/23, and excluding the NI Ambulance Service, shows that the total number of complainants who raised complaints with HSC Trusts was 4,826. In the same period the number of complainants who sought casework support from the PCC in regard to services provided by these HSC Trusts was 453, or 9.4% of the total. Casework support refers to circumstances where we provide advocacy support to individuals, and, or families, including formal HSC complaints and SAIs. The PCC is not in a position to comment on whether or not all of these contacts are recorded by Trusts on their systems as complaints. In 2022/23 the PCC provided a further 837 people with advice and information.
95. The following table shows the total number of complainants by Trust and the percentage of complainants in each Trust supported by the PCC. Comparisons between Trusts may be affected by the different range of services provided by each Trust. The Belfast Trust for example provides a wide range of regional services. There are also differences in the demographics between Trusts and there may be differences in the availability of advocacy services from third sector providers between different Trust areas. It is not possible to say what impact these differences have on the figures in these tables.



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Complaints to HSC Trusts in the Year 2022/23			
Trust	Total Number of Complaints made by members of the public 2022/23	Total Number of PCC cases⁷ in 2022/23	PCC Cases as a % of Total Trust Complainants
Belfast Trust	1,633	155	9.5%
Northern Trust	840	95	11.3%
South Eastern Trust	865	95	11.0%
Southern Trust	830	60	7.2%
Western Trust	658	48	7.3%
NI Total	4,826	453⁸	9.4%

96. The PCC remit is not confined to hospital complaints. It covers both health and social care services and services provided in primary care for a population of 1.9 million. The PCC budget is £1.9m and its whole time staff equivalent is 34.9 staff when all posts are filled, to discharge all of its functions. The PCC is not resourced to provide advocacy support beyond the current caseload. The PCC is not resourced to provide independent advocacy in SAIs. More importantly, the PCC believes that it is essential that service provider organisations take the lead for, are responsible for and should be held to account for maintaining an accessible, supported, fair complaints process which supports learning as part of the expectation that they will provide a safe and quality service. There are many circumstances in which members of the public will wish to be supported by the PCC as an independent advocacy organisation but the PCC does not wish to see the responsibilities and accountability of service provider organisations weakened or diminished.

⁷ In 2022/23 the PCC provided a further 837 people with advice and information. Cases refer to circumstances where we provide involved advocacy support to individuals, and, or families, including formal HSC complaints and SAIs.

⁸ There were a further 116 cases which were attributed to Dental, GP, NIAS, Other or were unspecified



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130. The current complaint system places the onus on the service provider to address and resolve fairly the complaint. The PCC believes that this is the correct approach. The PCC would welcome changes to the system which provide more independent assurance that HSC Trusts are adhering to the requirements of the Department's Direction on complaints and Departmental guidance and standards on complaints as well as SPPG guidance on SAs.
131. The PCC would also welcome changes to the governance requirements placed on HSC Trusts to require them to report to their Boards on a regular basis, hard data and evidence against the requirements of complaints guidance and standards and the Complaints Direction including the Training of HSC Trust staff and the monitoring of contractual arrangements with organisations commissioned to provide services on behalf of a Trust. This would have the twin benefits of providing the Boards with assurance on the operation of the complaints procedure within their Trusts whilst reasserting the primary responsibility of Trusts to address the concerns raised by complainants. Action taken by Trust Board's to review the data would enhance their ability to monitor the quality and safety of the services they provide

1. PCC would welcome an amendment to the Departmental Direction and update to the Guidance to require Trust Boards to report on how they have met the specific requirements in the Complaints Direction, Standards and Guidance.

132. The PCC is working to strengthen further how it works more closely with third sector organisations to utilise their networks to increase knowledge and understanding of the role of the PCC (para 70). We are also working to raise awareness with the public and the Trusts. This will involve engaging with Trusts to jointly review the material and communications that Trusts send or provide to complainants to ensure that references to and information about the PCC receive sufficient prominence and provide clarity on how to easily contact the PCC.



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83. *Each Trust should publish in its Annual Report, details of every SAI related patient death occurring in its care in the preceding year and particularise the learning gained therefrom.*

Department

86. *The Department should expand both the remit and resources of the RQIA in order that it might (i) maintain oversight of the SAI process (ii) be strengthened in its capacity to investigate and review individual cases or groups of cases, and (iii) scrutinise adherence to duty of candour.*

101. There may be other recommendations from the Hyponatraemia Inquiry, in addition to those included in this statement, which would be of interest to the Urology Services Inquiry. A number of these recommendations are relevant to addressing underlying issues with the SAI review system. In the context of the PCC's role in the SAI process, which is focussed on providing advocacy services for individuals and their families, and promoting their engagement, Recommendation 37(iv) is particularly relevant:

37. *Trusts should seek to maximise the involvement of families in SAI investigations and in particular:*

(iv) A fully funded Patient Advocacy Service should be established, independent of individual Trusts, to assist families in the process. It should be allowed funded access to independent expert advice in complex cases.

102. The PCC strongly supports the introduction of this advocacy service which whilst it will not address other underlying problems with the SAI process will at least mean that service users can be routinely properly supported through the SAI process.

103. The complaints system is focussed on **seeking a resolution to complaints** raised by individuals and their families. The SAI review process is different in that it is a system mechanism designed to **identify learning** when something has gone wrong. Whilst some SAI reviews arise out of a complaint made by a service user or their family, many SAIs are initiated without a HSC complaint having being made.



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199. There are significant issues with the operation of the SAI process which the PCC hope the current review by the Department of the process will address. The PCC view is that there is a need to implement the recommendations of the Hyponatraemia Inquiry set out at paragraph 100 101 above.
200. To set in context the examples of SAI practice experience it is essential to understand the starting point for the PCC. The majority of the public who seek support from the PCC have experienced harm resulting from the service received from statutory providers. They have described a negative and distressing engagement experience when trying to find a resolution with the statutory body. Whilst this may not be true for all service users, it is for the those who have availed of the PCC advocacy service.
201. The PCC reached out to families in advance of completing this Corporate Witness Statement requesting permission to highlight their experiences. Paragraph 97 details one family's experience over a 5-year period with the PCC assisting them to engage across the system, including the SHSCT. The second family experienced a Level 2 SAI review which was conducted following the death of daughter / sibling by suicide, while under the care of the Southern Trust. The following sets out their experience on being advised that an SAI was to take place;
- No information was provided as to how Trust/GP records could be obtained, this would have made the initial meeting with the Chair of the review panel more productive.
 - SAI was deemed Level 2 without any discussion with the family.
 - Terms of reference of the SAI were presented to the family but at the early stage of the process it was not made clear that these could be challenged,
 - The family had no independent advice.
 - Initial contact person within the governance office was absent for a prolonged period of time, and the family were not provided with a suitably senior alternative in his absence.



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- The family had requested a meeting with the lead professional, prior to issue of the draft SAI report, this request was never passed to him by the governance office.
- There was a lack of regular updates thus had to constantly seek information.
- Family input was not considered to be an integral part of the review process,
- Support from PCC at this time was intermittent as the officer worked part time and then left on maternity leave.
- Lack of confirmation that draft report would be available on the date promised.
- The Trust insisted on meeting with us to explain the report content despite the family telling them on multiple occasions that we would take the report, read it, respond and then ask for a meeting.
- A series of meetings with the Southern Trust, facilitated by the PCC eventually took place, virtually, including a meeting with a new Chair of the SAI panel.
- Following the finalisation of the SAI, the family were offered an opportunity to escalate our concerns with the office of the Public Service Ombudsman.
- The Ombudsman accepted our case for investigation.
- The SAI process certainly caused further harm to my family, not the investigation itself but the lack of engagement and communication, lack of openness and willingness to answer all questions asked. We were not treated as equals.
- On reading the RQIA review of the systems and processes for learning from SAIs (June 2022) it is obvious that what we were asking for from the Trust should have been delivered, we were not asking for anything that was unreasonable.
- Many straightforward questions remain unanswered in the final SAI report.
- The family requested that their response to the draft report be included as an Appendix to the final report, this did not occur.

202. The timeframes of SAI's usually relate to the actual time required to complete an SAI Review. This does not take into consideration the timeframe to

following day and the next meeting would take place on Friday 4th December.

The Trust would finalise the paper for the Assurance Group after this meeting and would forward to Paul for sending to the DoH.

- **SAI Terms of Reference** – Brid confirmed that the SAI Terms of Reference document had been agreed and signed off. An interim update report is to be submitted by the Trust by 15th December 2020.

The involvement of HSCB DRO officer was discussed. Brid noted that the SAI process would be completely independent. Melanie confirmed to date there were 9 SAIs and 1 overarching SAI. There are potentially another 6 cases which may meet SAI classification but the process for these and other potential SAIs will need to be clarified following the Ministerial announcement of a public inquiry.

Brid added that SAIs can highlight completely different scenarios. Some SAIs may have potential for learning, but not all. Therefore a review is necessary.

Paul added that if the SAI process ceases then a clear understanding of the future process must be evident before this happens. Maria highlighted the length of time taken to identify a Chair for the Muckamore inquiry and noted her concerns would be around the gap from now until the public inquiry is up and running.

Brid noted that the process to be followed may be a case note review and any themes from this may be fed into the public inquiry.

Paul added that the question of further SAIs would need additional discussions at the DoH Urology Assurance Group (UAG) meeting next Friday 4th December.

The FAQ's that had been prepared by the Trust are being revisited due to the Ministerial Announcement in respect to a Public Inquiry.

GP Letter - Maria had confirmed that a letter had gone out via Dr M O'Brien in advance of the Ministerial statement.

PCC Representative - It was agreed that **Caroline** would contact Patient Client Council (PCC) to invite them to participate in this group.

Clarification to be sought from Assurance Group 4th December

Caroline to contact PCC regarding representation on this group.

Trust update on Progress

3 **Martina** agreed to circulate the update to the team tomorrow, Friday 27th
See below:

Martina to circulate update on progress to group by Friday 27th

Southern Urology Co-Ordination Group Minutes

Thursday 26 November 2020, 15:30

Via Zoom

	Item	Actions
1	<p>In Attendance</p> <p>Paul Cavanagh (Chair) Mark Haynes Melanie McClements Brid Farrell Stephen Wallace Ronan Carroll Martina Corrigan Caroline Cullen Maria O’Kane Sylvia Irwin Helen Rogers</p> <p>Apologies Jane McKimm</p>	
2	<p>Actions from Previous Meeting</p> <p>Paul requested an update from the Trust since the Ministerial announcement on Tuesday. Melanie referred to the preparatory work with communications and noted the Trust’s surprise at the announcement of a public inquiry.</p> <p>Melanie confirmed that a meeting had been held with the clinical teams the morning of the announcement and this had been followed up with a further meeting the next day.</p> <p>Melanie referred to the information line which was now operational. In the first few days since the announcement she noted the line had been steady, but not inundated with calls. She noted the mixture of sentiments and emotions and the affect that these personal accounts had on the staff manning the lines.</p> <p>The Trust confirmed there had been a few requests from the media for additional information, but the initial media interest had been less than expected.</p> <p>Martina confirmed there had been 37 calls to the information line on the first day, 36 calls the second day and currently 10 calls today prior to the meeting. One e-mail had been received into the designated e-mail address and as yet there had been no contact by GPs to the GP information line.</p> <p>Paul noted there would be no Urology Assurance Group (UAG) meeting the</p>	

DoH/HSCB/SHSCT Meeting with PCC to discuss PCC role in Urology Process

Minutes

Thursday 20th May 2021, 1.00pm,

Via Zoom

1	Item	Actions
	<p>In Attendance</p> <p>Paul Cavanagh (Chair) Melanie McClements Caroline Cullen Patricia Kingsnorth Michael O’Neill Vivian McConvey Paula Ferguson Johnny Turnbull Sylvia Irwin</p>	
2	Welcome & Apologies	
	Paul welcomed everyone to the meeting and noted the purpose of the meeting was to discuss the role of the Patient Client Council in the Urology Inquiry process.	
3	Update on current position	
	<p>Melanie gave a brief overview of the progress to date and she noted the reviewed to date covered the period January’19 to June’20 and the following main points were noted:-</p> <ul style="list-style-type: none"> ➤ To date there had been 9 SAIs and 1 overarching SAI report ➤ 8 SAIs have been signed off by the families ➤ 1 family has requested extra time to review the report ➤ All SAI reports have been submitted to DoH and HSCB ➤ The Trust has appointed a Family Liaison Officer as the first point of contact for all families and feedback from the families to date has been positive ➤ The Trust has engaged IS support and additional capacity to focus on the needs of patients. ➤ The process has now moved from SAI process to Structured Clinical Record review. Melanie explained what this would involve. ➤ The Patient Information Line had experienced reasonably less activity than the Trust had anticipated. Up to last week, a total of 154 calls had been received by the Trust ➤ The GP Information Line had received a very small number of calls ➤ The Trust has a communication plan to ensure that they are dealing with all queries and there is also a link on the Trust website. ➤ Meetings with DoH and HSCB colleagues are ongoing on a regular basis. <p>Paul noted the Trust has identified 4,000 patients of concern and to date 60% of these have been reviewed by the Trust. The issues found included admin issues,</p>	

test results issues, medication issues, etc. There was also the matter of Private Patients to be addressed and some could be Rol patients.

In light of all the above, Paul noted the Public Inquiry could take years to complete.

4

Involvement of PCC

Vivian advised that she and Johny had met to discuss the update from the meeting on 13th May and she commended the Trust for the comprehensive range of processes already in place and highlighted the appointment of the Family Liaison Officer.

Vivian added that she had not seen any evidence of support/action groups. Meanie agreed, but highlighted the swell of support for AOB on social media. Vivian noted this may change as evidence starts to come out of the Public Inquiry.

Caroline noted that litigation may also be another contributing factor.

Vivian questioned what role or added value PCC could bring to the process. Michael highlighted the experience that PCC had gleaned from their involvement in other inquires, such as the Muckamore Inquiry and the Neurology Inquiry.

Vivian noted that Muckamore Inquiry had a dedicated PCC staff member and this could increase to 2 members of staff.

Patricia noted that one family had approached her regarding setting up of a support group, however, other families did not wish to go public with their involvement.

This was highlighted as an area for potential PCC involvement.

Paul noted that the support group could grow as the inquiry progresses and the Trust could not continue to maintain 1 to 1 sessions going forward. Paul also noted that the Public Inquiry would also have a view on this and this would have to be considered.

The Structured Clinical Record Review process (SCRR) versus the SAI process was highlighted and discussed. Patricia advised the Trust is developing a leaflet and she requested Vivian to review this from a patient perspective. The outcome would be a letter format as the template could not be handed over to families.

Vivian talked through what format the process could take and different options were noted.

Patricia advised the Trust intended to keep the complaints process open if families feel they want to take this route. She also highlighted the importance of managing the expectations of patients.

Patricia noted that all patients would be reviewed first before a decision was made to go to SCRR. All patients would receive a letter advising them that their records



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163. In instances where the PCC becomes aware of specific issues with a Trust, the PCC will engage directly with the Trust or can alert other statutory bodies such as RQIA. This relates to casework or group advocacy. The PCC believes that strengthening the requirement for Trusts to provide information to the public on actions they have taken to address issues identified in response to complaints and SAIs will provide further clarification on action taken and how this will protect the public in the future. However, more of this information should be in the public domain through the annual quality reports.

1. More robust independent monitoring of Trust responses to SAIs and complaints is required.

Review of PCC casework/complaints relevant to the Inquiry

164. To assist the Inquiry, the PCC has reviewed the records PCC holds and identified any complaints relevant to the Urology Services Inquiry. The case evidence will be provided in three sections. Pre-2009, 2009 to 2019 and 2019 to 2024, reflecting periods of change in the PCC's operations and practice model, detailed later in this statement. The PCC has forwarded to the Inquiry the documents which PCC holds about each of these complaints.

165. From 2012 PCC implemented a case management system called 'Alemba' to record case files in relation to complaints referred to the organisation. The PCC is also in possession of a number of hard copy case files transferred from the legacy Health and Social Services (HSS) Council when PCC was set up in 2009 or that were dealt with by PCC from 2009 until the 'Alemba' case management system was introduced in 2012. All case file record sources, either Alemba or hard copy, were reviewed. The table below sets out the number of complaints relevant to this Inquiry.



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Year	SHSCT cases
Pre-2009 – HSC Councils	4
2009 – 2019 PCC	26
2019– present day PCC	7
Total	37

166. In relation to the **4 cases from pre-2009**, 1 case, dating back to 2001, related to a patient under the care of Mr O'Brien, however, the quality of Mr O'Brien's care was not the subject of the case, which focused on waiting times and the attitude of staff. From the evidence available in the case files no concerns have been identified regarding how the cases were actioned in line with PCC practice guidance.

167. In relation to the **26 cases from the period 2009-2019**, 8 cases related to patients under the care of Mr O'Brien, or Mr O'Brien was referenced within the case notes. 6 of these 8 cases related to waiting times or a delay in follow up procedures. From a review of the case documentation recorded at the time, the PCC worked with the Trust and the patients/clients, and the issues were resolved to the client's satisfaction. 1 case related to concerns about out- and in-patient care at Craigavon Area Hospital. This case was investigated by the Trust, who concluded the treatment was appropriate. The client subsequently elected to take legal action, and the case was closed by the PCC, which is a pre-legal service. The remaining case related to a patient who, through a private appointment with Mr O'Brien, was advised he would be placed on the NHS list, but this did not occur. The case was resolved, with support of PCC, with an NHS appointment for surgery received by the patient.



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168. Of the remaining 18 cases, which were not under the care of Mr O'Brien; 10 related to waiting times or delays in procedures, with the remaining covering issues concerning diagnosis, vaginal mesh and care quality. From the evidence available in the case files no concerns have been identified regarding how the cases were actioned in line with PCC practice guidance.
169. Of the **7 cases identified from 2019 – present**, none referred to Mr O'Brien. 3 cases related to waiting times or delays in procedures; 2 concerned support and information provision regarding SAIs. A further case was a general query from a third party concerning the Urology Inquiry. Advice was provided regarding PCC services and support, however, no direct support from PCC was sought by the third party or a member of the public. The final case related to a patient who wished to complain about care and treatment during a day procedure. The patient did not follow up on initial contact, or respond to PCC, and the case was closed. From the evidence available in the case files no concerns have been identified regarding how the cases were actioned in line with PCC practice guidance.
170. In conclusion, from our analysis of the limited number of cases relating to Urology services, which span over a 20-year period in the SHSCT area, it would be difficult if not impossible to have identified systemic issues in general, and specifically to the Urology Services Inquiry's Terms of Reference. The concerns raised regarding waiting times, delays in procedures and quality of care, were similar to those shared across all programmes of care and Trusts in Northern Ireland.
171. On the basis of the evidence available to the PCC only a small number of complainants have approached the PCC seeking assistance in raising a complaint about Urology services in the Southern Trust. The nature of most of these complaints is typical of complaints about other services particularly in relation to waiting lists and waiting times for example. On the basis of the evidence provided to the Inquiry, the majority of the concerns about Urology and Mr O'Brien were identified by management and through reviews of cases by the Trust through lookback exercise and clinical records reviews. These cases would not have come to the notice of the PCC in our role under the complaints



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procedure and the Southern Trust engaged 'Inspire' rather than the PCC to support service users through the lookback exercises. Inspire is an all-Ireland charity and social enterprise providing services to people living with mental ill health, intellectual disability, autism and addictions to ensure that they live with dignity and realise their full potential. Department of Health guidance on Lookbacks does not require HSC Trusts to engage with PCC as part of these Lookbacks.

1. The majority of the cases in the Southern Trust were discovered due to Look Back Reviews rather than through patient complaints.
2. The PCC was not alerted by the Trust at the time when the Lookback Review was initiated

172. PCC provide a break down and analysis of our advocacy and support work, including complaints and SAIs in our Annual Reports⁹. PCC do not, however, provide this information broken down by HSC Trust in our Annual Reports. To assist the Inquiry, PCC have provided in the table below our 2022-2023 data broken down by HSC Trust area, and the Programme of Care to which cases related.

⁹ See links to our annual reports in 2022-23, 2021-22 and 2020-21, 2019-20. Annual Reports prior to 2020-21 did not record PCC advocacy support by Contacts and Cases.

- [PCC-Annual-Report-and-Accounts-2022-23 \(4\).pdf](#)
- [Annual-Report-and-Accounts-2021-22 \(3\).pdf](#)
- [Annual-Report-and-Accounts-2020-21.pdf](#)
- [Annual-Report-and-Accounts-2019-20 \(2\).pdf](#)



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integrity of their work. Effective independent advocacy organisations do not seek confrontation but they maintain the principle of primary accountability to the people they serve'.

1. Recognising the critical nature and urgency for review and change within the SAI process the PCC has established a bespoke engagement platform with membership drawn from families with extensive experience of the SAI process.
2. From 2020, PCC has been developing an SAI advocacy support model for families. Thus far PCC have been unable to secure the additional funding to enable a service to meet the demand and complexity of this work.
3. In contrast to the Complaint's Direction, the PCC's role is not clearly defined or set out in the HSCB's SAI Guidance.
4. Trust Reports need to use clear and unambiguous language and to be completely forthright in describing service failures.
5. From serious incident to SAI review and implementation of recommendations and service change can be an extensive amount of time. In the interim patient safety can be at risk.
6. Increased advocacy support should be independently commissioned to support families through the SAI process as stated in Recommendation 37 of the Hyponatraemia Inquiry report.
7. Advocacy providers require to be commissioned in a manner that ensures they can be true to the principles of independent advocacy.

206. As set out at paragraph 106 PCC are working with individuals who have experience of the SAI process with the intention to inform the Departmental review of SAI policy and procedures which is ongoing. Issues identified by members of this engagement platform to date include, but are not limited to, the following:

When harm or death occurs through action or omission on the part of the HSC, patients, victims, their families and the general public want an investigation that is:

- *Independent, and seen to be independent of the Trusts involved in the incident.*