



TRUST BOARD / SLT COVER SHEET

	<i>The cover sheet purpose is to provide the Trust Board/Committee with a clear summary of the paper being presented, how it impacts on the people we serve, key matters for attention and the ask of the Trust Board/Committee</i> <i>The Accountable Director must satisfy themselves that the cover sheet is accurate and fully reflects the paper. The expectation is that the Accountable Director has read and agreed the content of both the cover sheet and paper.</i>	
Meeting and Date of meeting	Trust Board September 24th, 2026	
Title of paper	Updates on Urology Services Inquiry and Muckamore Abbey Inquiry	
Accountable Director	Name	<i>Dr Stephen Austin</i>
	Position	<i>Medical Director</i>
Report Author	Name	<i>Dr Stephen Austin</i>
	Email	<i>Medical Director</i>
This paper sits within the Trust Board role of:	Accountability	
This paper is presented for:	Information <i>(Notes on completion at end of document)</i>	
Links to Trust Strategic Priorities 	☒	Collaborative Working
	☒	Learning Organisation
	☒	Safety, Quality & Experience
	☒	Community First
	☒	Whole-Life Approach

1. Reason for Presentation of Paper / Report

Update following publication of Urology Services Inquiry report in June 2026

2. Detailed summary of paper contents:

Urology Services Inquiry

The paper updates on the findings of the Urology Services Report – with particular emphasis on the impact of failings on patients and their families; Inquiry Chair's clarity around what the report looked at; what the panel reported on and importantly what the USI was not tasked to examine. The Inquiry Chair emphasised that the clinical practice of health professionals was not part of the Inquiry Terms of Reference and if deemed necessary this will be the remit of professional regulatory bodies eg General Medical Council.

The report looked at Governance within the Trust in the timeframe under review, primarily 2010 – 2020, and the governance structures that existed in that time. It was not an Inquiry into Mr Aidan O'Brien, nor was the Inquiry limited to Urology Services within the Trust. It looked at Trust-wide practice and culture, and how to strengthen leadership, governance, culture and accountability across the system, so that patient safety is not simply an expression, but the clear and constant priority.

The Inquiry report is contained in five chapters across four volumes:

Chapter 1 – Patients

Chapter 2 – Maintaining High Professional Standards

Chapter 3 – Clinical Aspects

Chapter 4 – Governance

Chapter 5 – Medical Management and Leadership

There are three overarching recommendations:

1. The Department should formally declare patient safety to be the dominant and primary purpose of health care.
2. Need for a comprehensive leadership development programme.
3. A sustained programme of work by the Department and the Trust and real investment in data and information systems.

The Trust has completed its initial consideration of the report and is taking account of improvement work already undertaken within the Trust which has been referred to in the Inquiry Report. Further learning from the Inquiry will inform our continued improvement over the coming years.

The extent to which the Inquiry Recommendations have been already partially or fully implemented and work has been reviewed by the Trust (gap analysis). The next steps are the development of a comprehensive workplan to address the full implementation of recommendations, based on the gap analysis.

Muckamore Abbey Inquiry

Following revelations in 2017 of the abuse of patients by staff at Muckamore Abbey Hospital which cared for people with learning disabilities and mental health problems, Robin Swann, Minister for Health, in 2020 ordered that a Public Inquiry be held into that abuse and related matters. The first formal hearing day was 6 June 2022, and the first witness gave evidence on 28 June 2022. In total the Inquiry heard from 235 witnesses including a number of service users and over 90 relatives of service users. Approximately 40,000 documents were provided and considered by the inquiry. The final report of the Public Inquiry was published on 18th June 2026.

The Inquiry was ordered to be held at the same time that investigations by the PSNI into the abuse were conducted and, at the same time as individuals were being charged and taken to court. Although at the time of writing, no one has yet faced a Crown Court trial, the Inquiry had to be conducted so that it did not interfere with the criminal process. This was not an easy task and resulted in some of the evidence having to be given under restriction orders so that it was not heard by the general public

The Inquiry report states, “patients were abused at Muckamore Abbey Hospital (MAH). It is important to state that bold and simple fact. The abuse did not involve every patient nor every member of staff, nor a majority of the staff. But many patients had their lives made miserable by systematic bullying by certain members of staff whose job it was to look after them. Many people suffered at MAH, their lives were made needlessly miserable. They are some of the most vulnerable people in our society and they were failed badly by the health system which was meant to care for them and protect them”.

The Inquiry Report contains 106 recommendations and runs to 702 pages. 63 recommendations are for (all 5) Trusts, with 42 for independent/3rd sector providers (note that a recommendation may have more than one responsible organisation listed against it) and 34 for DOH/SPPG.

As a first step towards implementing the recs from the MAHI and Urology Services Reports, the Minister convened a Quality and Safety summit on 30 June 2026 which brought together Health and Social Care (HSC) system leaders, including Trust Chief Executives, Chairpersons and Chairs of the newly established Patient Safety and Quality Committees. He laid out his vision on the responsibilities and critical role that HSC organisations,

particularly Trusts, hold in strengthening patient safety, culture, governance and accountability.

To provide oversight and consistency on responses, an Inquiries Implementation Programme Management Board (IIPMB), chaired by the Permanent Secretary, has been established. While the MAHI Report will require specific implementation across the Learning Disability service area, the IIPMB will ensure a consistency of approach and transparency of implementation. As the overarching authority within this process the IIPMB ensures alignment across the Department, wider HSC and accountability for the delivery of inquiry recommendations.

The Trust is working with other HSC Trusts and the Department to consider the inquiry recommendations implementation.

Areas of improvement/achievement:

The Urology Services Inquiry recognised and commended the notable changes and improvements that the Board has undertaken since the Inquiry began in 2021. Staff displayed a willingness to learn and improve. The inquiry panel acknowledged that Trust had demonstrated a willingness to embrace the need for cultural change and for systems to continue to develop.

4. Areas of concern/risk/challenge:

The Urology Services Inquiry identified seven areas of action which at times overlap because patient safety depends on the whole system working together. The areas are:

- a. Patient focus including complaints;
- b. Organisational development and cultural reform;
- c. Board and senior leadership development;
- d. Governance;
- e. Serious Adverse Incidents;
- f. Medical leadership and the management of doctors in difficulty;
- g. Urology and Cancer services.

5. Impact on Statutory Duties: Provide details on the impact of the following and how.	
<i>Financial Impact</i>	<i>Safety and Quality Impact</i>
Yes, there are Financial Impacts	Yes, there are Quality, Safety or Experience Impacts
6. Risk Assessment (Risk level and state if a risk assessment be completed)	
<i>Gap analysis underway to inform risk assessment</i>	
7. Other Business Intelligence/data (If appropriate)	
8. Impact: Provide details on the impact of the following and how. If this is N/A you should explain why this is an appropriate response.	
Corporate Risk Register	
Board Assurance Framework	
Equality and Human Rights	

Trust Board Role Fulfilment

Strategy	<i>Papers in this category should address forward-looking priorities, long-term objectives, or service transformation. These are typically focused on shaping the future of the organisation and will often involve decisions on direction, investment, or innovation.</i>
Culture	<i>These papers aim to influence or reflect the values, behaviours, and staff or patient experiences within HSC. They may relate to leadership development, equality, diversity and inclusion, staff engagement, or initiatives intended to reinforce our organisational ethos.</i>
Accountability	<i>Papers falling into this area relate to governance, assurance, performance monitoring, compliance, and risk. They provide evidence that responsibilities are being fulfilled, standards are being met, and corrective actions are being taken where necessary.</i>

Reasons for Paper Presentation

Approval	<i>Used when an item requires a formal agreement or endorsement by the meeting / committee members. Examples are approving minutes, budgets, proposals or policies.</i>
Assurance	<i>Used when an item can be measured against a certain criteria / standard. Examples are a project is on course with delivery or financial targets are being met.</i>
Information	<i>Used when an item is presented for the purpose of updating or informing the attendees without requiring a decision or action, such as reports, updates, or announcements.</i>
Discussion	<i>Used when an item is listed primarily for open discussion, brainstorming or gathering input from the members without requiring an immediate decision.</i>

Urology Services Inquiry Update

The Urology Services Inquiry final report was launched on June 24th 2026 by Inquiry Chair, Christine Smith CBE KC. The Inquiry was announced by the then Health Minister Robin Swan in 2020. Outlining the purpose of the report in her comments at the launch of the report, the Chair stated:

“This Inquiry was set up following a series of Serious Adverse Incidents (SAIs) involving one consultant urologist in the Southern Health and Social Care Trust (the Trust). It was set up under the Inquiries Act 2005, and its purpose is set out in its Terms of Reference. These can be found both in the Report and on the Inquiry’s website. Dr Swart and I are satisfied that we have addressed all the Inquiry’s Terms of Reference in the Report.

The SAIs that triggered this Inquiry revealed significant patient harm, as did other cases the Inquiry considered. Some of the patients died. The Inquiry looked at the harm or potential harm caused to patients, explored how that occurred and why the scale of harm was not fully recognised. The Inquiry did not set out to determine causation in each individual case, that was not our task, but we are satisfied from what we read and heard that patients were harmed.

Patients suffered delays in the diagnosis of cancer; they suffered delays in receiving treatments after they had been diagnosed; they sometimes received non-standard treatment without suitable explanations or adequate justification; the results of important investigations were not examined in a timely way; they were not scheduled for follow-up treatment, such as the removal of stents; and they were not kept fully informed about their treatment.

It goes without saying that if this harm had been prevented, then the patients and their families would have suffered less and the overall experience and outcomes of care would have been better. Accordingly, the Inquiry looked to see whether and how the harm might have been prevented. This meant that our work has been predominantly concerned with leadership and governance at the Trust.”

Reference: Statement from Christine Smith CBE KC, Chair of the Urology Services Inquiry launching the Inquiry’s Report.

This statement sets out clearly that the Inquiry was not an examination of the professional clinical practise of the many staff who supplied witness statements or appeared in person to give evidence. Rather, it was an examination of the governance arrangements and leadership in the Trust during a timeframe that eventually extended from around 2010, until 2020 when Mr O’Brien retired from the Trust. Clinical concerns relating to Mr O’Brien are an on-going matter for the General Medical Council.

The Trust reiterates its sincere apology to affected urology patients and to their families because the care provided by the Trust fell below what was acceptable and that in some cases caused distress or contributed to harm.

The Trust deeply regrets the opportunities we missed to intervene and take action. It was distressing and difficult to listen to the patients and families tell of their experience in our Trust – their personal stories have helped shape our response to, and engagement with, the Inquiry and will help drive ongoing meaningful improvement.

The report runs to four volumes, with five chapters covering:

- Patients;
- Maintaining High Professional Standards;
- Clinical Aspects;
- Governance; and
- Medical Management and Leadership.

There are three overarching recommendations:

- The Department should formally declare patient safety to be the dominant and primary purpose of health care.
- Need for a comprehensive leadership development programme.
- A sustained programme of work by the Department and the Trust and real investment in data and information systems.

There are also seven specific areas for action:

- i Patient focus including complaints;
- ii Organisational development and cultural reform;
- iii Board and senior leadership development;
- iv Governance;
- v Serious Adverse Incidents;
- vi Medical leadership and the management of doctors in difficulty;
- vii Urology and Cancer services.

Also contained within the report are a number of targeted recommendations, specifically relating to MHPS, Governance and Medical Management and Leadership.

Current Progress

The Trust has noted the comments from the Inquiry that during the Inquiry process, Southern Trust and its staff contributed openly and transparently when giving written and oral evidence to the Inquiry. The Trust remains committed to continuing being open and transparent as we move to implementation of the Inquiry Recommendations.

Since the failings relating to the concerns about Mr O'Brien's care were first identified, the Trust has undertaken a systematic and wide-ranging programme of improvements. These improvements have been supported by a team of experts from across the UK, who have worked alongside the Trust's senior management team as a 'critical friend' providing independent challenge and support to the Chief Executive and Directors to improve organisational health, maximise safety, quality and the experience for patients / service users and staff.

Over the last 6 years, we have initiated improvements in our systems and structures of management, training, corporate governance and clinical and social care governance. Learning from the Inquiry will inform our continued improvement over the coming years.

Learning from the Inquiry has also informed the Trust's Vision and Strategy for 2025 – 2030, setting out a five-year journey of improvement across all areas of the Trust.

Trust Consideration of the USI Report and Next Steps

The Trust has completed its initial consideration of the report and, taking account of improvement work already undertaken within the Trust which has been referred to in the Inquiry Report, has reviewed the extent to which the Inquiry Recommendations have been already partially or fully implemented and work which still needs to be completed to ensure full implementation (i.e. a gap analysis). The Trust is also considering broader learning from the detail of the Inquiry Report.

Next Steps

The next steps are the development of a comprehensive workplan to address the full implementation of recommendations, based on the gap analysis.

The Trust is also assessing the findings as they relate to staff who were identified by the USI panel as having information relating to the Inquiry Terms of Reference.

To ensure fairness and impartiality in this process, an external adviser will be appointed to work with the Trust to review the findings relating to staff and develop an appropriate process for reflection, learning and development for staff whose who were connected to the events identified in the report and who openly and honestly contributed to the Inquiry process. This process is primarily focused on those staff who remain employed within the Trust. This is complex and sensitive work which the Trust is progressing, cognisant of the need to manage the process in a just, fair and timely manner.

Professional regulatory bodies will also independently assess the report's findings, and the Trust will be working closely with the Department of Health Inquiries Implementation Board to share regional learning to inform the broader HSC improvement agenda.

A further update on progress, including information on the recommendation implementation workplan, will be provided at the next Trust Board meeting on 26th November 2026.

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