

**Stinson, Emma M**

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**From:** Young, Michael  
**Sent:** 15 December 2021 09:48  
**To:** Stinson, Emma M  
**Subject:** FW: Personal Information redacted by USI

Section 21

-----Original Message-----

**From:** Young, Michael  
**Sent:** 03 December 2015 22:29  
**To:** Corrigan, Martina  
**Subject:** RE: Personal Information redacted by USI

Appears to have been seen

No letter

Us request notes clinically benign prostate and not emptying bladder Psa is really much the same as in 2011

I would suggest that this is not serious but pt and gp are not in the loop Two options - put on to AOB review clinic (as this is probably what AOB thinking when is note benign feeling gland) or send email to AOB asking for his outcome of the consult and if no response gained then pt will be added to one of his clinics

**From:** Corrigan, Martina  
**Sent:** 02 December 2015 19:36  
**To:** Young, Michael  
**Subject:** FW: Personal Information redacted by USI  
**Importance:** High

Can we discuss please?

Martina

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

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

**From:** Cunningham, Andrea  
**Sent:** 02 December 2015 13:56  
**To:** Corrigan, Martina  
**Subject:** FW: Personal Information redacted by USI  
**Importance:** High

Martina,

See below -Consultant does not use clinic outcome sheets. Clinical decision outstanding.

Regards  
Andrea

Andrea Cunningham  
Service Administrator  
Ground Floor  
Ramone Building  
CAH

E: [Redacted] Personal Information redacted by USI  
T: [Redacted] Personal Information redacted by USI

From: Browne, Leanne  
Sent: 27 November 2015 11:58  
To: Elliott, Noleen  
Cc: Cunningham, Andrea; Coleman, Alana  
Subject: FW: [Redacted] Personal Information redacted by USI  
Importance: High

Hi Noleen

[Redacted] Personal Information redacted by USI attended EUROAOB 22nd June, no follow-up has been arranged. Can you check the outcome sheet to see if he needs reviewed or discharged please.

Thanks

Leanne

From: Coleman, Alana  
Sent: 24 November 2015 12:05  
To: Browne, Leanne  
Subject: FW: [Redacted] Personal Information redacted by USI  
Importance: High

Hey,

No response to below queries.

Thanks  
Alana

From: Coleman, Alana  
Sent: 14 October 2015 16:03  
To: Elliott, Noleen

triaged in December 2016 and being particularly surprised by the volume. (**Relevant document located at S21 No 55 of 2022, 118. 20170103E re informing consultants**).

64.11 Around the same time as the triage issue of November 2015, I was informed about a further issue related to the lack of follow up arrangements being defined after a clinic appointment for a patient in June 2015. Firstly, a dictated letter was not available on the ERC patient record and, secondly, it appeared that Mr O'Brien did not use the clinic outcome sheet (**Relevant document located at Relevant to Acute/Evidence after 4 November Acute/Document No 77/Mr M Young/ 20151203** Personal Information redacted by the USI ). The outcome sheet was an integral part of the clinic process as it allowed a secretary to know in advance of doing the typing if there were important issues to address and who had actually attended the clinic. I was not aware that Mr O'Brien did not do this as it had been discussed before at departmental level. *This requires verification as other correspondence does record outcome sheets being available* (**Relevant document located at Relevant to Acute/Evidence after 4 November Acute/Document No 77/Mr M Young/ 20170113 Pts for review SWAH, 20170113 Pts for review SWAH A**). There are further examples of delayed / undictated letters for greater than six months, which interrupted clinicians' understanding of the patient's planned care pathway in late 2015 and in August 2016 (**Relevant document located at Relevant to Acute/Evidence after 4 November Acute/Document No 77/Mr M Young/ 20151219** Personal Information redacted by the USI **and Relevant to Acute/Evidence after 4 November Acute/Document No 77/Mr M Young/ 20160824** Personal Information redacted by the USI ). I was under the impression by August 2016 that the Clinical Director, Colin Weir, may have been planning a meeting with Mr O'Brien. Charts misplacement and undictated letters appears to have continued till October 2016 when I suggested the patient in question be put on to my clinic and direct correspondence sent to Mr O'Brien to return the chart promptly (**Relevant Document located at Relevant to Acute/Evidence after 4 November Acute/Document No 77/Mr M Young/ 20161014** Personal Information redacted by the USI ).

64.12 Concerns about Mr O'Brien's performance, apart from my offer of help with the triage, were initiated by the Trust Management Team of Mrs M. Corrigan and Mrs

1 matters having regard to your obligations under the  
 2 GMC's Good Medical Practice Guide? For example, you  
 3 are required as a practitioner to take prompt action if  
 4 you think that Patient Safety, Dignity or Comfort is  
 5 being compromised. Is that what, in a sense, drives 15:52  
 6 this, not necessarily the written word but that kind of  
 7 principle as a practitioner?

8 A. Yes. Each time I've raised a concern, it's about  
 9 fundamentally Patient Safety. It's a concern that  
 10 there is a patient risk associated with the concern. 15:52

11 91 Q. In your time practising in the Southern Trust, you've  
 12 referred, and I read it out a short time ago, about the  
 13 need for practitioners to work within the established  
 14 processes, to do the things that they are asked to do  
 15 in a timely fashion or to report if they are unable to. 15:53  
 16 In your experience, was Mr. O'Brien an outrider in that  
 17 respect or did you, within the Urology Service, find  
 18 that even periodically, other colleagues behaved in  
 19 a manner which might be regarded as irresponsible as  
 20 regards Patient Safety. 15:53

21 A. I never had cause to have the same concerns as I had  
 22 with regards Mr. O'Brien for any of my colleagues.  
 23 Within the evidence is an example of an exchange which  
 24 is around the DARO process which is one of the safety  
 25 nets for patients who have had scans done and are 15:54  
 26 waiting results. If I have seen a patient who is  
 27 having a CT scan, I might want to see them in clinic in  
 28 X months' time, but if I have requested a scan to be  
 29 performed in, say, December, administratively that is

**Stinson, Emma M**

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**From:** Haynes, Mark [Personal Information redacted by the USI]  
**Sent:** 11 January 2017 12:45  
**To:** Boyce, Tracey  
**Subject:** FW: Patient 103

As discussed below is correspondence between [Personal Information redacted by USI], Martina Corrigan and me regarding a patient who had no letters from previous consultations. The letter [Personal Information redacted by USI] refers to stating that the patient was to have her non functioning kidney removed was an e-discharge from [Personal Information redacted by the USI]. She had been seen in [Personal Information redacted by USI].

I first saw her when admitted [Personal Information redacted by USI] she had her surgery later that month.

Mark

-----Original Message-----

**From:** Haynes, Mark  
**Sent:** 12 April 2016 13:28  
**To:** Corrigan, Martina  
**Cc:** [Personal Information redacted by USI] [Personal Information redacted by the USI]  
**Subject:** RE: Patient 103

I saw this lady this morning on my ward round.

I have not been involved in her care to date, I have not received a referral, there are no letters on ECR and her notes detailing previous consultations were not available to me on the ward..

I have discussed a plan going forward that will depend upon how her current pain settles. If it does not settle she will get a nephrostomy, either way I will be looking to arrange an urgent lap nephrectomy. I cannot at present be certain of the date but would hope that it'll be before the end of May.

Mark

-----Original Message-----

**From:** Corrigan, Martina  
**Sent:** 12 April 2016 08:08  
**To:** [Personal Information redacted by USI]  
**Cc:** Haynes, Mark  
**Subject:** RE: Patient 103  
**Importance:** High

Good morning,

This patient was admitted this morning via A&E under Mark Haynes. I have copied Mark into this email.

Thanks

1 Some clinics have been doing that for years, that what  
2 written to the GP goes to the patient as well. I have  
3 a little bit of concern about that because sometimes  
4 there can be -- there can be big words used that you  
5 have to interpret for the patient and, yet, you want to 15:12  
6 give the right information to the GP. But certainly  
7 having a letter written to the patient is becoming more  
8 common practice. But I would specifically write to the  
9 patient if there was something that the patient needed  
10 to know and to take away from the consultation, shall 15:12  
11 we say.

12 131 Q. Yes. Just in terms of Mr. O'Brien's practice, I want  
13 to just dwell for a few moments on how Mr. O'Brien's  
14 practice appeared to impact on his colleagues.

15 15:13  
16 If I can bring you to something that Mr. Haynes said in  
17 evidence. It is at TRA-00867. So he's explaining the  
18 context where this is that when both Mr. Haynes and  
19 Mr. O'Donaghue commenced in The Trust in 2013, to some  
20 extent they took on some of Mr. O'Brien's cases. It 15:14  
21 was a review of his backlog, as I understand it, and  
22 that was part and parcel of it. Mr. Haynes recounts  
23 that:

24  
25 "Progressively as I recognised that that was the way he 15:14  
26 worked, I would have raised -- so during them times  
27 when we moved up to six when Mr. O'Donaghue started, we  
28 would have tried to work as a team and as individuals  
29 and as new starters. Myself and Mr. O'Donaghue seeing

1 some patients who Mr. O'Brien had seen previously and  
2 both of us raised a concern, along with Mr. Glackin and  
3 Mr. Young when they were doing it that you didn't have  
4 any documentation about the decision making that had  
5 gone on before. There wasn't a letter available and so 15:15  
6 it made reviewing these patients very difficult."

7  
8 Mr. O'Donoghue in his evidence last month recalled that  
9 when he was taking patients to theatre and going to the  
10 chart he was sometimes left wondering what the purpose 15:15  
11 of the visit to the theatre was. Is that something  
12 that was recounted to you, perhaps, as a complaint and  
13 was it something you experienced yourself?

14 A. Mr. O'Brien's patients and myself didn't really  
15 interlink because we had our own lists to look after. 15:15  
16 Mr. O'Donoghue and Mr. Haynes were coming as new and  
17 they were taking, as you say, the backlog of  
18 Mr. O'Brien's list here. Now, this had been brought up  
19 at some of our departmental meetings, you know, and  
20 I did ask Mr. O'Brien why, you know, there wasn't 15:16  
21 something in the chart. Mr. O'Brien usually liked to  
22 have maybe one letter to cover the whole episode of the  
23 patient, not the episode of the date, but the whole  
24 arena of what that patient's journey was.

25 15:16  
26 That is a fine approach if everything is all very sort  
27 of concerted and quick but in our arena to get somebody  
28 back for a review was taking a long time. Now, I'm not  
29 so sure about the writing in the chart, I'm not aware

1 of that. But I know that he would have written in the  
2 charts. I don't know if it was as infrequent as is  
3 commenting here but, certainly, there didn't appear to  
4 be a dictated letter. I mean, I do remember one  
5 occasion at a departmental meeting, I was getting 15:17  
6 rather frustrated with the situation. Even if somebody  
7 comes to your outpatients and you consultant with them  
8 and there's no change in the plan, you know, let's just  
9 run with what was going, you know, that's what you  
10 write down "no change in plan". But at least that lets 15:17  
11 the next person coming along know that that's what your  
12 train of thought was. But if there's no letter or  
13 nothing written in the chart, as you pointed out there.  
14 But undoubtedly a dictated letter is the best, in my  
15 view. And the reason for that is that that now goes on 15:18  
16 to the NIECR system, so it's on the computer. Written  
17 notes on the chart, I must confess the chart issue in  
18 Craigavon, you know, they're a bit higgledy-piggledy  
19 and sometimes you might miss somebody's writing.  
20 That's maybe a finer point. If you look through 15:18  
21 a chart you probably will find it but sometimes it can  
22 be a little bit on the difficult side. But certainly  
23 a dictated letter is the way to go and even, as I say,  
24 if there's no change in plan, at least write that.

25 132 Q. As we've observed from Mr. Haynes' remarks, there's an 15:19  
26 importance residing in the principle of continuity of  
27 communication that was, it appears, somewhat frequently  
28 missing from Mr. O'Brien's clinical practice. I think  
29 there is a dispute on the final numbers as found by

67.1 Triage of Red Flag referrals should theoretically be processed on a daily basis as per Trust Guidelines. Such prompt triage, however, did not as such concern myself as the patients in general terms were not going to be seen that quickly and with the advanced triage system a scan was a likely test to have been completed in between referral and being seen. We often still meet our target times. The important point however was that the Red Flag patients were all identified. Red Flag letters sent by the GP were straightforward and easily identified by colour of the paper they were printed upon or the GP logged this at the top of the page.

67.2 We as a collective department agreed that triage was best performed by consultants. I personally regarded this as important for the reason that it was the screening of the 'Urgent' and especially the 'Routine' GP category referrals as being the most important. This was to ensure that what was defined as 'Routine' by the GP was in fact correct or whether, instead, there was some indication that needed upgrading to a Red Flag.

67.3 So concern existed if the 'Routine' and Urgent' letters had not been screened. This is part of the reason for asking for the letters to be returned following triage so that the Trust's Booking Office can process appropriately. Albeit only after Mr O'Brien's return to work I had a conversation with him on this precise point noting the importance of the 'Routine' referral. He agreed. My role as Lead Clinician did not extend to risk assessment. Once these issues were raised then the medical and administrative management structure were the team to complete this assessment. However, as a group we were involved in the risk assessment when asked to address the un-triaged letters in early 2017.

67.4 Undictated correspondence following a clinic appointment is a risk from the perspective that other clinicians may not know the outcome of a consultation. This would be the case for a GP as they would not have access to the chart. Hospital team would have the benefit of seeing the written commentary but not any other thoughts. Without the return of 'Outcome Sheet', the secretary would also not know how to process the patient when the letter is undictated. I believe Mr O'Brien had liked to dictate after the completion of the patient journey. This, however, missed opportunities for other clinicians to be kept informed in-between times. At several unspecified and un-minuted Departmental meetings, this had been raised with and without Mr

O'Brien's presence. The secretarial management would have been aware of these points.

67.5 The lack of availability of viewing a chart opens the possibility of a patient not giving a clinician the full medical history necessary. This is not so much an issue now as most, if not all, of the medical history is on the ECR system. I understand that the administrative management teams would have directly contacted Mr O'Brien if a chart was missing.

67.6 The more recent issues of late referral onwards to oncology, I was not aware of until Mr O'Brien retired. However, this is an obvious example of a patient safety issue.

67.7 So, in summary, I believe that potential risk to patient care and safety was recognised. For example, the risks associated with untriaged or undictated letters may impact on patient care and safety, especially if the result was delay in diagnosis of a condition that has a time dependant treatment pathway. It is appreciated that issues were brought to my attention by the management structure, however, assessing risk and determining remedial actions were not within my domain, albeit that my colleagues and myself were involved in implementing some of the necessary remedial actions (e.g., working through untriaged referrals in early 2017 – see Q66). It was recognised that this was an issue for the higher management structure, rather than the Lead Clinician role, to sort out.

**68. If applicable, please detail your knowledge of any agreed way forward which was reached between you and Mr. O'Brien, or between you and others in relation to Mr. O'Brien, or between Mr. O'Brien and others, given the concerns identified.**

68.1 As noted previously, I helped with periods of doing his triage.

68.2 Other areas of help included the fine-tuning of the monthly schedule. The SWAH urology clinic was monthly and was an all-day clinic. Reasonable travel time was involved for the clinicians, namely Mr O'Brien and myself, to attend and return from this clinic. It was always a Monday. Mr O'Brien liked to have time set specifically aside the day after the clinic to do all the administration associated with

in his responding to requests for information from the Litigation Department. I cannot recall the approximate date nor the outcome of the conversation which involved myself, Mr Weir (CD for Urology/ENT), and Dr McAllister (AMD SEC/ATTICS). As I recall, Dr McAllister had a notebook that he took to meetings but I do not know if he made notes during this discussion (see response 61.4).

62.3 As detailed above in answer to the previous question, I had previously raised concerns relating to Mr O'Brien's preferential treatment of patients he had seen initially as private patients and I expect that I would have also discussed this in person with various individuals but cannot remember any specifics.

62.4 I have also detailed that issues with regards to a lack of letters on patients' electronic care records and a lack of notes had been raised by consultant urologists, including me, specifically with regard to the impact on our ability (as a team of urologists) to provide care to emergency admissions and review patients awaiting review with Mr O'Brien. These concerns would have been raised in regard to emergency admissions and have been described in previous responses (e.g., 61.3 and 61.5 above). This was also discussed in departmental / consultant meetings throughout my time in Southern Trust, in particular when discussing review of long waiting patients who had previously seen Mr O'Brien, with recognition that review of these patients would take longer due to the paucity of information regarding previous attendances. I recall an occasion where Mr O'Brien challenged the need for contemporaneous correspondence detailing each consultation stating words to the effect of, '*... the only two people who need to know the content of the consultation and plan are me and the patient.*'

62.5 I had escalated concerns regarding absence of notes on IR1 Patient 102 see 61.3).

62.6 I had also escalated concerns regarding lack of triage and apparent inaction on radiology reports containing significant findings (CT showing renal cancer – see: IR1 Patient 92 ). Please see 44. 20180717 Datix Irrelevant redacted by the USI, 45. 20201113 Final Report Irrelevant redacted by the USI 46. 20210719 Approved Action Plan to HSCB,

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## Record your work clearly, accurately and legibly

- 19** Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.
- 20** You must keep records that contain personal information about patients, colleagues or others securely, and in line with any data protection law requirements.<sup>14</sup>
- 21** Clinical records should include:
- a** relevant clinical findings
  - b** the decisions made and actions agreed, and who is making the decisions and agreeing the actions
  - c** the information given to patients
  - d** any drugs prescribed or other investigation or treatment
  - e** who is making the record and when.

1 consultant comparators, which is quite nice.  
 2 Dictation, did the other urologists have a difficulty  
 3 there, or was there --

4 A. My understanding was they were all using digital  
 5 dictation. They were using the system that was there 16:05  
 6 to enable that to be done and the dictation was being  
 7 done after every clinical contact. I think again some  
 8 of that came as a surprise to his colleagues as part of  
 9 the lookback review that was done, that there was maybe  
 10 multiple contacts with a particular patient before 16:05  
 11 there was an actual dictated note of what was happening  
 12 with that patient. It was very clear to us that that  
 13 was not the practice of the other clinicians.

14 269 Q. Just lastly, again on the subject of letters. We heard  
 15 that Martina Corrigan some time off and with respect to 16:06  
 16 the return-to-work there was a gap. Now, the one  
 17 person who knows about your letters is your secretary?

18 A. Yes.

19 270 Q. Was there a reason why Mr. O'Brien's secretary wasn't  
 20 involved in this process about monitoring? 16:06

21 A. About monitoring? Yes, Mr. O'Brien's secretary was  
 22 interviewed as a witness at the early part and  
 23 I believe - and, again, I could be wrong on this - but  
 24 I believe it was probably down to the fact that these  
 25 concerns were already previously known to his secretary 16:06  
 26 and hadn't been escalated. Again, for a lot of  
 27 reasons to do with that consultant/secretary  
 28 relationship, etcetera, but to involve her in that  
 29 monitoring when going forward when those issues would

1           There were no issues related to this arrangement.  
2           There were also audiotypists to aid the secretarial  
3           workload on typing patients' letters due to the large  
4           volume. "

10:53

6           Now, there has been evidence before the Inquiry of  
7           administrative delays on some issues. The triage,  
8           we've discussed. You didn't do that as a registrar  
9           and, as I understand it, you have no problems with the  
10          triage system as a consultant since you've come back as  
11          well, either in 2019 or currently? 10:54

12          A.    Well, I have no issue in undertaking it and doing it,  
13          no!

14    41    Q.    There's no backlog, from your perspective?

15          A.    No. 10:54

16    42    Q.    Do you understand if there's a backlog at all in triage  
17          in the unit at the moment?

18          A.    No, not for me or the consultants I currently work with  
19          I'm aware of any backlog. Certainly when I take over  
20          from whoever has been on the prior week, the triage is  
21          done and, before I hand over to the next one, the  
22          triage is done. 10:54

23    43    Q.    In relation to dictation from you as a consultant when  
24          you're dictating your letters after clinics, for  
25          example, is that something that you have always done  
26          right away? 10:54

27          A.    Yes.

28    44    Q.    Immediately after seeing your patient or at the end of  
29          the clinic?

- 1 A. Immediately after seeing a patient in clinic in the  
2 room, I would dictate a letter. And I have a system on  
3 the outcome sheet that I then tick next to the box of  
4 the patient's addressograph to know I've done it.
- 5 45 Q. And that's done electronically now with the tapes? 10:55
- 6 A. Yes.
- 7 46 Q. And in relation to review follow-ups, when you were  
8 back in 2019 did you experience any backlog on reviews  
9 or delays in patients coming back?
- 10 A. I noted that when I then took a consultant job, that 10:55  
11 the Trust had a long backlog of operating and reviews  
12 to be seen. It was not something you are overly aware  
13 of as a registrar -- you're there to train and you're  
14 there to undertake your service requirement for that  
15 point. It became a different appreciation of a service 10:55  
16 as a consultant and so in the very -- I was only there  
17 for a brief time in '19, but, noting a backlog,  
18 I undertook a number of extra clinics to help the  
19 backlog to try and alleviate the pressure on the lists.
- 20 47 Q. And, as a registrar, you said you wouldn't have been 10:55  
21 aware of that particular administrative burden, but  
22 when you came back as a consultant were you surprised  
23 by the extent of the backlog, or was it something that  
24 just seemed to be accepted as being there?
- 25 A. I was -- it's -- in starting a consultant job, it's not 10:56  
26 something you overly want in a way, because you want to  
27 be able to see patients in a timely manner. So it was  
28 something which I was slightly taken aback by the  
29 actual depth of the waiting list, yes. But, in



1 outpatient clinic, 1st January". And that would've  
2 went to the outpatient team or the clerk at the front  
3 of Outpatients and they would've sent that with all of  
4 the notes back to my secretary to get the letters  
5 typed. 11:31

6  
7 The other way which was done, primarily in Vascular,  
8 from what I remember, was that because the clinics were  
9 very busy, with a very high turnover, that they asked  
10 you to do your dictation all at the end. So you 11:31  
11 would've held onto all of the notes in the room and  
12 then when all of the patients were seen, you would've  
13 went through and then dictated all of the letters at  
14 the end of the clinic. I personally disliked that,  
15 because, you know, many vascular or many urology 11:31  
16 patients have similar problems and, therefore, you  
17 know, I wouldn't have been able to remember the  
18 intricacies of each of the notes. So I always dictate  
19 the letter after I see the patient.

20 56 Q. And did you ever find yourself falling behind with 11:31  
21 dictation?

22 A. So, that would've happened at the time. So I would've  
23 sign the patient, dictated the later, put the notes to  
24 one side and moved on the see the next patient. So the  
25 outpatient dictation always would've happened at the 11:31  
26 time and always would've finished by the end of the  
27 clinic.

28 57 Q. So, based on your workload, it was manageable for you  
29 to be able to do that, either at the time or at the end

1 of the clinic, without falling behind?

2 A. Oh, it was just part of your clinic time is that you  
3 had time built into that so that you would be able to  
4 do your dictation as part of seeing the patient. It  
5 was considered part of your allocated four hours, is 11:31  
6 that you had that time to see the patient and dictate  
7 on them and book whatever investigations or procedures  
8 they needed.

9 58 Q. And at the time that you were there in 2012, was triage  
10 part of your role? 11:31

11 A. It was.

12 59 Q. And what way was it carried out when you started your  
13 post at Craigavon?

14 A. So you would've got paper triage letters from GPs or  
15 from A&E or from other consultants and that would've 11:31  
16 went to a central appointments and they would've then  
17 date stamped it and sent it to individual consultants  
18 for triage. Because there were five of us, it would've  
19 been split between the five of us. I don't remember  
20 how that they chose, I assumed it was just, you know, 11:31  
21 evenly sort of given to all of the consultants. Like,  
22 I don't honestly know how it happened, but I knew that  
23 every day I would get a folder that had a number of  
24 triage letters in it and then it was my job to triage  
25 those. 11:31

26 60 Q. And again, was that something that you ever weren't  
27 able to do because of your other commitments, or was it  
28 something, a bit like your dictation, you just factored  
29 into your working day?

1 Now, on a Tuesday morning it is usually day surgery  
 2 unit work in Craigavon which was either between  
 3 Mr. O'Brien or myself. So we set it -- at that point,  
 4 we did our scheduling programme once a month that,  
 5 specifically for Mr. O'Brien, that if he was at the 10:56  
 6 Southwest on the Monday, he didn't do the Tuesday  
 7 morning day surgery list because that's when he wanted  
 8 to catch up with the clinic on the day before.

9 17 Q. Do you mean catch up on administration?

10 A. Well, administration of the clinic associated with the 10:57  
 11 clinic the day before. Now, I mean, I was able to  
 12 complete by administration and dictation at the clinic  
 13 or when I went home at night. Mr. O'Brien was a bit  
 14 slower, maybe took a little bit longer, but  
 15 we accommodated that by time out on the Tuesday morning 10:57  
 16 to do that admin. So that's maybe a slightly different  
 17 type of support, it's more sort of targeted. Again, it  
 18 is a bit like Mr. Suresh, it was an educational  
 19 programme he needed to go on to get taught. As far as  
 20 Mr. O'Brien is concerned, he does not need to be taught 10:58  
 21 surgery. Mr. O'Brien is a very competent surgeon,  
 22 there's no doubt about that, so that's not what he  
 23 needed. But he needed support from the admin and that  
 24 admin was in time. That is just an example.

25 18 Q. Just to summarise from what we have so far looked at 10:58  
 26 this morning, in terms of your role as clinical lead,  
 27 you did have a responsibility to intervene and show  
 28 some element of managerial output when it came to  
 29 dealing with doctors who were in difficulty, for

1 If I run over slightly into the next patient's time,  
 2 I will dictate at the end of the clinic.

3  
 4 I mentioned earlier that our outpatient design was  
 5 meant to have had some time at the end of the clinic to 15:10  
 6 incorporate admin. That was fine, I think, at the  
 7 beginning when we were setting up after the 2010  
 8 regional review. That's the way we had set it then.  
 9 I think that's more than likely slipped and there's not  
 10 precise time at the end. But in theory the clinic slot 15:10  
 11 time should incorporate both a consult, the writing,  
 12 and the dictation. Now, again, if you are a bit slow  
 13 most -- well, most of my clinics are on in the  
 14 afternoon, I stay until that dictation is done, whether  
 15 that is 7 o'clock at night or 5:30, but for me it's 15:11  
 16 there and then. To take the chart off to an office to  
 17 do is up to the -- it is up to the clinician, but most  
 18 of the charts are bundled up and put into a box and  
 19 sent to the secretary from the outpatients' department.

20 129 Q. You talked about dictating a letter to the general 15:11  
 21 practitioner, a copy of that would go on the chart,  
 22 would it?

23 A. When that's dictated it goes into the chart and in  
 24 modern times now it goes on to the NIECR.

25 130 Q. Just a point of fine detail. Do you ever see fit to 15:11  
 26 dictate a letter to the patient directly arising out of  
 27 such a clinical episode?

28 A. There has been a move now to copy the patients more  
 29 into the correspondence. For me that's relatively new.

1 on it, was causing difficulty?

2 A. Yes.

3 238 Q. You would also have appreciated that you were in  
4 difficulty in being able to progress your dictation --

5 A. Yes. 16:34

6 239 Q. -- in the manner that you must have known was expected  
7 of you by the Trust?

8 A. Yes.

9 240 Q. In that kind of context, should you not be going and  
10 saying, listen, it may not be entirely visible to you 16:34  
11 but I have these notes at home because I'm running  
12 behind with my dictation and I will endeavour to catch  
13 up, in much the same way you said to Mrs. Corrigan in  
14 the autumn of 2016 as you were going into some period  
15 of absence. Should you have been more transparent 16:34  
16 about that?

17 A. I hadn't thought about it. On thinking about it now,  
18 possibly, yes. In the course of asking the question,  
19 you referred to dictation as something that was  
20 expected of me. I hadn't read or heard of that 16:35  
21 expectation prior to this issue arising. I wasn't  
22 aware that there was any expectation on the part of the  
23 Trust, certainly, that there should be dictation done  
24 at the end of each consultation. I'm not saying that  
25 it's not optimal to do so, I'm just making that point. 16:35  
26 I suppose, actually, that that contributes to my not  
27 reporting to the Trust in a more transparent way.

28  
29



## Urology Services Inquiry

556. The retention of GP referral letters in the filing cabinet in my office was closely related to and was a consequence of the non-triage of referrals. I always accepted, and still accept, that triage of referrals is an important task. The failure of referrers to reliably categorise the urgency of referrals and the Trust's failure to ensure that there was an adequate system in place whereby triage could be performed, did impact on patient safety [as did the difficulties that I experienced in carrying out triage]. It was not my role to conduct risk assessments in terms of the extent of this risk. However, as stated above, I made the Trust aware on countless occasions over many years that I was struggling with triage, and not completing it for non-red flag cases, as I had found it impossible due to the conflicting pressures of work. It was the responsibility of the Trust to assess and address the risk arising from this. The Trust failed to do so even though I and others had repeatedly brought the issue to its attention.

557. In terms of non-dictation after clinics and day procedures, I have previously accepted and continue to accept that this was sub-optimal. It could have impacted on patient safety. However, it was determined in 2017, during the course of the formal investigation, that no patient had been exposed to the risk of harm, as I had taken every measure to mitigate this risk by identifying and prioritising urgent cases requiring a prompt transfer of information. It was the responsibility of the Trust to assess this risk and to devise a system whereby I had sufficient time to cope with the excessive administrative demands placed upon me. I am unaware of any failure to dictate letters following discharge of patients from the Day Surgical Unit.

558. With regard to not adding patients to the Patient Administration System, I have related that I did not have access to the Patient Administration System for any such function. Therefore, patients could not have been impacted or at risk by my failing to carry out a function which I did not have. As the Inquiry will be aware from my response to Question 1 above, I have been able to demonstrate that the allegation that 2 out of 10 patients had not been added to the Patient Administration System by my secretary is simply untrue.

**Corrigan, Martina**

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**From:** Haynes, Mark <[Personal Information redacted by USI]>  
**Sent:** 26 November 2015 06:42  
**To:** Young, Michael; Corrigan, Martina  
**Subject:** Queue jumpers

Morning Michael

I emailed you on 2<sup>nd</sup> June 2015 about the ongoing issue of patients on waiting lists not being managed chronologically and in particular private patients being brought onto NHS lists having significantly jumped the Waiting List. As I have been through our inpatients in preparation for taking over the on-call today I have once again come across examples of this behaviour continuing. Specific patient details are;

[Personal Information redacted by USI] AOB  
Referred Sept 2015, Seen OP ([Personal Information redacted by USI]) Sat 10/10/15, Urodynamics @thorndale unit 6/11/15, Cystodistension 25/11/15.

[Personal Information redacted by USI] AOB  
Referred 28/10/15, Seen OP ([Personal Information redacted by USI]) Sat 7/11/15, GA cystoscopy 25/11/15 (?recurrent stricture)

I have expressed my view on many occasions. This is Immoral and unacceptable. Aside from the immorality of patients who have the means to seek private consultations having their operations on the NHS list to the detriment of patients without the means, who sit on the waiting list for significant lengths of time, the behaviour is apparent to outsiders looking in. The HSC board can see it when they look at our service and any of our good work is undone by this.

Can you advise me what action has been taken since I raised this?

Mark

**Corrigan, Martina**

---

**From:** Haynes, Mark <[Personal Information redacted by USI]>  
**Sent:** 27 May 2015 20:54  
**To:** Young, Michael; Corrigan, Martina  
**Subject:** FW: UROLOGY TOTAL URGENT WAITING LIST - AS AT 27.05.15  
**Attachments:** UROLOGY LONGEST URGENT WAITERS WITHOUT DATE FOR SURGERY - FOR SCHEDULING - 27.05.xlsx; UROLOGY TOTAL URGENT WAITING LIST - AS AT 27.05.15.xls

**Importance:** High

Dear Michael / Martina

I feel increasing uncomfortable discussing the urgent waiting list problem while we turn a blind eye to a colleague listing patients for surgery out of date order usually having been reviewed in a Saturday non NHS clinic. On the attached total urgent waiting list there are 89 patient listed for an Urgent TURP, the majority of whom will have catheters insitu. They have been waiting up to 92 weeks.

However, on the ward this week is a man ([Personal Information redacted by USI]) who went into retention on 16th March 2015, Failed a TROC on 31st March 2015. He was seen in a private clinic on Saturday 18th April and admission arranged for 25th May with a view to Surgery 27th May. The immorality of this is astounding and yet this is far from an isolated event, indeed I recognise it every time I am on the wards and discussing with various members of the team it is 'accepted' as normal practice. I would not disagree with any argument that this patient got the treatment we should be able to offer to all but it is indefensible that this patient waited 5 weeks while another patient waits 92 weeks. Both with catheters insitu for retention. An argument that this man was very distressed with his catheter does not hold with me. All of our secretaries can vouch for many patients in this situation being in regular contact because of catheter related problems.

This behaviour needs to be challenged a stop put to it. I am unwilling to take the long waiting urgent patients while a member of the team offers preferential NHS treatment to patients he sees privately. I would suggest that this needs challenging by a retrospective audit of waiting times / chronological listing for all of us and an honest discussion as a team, perhaps led by Debbie. The alternative is to remove waiting list management from all of us consultants and have an administrative team which manages the waiting list / pre-op / filling of waiting lists in a chronological order.

Happy to discuss and plan a strategy for taking this forward.

Mark

**From:** Glenny, Sharon  
**Sent:** 27 May 2015 14:32  
**To:** Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Suresh, Ram; Young, Michael  
**Cc:** Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; Loughran, Teresa; Robinson, NicolaJ; Troughton, Elizabeth  
**Subject:** UROLOGY TOTAL URGENT WAITING LIST - AS AT 27.05.15  
**Importance:** High

Hi Everyone

Following the departmental meeting last week and discussion re urgent waiting times and volumes with consultants for elective surgery – I have attached a total urgent waiting list for your review.

## Corrigan, Martina

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**From:** Young, Michael  
**Sent:** 27 May 2015 21:36  
**To:** Haynes, Mark; Corrigan, Martina  
**Subject:** RE: UROLOGY TOTAL URGENT WAITING LIST - AS AT 27.05.15

Internal email for those on this circulation only

Point taken

Agree

Play a straight honest game.

We are best placed defining our lists but at risk if above comments not taken on board.

Management not playing straight either by resetting patients clock.

But this is not the approach I want for the Dept

Few issues not prepared to put on paper about process = so discuss later.

Discussion required.

Mark's points very valid – I fully appreciate the questions raised

MY

Lead

From: Haynes, Mark  
Sent: 27 May 2015 20:54  
To: Young, Michael; Corrigan, Martina  
Subject: FW: UROLOGY TOTAL URGENT WAITING LIST - AS AT 27.05.15  
Importance: High

Dear Michael / Martina

I feel increasingly uncomfortable discussing the urgent waiting list problem while we turn a blind eye to a colleague listing patients for surgery out of date order usually having been reviewed in a Saturday non NHS clinic. On the attached total urgent waiting list there are 89 patients listed for an Urgent TURP, the majority of whom will have catheters in situ. They have been waiting up to 92 weeks.

However, on the ward this week is a man ( Personal Information redacted by the USI ) who went into retention on 16th March 2015, failed a TROC on 31st March 2015. He was seen in a private clinic on Saturday 18th April and admission arranged for 25th May with a view to surgery 27th May. The immorality of this is astounding and yet this is far from an isolated event, indeed I recognise it every time I am on the wards and discussing with various members of the team it is 'accepted' as normal practice. I would not disagree with any argument that this patient got the treatment we should be able to offer to all but it is indefensible that this patient waited 5 weeks while another patient waits 92 weeks. Both with catheters in situ for retention. An argument that this man was very distressed with his catheter does not hold with me. All of our secretaries can vouch for many patients in this situation being in regular contact because of catheter related problems.

This behaviour needs to be challenged a stop put to it. I am unwilling to take the long waiting urgent patients while a member of the team offers preferential NHS treatment to patients he sees privately. I would suggest that this needs challenging by a retrospective audit of waiting times / chronological listing for all of us and an honest discussion as a team, perhaps led by Debbie. The alternative is to remove waiting list management from all of us consultants and have an administrative team which manages the waiting list / pre-op / filling of waiting lists in a chronological order.

1           A.    Yeah. My approach to when patients contact my  
 2                    secretary in this same situation, is you typically  
 3                    advise them and the GP of the issues with our waiting  
 4                    list, but that, unfortunately, I have to manage  
 5                    patients chronologically which means I won't be 10:44  
 6                    bringing their treatment ahead of someone who has  
 7                    waited longer, but equally I won't bring someone ahead  
 8                    of them who has waited shorter. Also, where patients  
 9                    are distressed, I will also arrange a Clinic Review to  
 10                   discuss this directly with them and work with our 10:44  
 11                   colleagues in the Community Continence Team, our  
 12                   Primary Care colleagues and our Clinical Nurse  
 13                   Specialist colleagues to see what measures we can put  
 14                   in place in the interim to alleviate the problems the  
 15                   patient is getting. 10:45

16       26 Q.    Just scroll up a little. Scroll up so I can see the  
 17                   last paragraph.

18  
 19                    You say: "The behaviour needs to be challenged and  
 20                    a stop put to it" I think that should read. You say 10:45  
 21                    you are: "... unwilling to take the long waiting urgent  
 22                    patients while a member of the team offers preferential  
 23                    NHS treatment to patients he sees privately. I would  
 24                    suggest that this needs challenging by a retrospective  
 25                    audit of waiting times/chronological listing and an 10:45  
 26                    honest discussion as a team..."

27  
 28                    Do you know if your suggestion of a scientific audit  
 29                    to assess the extent of this problem was conducted at  
 that

1 time?

2 A. Not at that time, to my knowledge.

3 27 Q. If we scroll up to page 254106?

4

5 At the tail-end of the year, some six months later, you 10:46  
 6 are writing again to Mr. Young and Mrs. Corrigan and  
 7 you have entitled this e-mail "queue jumpers". Is this  
 8 essentially the same subject?

9 A. Yes.

10 28 Q. Before we get into the e-mail, why are you writing 10:47  
 11 again?

12 A. Because once again, as I say in that top paragraph:

13

14 "As I have been through our inpatients in preparation  
 15 for taking over the on-call today have once again come 10:47  
 16 across examples of this behaviour continuing".

17

18 I am taking over as urologist of the week and I have  
 19 identified two patients there who have had very short  
 20 waiting times and been brought in for surgery, having 10:47  
 21 been seen privately.

22 29 Q. Just let me see if I can see Mr. Young's response on  
 23 this. No, I may not have it. I will refer to it maybe  
 24 later, if necessary. This is the tail-end of 2015.  
 25 Again, is the problem, as you see it, resolved at that 10:48  
 26 point?

27 A. Absolutely not, it's still happening.

28 30 Q. Okay. Are you aware of any initiative undertaken,  
 29 either by Mr. Young or by Mrs. Corrigan, to address it?



## Urology Services Inquiry

vii. I was made aware by Mr Mackle that there may have been an issue/concern that Mr O'Brien appeared to have performed more benign cystectomy operations than any other consultant urologist and it was felt that it needed to be investigated to see if there were valid reasons for those patients to have had this procedure performed. I was not directly involved, apart from facilitating the external reviewer (Mr M Drake) with 11 sets of notes. It would appear that this practice had been ongoing since 2005, but it was only raised as a concern in 2010.

### *Notes in the bin*

viii. In June 2011 it was brought to my attention by Sr S Tedford, Ward Manager of Ward 3 South, that the ward clerk had advised her that she had found hospital notes in the bin on the ward and, on further investigation, we discovered that Mr O'Brien was responsible. I brought this to the attention of Mrs Trouton and Mrs Helen Walker, Assistant Director of Human Resources, and I am aware that Mr Brown and Mrs Parkes did a formal investigation into this.

### *Booking Private Patients for a procedure ahead of NHS patients*

ix. Mr Haynes raised this issue with me towards the end of 2015 and advised myself and Mr Young of some specific patients who were private patients being brought onto NHS lists and significantly jumping the Waiting List. I advised Mr Haynes to speak with Mr Young on this issue and it is my recollection that, at this time, nothing was followed through on this but I have since learned that this was a common practice of Mr O'Brien's for a quite a number of years. However, I am not able to be more specific with timeframes due to this being verbal conversations with other members of staff who worked in theatres, on 3 South ward or in the Elective Admissions ward.

1 146 Q. Are you being deliberately careful about committing  
2 names to writing?

3 A. No, that's not meant.

4 147 Q. Sorry?

5 A. That's not meant to be deliberate. 15:58

6 148 Q. Okay.

7 A. I could have put in there: I have spoken before to  
8 Mr. O'Brien.

9 149 Q. Had you spoken to Mr. O'Brien about it and did  
10 you speak to him again? 15:59

11 A. If I put this in an e-mail then I have spoken to him  
12 but, again, a precise date of which I haven't got in  
13 a diary, I'm afraid. It's not something that I would  
14 keep in a diary. But from the e-mail here, I obviously  
15 have spoken to him. 15:59

16 150 Q. Yes. I suppose this is a serious concern on the part  
17 of Mr. Haynes, he's suggesting an audit of the cases.  
18 That wasn't done?

19 A. No. No, it wasn't done.

20 151 Q. Just in case anything pops out of it, the e-mail from 15:59  
21 Mr. Haynes, WIT-54106. I'm not sure if anything more  
22 turns on it, but that's the reference. While that's  
23 coming up -- yes, there it is. So it's a patient  
24 apparently referred September 2015, seen on a Saturday,  
25 10th October, and then in for treatment on 6th 16:00  
26 November. It's one of the cases that you go on to look  
27 at as part of Dr. Chada's investigation, Dr. Chada's  
28 MHPS process.  
29

1 Then another patient seen by Mr. O'Brien, again  
 2 privately, it would appear, Saturday 7th November and  
 3 then cystoscopy on the 25th November 2015. On the face  
 4 of it, those bald dates would cause you concern that  
 5 patients are being seen a lot quicker than the NHS 16:01  
 6 average, given the state of your lists?

7 A. Yes, these dates are short.

8 152 Q. Why was an audit -- fancy word for an investigation in  
 9 one form or another, not performed at that time?

10 A. Apologies, I'm afraid the ball was dropped on this one. 16:01  
 11 It was a word used in the middle of a long e-mail.  
 12 I probably should have had a look at it in more detail  
 13 at that time. I do accept that we didn't follow  
 14 through on it and, certainly after this second e-mail,  
 15 this was at the end of November into December, which is 16:02  
 16 usually a fairly active time in the Trust looking after  
 17 patients and I didn't follow through.

18 153 Q. Mrs. Corrigan has said that to the best of her  
 19 knowledge this concern about Mr. O'Brien's private  
 20 practice and the mingling with NHS work was not 16:02  
 21 addressed until into 2017 and the commencement of the  
 22 MHPS investigation. You said you had a word with  
 23 Mr. O'Brien. What did that amount to can you remember?

24 A. I can't remember the precise wording but, as per my  
 25 e-mail there, I've obviously had a general conversation 16:03  
 26 with him. I use that "in general". I think used the  
 27 words urodynamics there, so I know there was a long  
 28 urodynamics list. So I have obviously had  
 29 a conversation, I can't remember the precise detail of

1 it but I am logging that I've had one. Again, the  
 2 forcefulness of the conversation may not have got fully  
 3 through, but...

4 154 Q. He certainly, when he gave evidence before the Inquiry  
 5 in the spring of this year, I'll just bring it up at 16:04  
 6 TRA-04742, the last line. I am asking him the  
 7 questions. "Do you recall Mr. Young?" He clearly  
 8 pre-empts what I'm about to say. He says:

9  
 10 "I have no recall of, if you're asking specifically, 16:04  
 11 whether there was ever a discussion between Mr. Young  
 12 and myself about any allegation that any private  
 13 patients of mine were ever given preferential treatment  
 14 in the view of anybody else in the form of jumping the  
 15 queue, the answer to that is no. I have my own view on 16:05  
 16 queue jumpers."

17  
 18 He's emphatic or adamant that there was no such  
 19 discussion with you. You caveat your memory or your  
 20 recollection that there was a discussion by saying it 16:05  
 21 may not have been terribly forceful.

22 A. Yes. I can't remember the content of it and it may not  
 23 have come across as strong as it should do.

24 155 Q. In terms of the approach which clinicians should adopt  
 25 when carrying a private list as well as an NHS list, it 16:05  
 26 should have been well known to you and Mr. O'Brien and  
 27 other colleagues by that time, isn't that right?

28 A. Correct.

29 156 Q. You worked privately. Could I draw your attention to

**Hynds, Siobhan**

---

**From:** Young, Michael Personal Information redacted by the USI  
**Sent:** 26 November 2015 12:03  
**To:** Haynes, Mark; Corrigan, Martina  
**Subject:** RE: Queue jumpers

I had spoken before to the person in question re this issue in general and the justification of urgency – and I agree since the waiting list for some things are so long eg urodynamics.  
Will have to speak again then

MY

From: Haynes, Mark  
Sent: 26 November 2015 06:42  
To: Young, Michael; Corrigan, Martina  
Subject: Queue jumpers

Morning Michael

I emailed you on 2nd June 2015 about the ongoing issue of patients on waiting lists not being managed chronologically and in particular private pa

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## Urology Services Inquiry

5. At paragraph 64.15 (WIT-51820), I wish to correct an omission.

a. I have stated as follows:

*'64.15 The issue in reference to private patients potentially having surgery at an earlier point than expected was first raised, to my knowledge, at the meeting in January 2017 as part of the lookback exercise and I am unaware of further meetings on same.'*

b. I wish to amend this to the following:

*'64.15 The issue in reference to private patients potentially having surgery at an earlier point than expected was first raised, **I believe, with me in an email from Mr Haynes on 27 May 2015 (WIT-54107) and subsequently in his further email of 26 November 2015 (WIT-54106). I believe that I spoke briefly to Mr Haynes at some point after the first email (I have a recollection it was after a ward round at the nurses' station) and asked him if he was aware of any clinical reason for the patient being seen in the timescales in question. I cannot recall if he responded then or later nor can I recall if I made any attempt to follow up the issue (although, for the avoidance of doubt, I accept that I should have done). I recall that I also spoke to Mr O'Brien at some stage, most likely at a point after receiving the first email, which would be consistent with what I have said in my response to Mr Haynes' second email (at TRU-270116 – 'I had spoken before to the person in question re this issue in general ...'). I cannot recall the detail of my conversation with Mr O'Brien but believe that I must have received some reassurance from him that he was not prioritising patients whom he had seen privately. I do not know if I spoke to Mr O'Brien again after the second email from Mr Haynes. On reflection, I believe that it might have been better for me simply to have escalated the second email to more senior managers. It is possible that at the time***



## Urology Services Inquiry

**I may have assumed Martina Corrigan would do this because the emails were sent to her as well as to me. It may well be that, as with the issue of follow up with Mr Haynes in respect of the first email, this issue simply got side-lined because of other more pressing day-to-day work. The next time any private patient issue was raised to my knowledge was at the meeting in January 2017 as part of the lookback exercise.'**

6. At paragraph 65.8 (WIT-51823), I have stated, 'I have had no other conversations on this point that I can recall.' This should state, 'I have had **little in the way of** other conversations on this point that I can recall **other than at interview for the MHPS and as described at paragraph 64.15 above.**'

### **Additional Material**

7. I wish to provide the following additional information, not already included in the 'Mr O'Brien' (Q61 to Q74) section of the Section 21 Notice:
- a. When triaging on 30<sup>th</sup> July 2018, I observed in correspondence from the A&E department that the patient had seen Mr O'Brien and had recently been commenced on Desmopressin 200 micrograms. She had a subsequent admission with hyponatraemia in June 2018. Her hyponatraemia did resolve and correspondence from Mr O'Brien did acknowledge the relationship between the Desmopressin dosage and her hyponatraemia. On seeing this correspondence, I emailed Mr O'Brien to note that the correct dose of the medication for an elderly lady was 25 micrograms (see 2. 20180730 -Email MY to AOB Desmopressin). I thought he would appreciate this correspondence. On reviewing the situation, I note that the correct dose was recorded on a discharge comment of October 2018. My memory of this episode was only triggered in very recent times (when seeing another elderly patient potentially in need of Desmopressin). Having reflected on it, I acknowledge that an option open to me in 2018 would have been to complete an IR1 form. I

Trouton, this being passed to them, the delays having been noted by the Booking Office and Red Flag Team.

64.13 At the time, I was not aware of the meetings held by the Medical Director, Dr Wright, or Clinical Director, Mr Weir, with Mr O'Brien as mentioned in the subsequent correspondence of Mr Haynes. ***(Relevant document located at Relevant to Acute/Evidence after 4 November Acute/Document No 77/Mr M Young/ 20181018 Return to Work AP).***

64.14 It was appreciated that Mr O'Brien was vocal about saying he had difficulty in completing triage as he did not have enough time. I know he wished to perform the 'advanced' triage in a detailed fashion and did not have enough time allocated to do this work. However, he had not indicated the extent to which he was behind in his triaging either in the number of referrals or the timespan they dated back, having had plenty of opportunity to do so in departmental meetings and in his appraisals with me from 2011 to 2016. From recollection, his voiced concerns on triage were from after the time of the introduction of the Urologist of the Week. He raised his concerns at our departmental meetings, whether the topic was scripted for discussion or on an ad hoc basis. The quantum of consultants and the Head of Service at each of these departmental meetings over the years (2014 -18) did vary, however, we all were aware of his comments. It was pointed out that we felt the detail and depth he was aspiring to attain was above the necessary level to complete the totality of the triage for the week. Booking an investigation was the arrangement we had discussed initially when setting up the Urologist of the Week system. ***(Relevant document located at S21 No 55 of 2022, 139. Urol depart autumn 2018).*** I was not aware of anyone else that he had conversed with on this issue nor any correspondence he has produced other than in 2018 for the 'Developmental day' meeting.

64.15 The issue in reference to private patients potentially having surgery at an earlier point than expected was first raised, to my knowledge, at the meeting in January 2017 as part of the lookback exercise and I am unaware of further meetings on same.

64.16 The more recent concerns in reference to the SAIs in relation to delayed referral on to oncology and the prescribing of Casodex / Bicalutamide, I only became aware of around the time of Mr O'Brien's retirement.

1 Earlier in 2015, in April or May time, Mr. Haynes had  
 2 written to Mr. Young expressing concerns about how he  
 3 understood or how he perceived private patients were  
 4 being given an advantage by you. He alludes to that.  
 5 He says, 2nd June, just the bottom of the email there: 16:40

6  
 7 "I emailed you on 2nd June 2016 about the ongoing  
 8 issues of patients on waiting lists not being managed  
 9 chronologically and in particular private PA".  
 10 16:40

11 Mr. Young responds, 26th November:

12  
 13 "I had spoken before to the person in question  
 14 regarding this issue in general and the justification  
 15 of urgency, and I agree since the waiting list for some 16:41  
 16 things are so long, for example, urodynamics. Will  
 17 have to speak again then".

18 He is saying - he doesn't name you - but he says he has  
 19 spoken to the person and the justification of urgency  
 20 and suggesting to Mr. Mackle will have to speak again. 16:41  
 21 So, he is suggesting to Mr. Haynes that he will have to  
 22 speak again to you, assumedly. A suggestion of two  
 23 possible conversations with you.

24 A. Yes.

25 244 Q. We will have to ask Mr. Young for his view on whether 16:41  
 26 they happened.

27 A. Yes.

28 245 Q. Do you recall Mr. Young --

29 A. I have no recall of -- if you're asking specifically

1 whether there was ever a discussion between Mr. Young  
2 and myself about any allegation that any private  
3 patients of mine were ever given preferential treatment  
4 in the view of anybody else in the form of jumping the  
5 queue, the answer to that is no. I have my own view on 16:42  
6 queue jumpers.

7 246 Q. Just if I can make the question more general then.  
8 You've narrowed the parameters of your answers to the  
9 question I have posed to you. Did he ever say to you,  
10 for example, generally, as regards your private 16:42  
11 practice, you just have to be careful that people  
12 moving from your private practice on to NHS treatment  
13 have to be -- that move has to be clinically justified  
14 in a context where we have a massive waiting list  
15 concern? 16:43

16 A. No. I remember actually one conversation that we did  
17 have that followed shortly after a multi-disciplinary  
18 meeting, where Mr. Young had submitted a case to be  
19 discussed, a patient who he had performed a radical  
20 nephrectomy on years previously, then years later, 16:43  
21 having remained well, she had a single lesion in her  
22 rib and it looked like as if it was a metastatic  
23 lesion. Should he biopsy it or should he just ask  
24 a thoracic surgeon to re-site that part of the rib.  
25 I think I was Chairing that MDM. Mr. Haynes objected 16:43  
26 to us discussing, at an NHS MDM, a patient who was  
27 being followed up by another person privately.  
28 I remember Michael -- I was doing appraisal at the  
29 time, so that's interesting. It could have been around

1 about this time in November/December '15. He raised  
2 with me about, you know, Mr. Haynes having a concern  
3 about private patients, and I couldn't understand why  
4 he would have any such concern. It was in the context  
5 of this particular event happening at MDM. We both -- 16:44  
6 I certainly passed it off as Mr. Haynes having  
7 a particular antipathy to private practice, and I have  
8 heard him express that before. He did conduct  
9 a private practice, as I recall, in Sheffield, and  
10 he didn't enjoy the experience. I think he felt that 16:45  
11 patients came along with a lot of expectations, that  
12 possibly they would be treated preferentially.

13  
14 So apart from that single episode, but I didn't come  
15 away from that with any concern that people thought 16:45  
16 I was giving any private patients of mine preferential  
17 treatment. I knew all private patients had the right  
18 to go on to an NHS waiting list of whatever kind.

19 247 Q. So if nobody, Mr. Young in particular, didn't send  
20 a shot across your bows or mention Mr. Haynes' concern, 16:45  
21 were you nevertheless confident in your understanding  
22 of what the rules of the game were in terms of private  
23 patients moving across into the NHS?

24 A. Yes. I think the only omission on my part is that in  
25 '15 and certainly until this was raised as an issue and 16:46  
26 I moved over entirely to digital dictation and so  
27 forth, I don't think, and I cannot recall whether there  
28 were these change of status forms that were available  
29 online. I certainly used them after January '17 or

- 1           A.    I think once Michael was having it raised by  
2                    a Consultant colleague he should have escalated it.
- 3    93   Q.    By escalating it, drawing it to your attention or  
4                    Mr. Brown's attention or dealing with it himself?
- 5           A.    If he dealt with it in June and it was still happening, 11:18  
6                    then it hadn't been resolved, therefore he needed to  
7                    escalate even further and I would have said that was  
8                    something I would have taken on myself.
- 9    94   Q.    Was it a known problem in the Southern Trust that  
10                   consultants were promoting their private patients 11:19  
11                   unfairly on to NHS lists?
- 12           A.    No. As I think I said the other day, I have had --  
13                    I did private practice myself and occasionally they  
14                    would have been brought in, but there were clinical  
15                    reasons for bringing them, there were genuine clinical 11:19  
16                    reasons, not routinely, they were not routinely bumped  
17                    up the list, and I was not aware that other clinicians  
18                    routinely moved patients up the list. In fact, I was  
19                    not aware that anybody was routinely moving people up  
20                    the list because they had been seen privately. 11:19
- 21    95   Q.    Was this an issue that was well-policed by the Trust,  
22                    in your view?
- 23           A.    I don't think the Trust had a system for -- actually,  
24                    when you ask was it policed, the Trust, as far as  
25                    I know, did not have a formal system for assessing it 11:20  
26                    and for looking into that and for auditing it, no.  
27                    I don't know if other Trusts do but I know our Trust  
28                    didn't.
- 29    96   Q.    Going back to your earlier answer that Mrs. Corrigan



**MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE  
MODERN NHS**

# **Maintaining High Professional Standards in the Modern NHS**

## **Introduction**

In December 2003, the Department of Health issued the document *High Professional Standards in the Modern NHS; a framework for the initial handling of concerns about doctors and dentists in the NHS*, under cover of HSC 2003/012. The framework consisted of two parts:

- Part I: Action when a concern arises; and
- Part II: Restriction of practice and exclusion.

The Department has now agreed with the British Medical Association and British Dental Association the remaining three parts of the framework covering new disciplinary procedures for doctors and dentists employed in the NHS. These are:

- Part III: Conduct hearings and disciplinary matters;
- Part IV: Procedures for dealing with issues of capability; and
- Part V: Handling concerns about a practitioner's health.

As with Parts I and II, Parts III, IV, and V of the framework have been drafted in close collaboration with NHS Employers and the National Clinical Assessment Authority.

The new procedure replaces the current disciplinary procedures contained in circular HC(90)9, as well as the Special Professional Panels ("the three wise men) provided for in HC(82)13 and abolishes the right of appeal to the Secretary of State held by certain practitioners under Para 190 of the Terms and Conditions of Service. The Directions on Disciplinary Procedures 2005 require all NHS bodies in England to implement the framework within their local procedures by 1 June 2005. It has also been agreed with Monitor that the framework should be issued to NHS Foundation Trusts as advice.

## Key Changes

The key changes are that:

- the distinction between personal and professional misconduct is abolished. Doctors and dentists employed in the NHS will be disciplined for misconduct under the same locally based procedures as any other staff member;
- there is a single process for handling capability issues about the practitioners professional competence closely tied in with the work of the National Clinical Assessment Authority;
- Health issues are routinely dealt with through the occupational health service;
- The employing Trust is squarely responsible for the disciplining of its medical and dental staff – not outsiders;
- There is scope bring in expert advice for panels considering capability issues;
- The capability panel will be handled by an independent chair;
- The same disciplinary procedures will apply to all doctors and dentists employed in the NHS.

## **Doctors' and dentists' disciplinary framework: introduction and explanatory note**

NHS organisations are required to have procedures for handling concerns about the conduct, performance and health of medical and dental employees, (excluding those who perform PCT Medical Services for the exercise of those functions, as far as they are covered by the Primary Care List System). Under the Restriction of Practice and Exclusion from Work Directions 2003, and the Directions on Disciplinary Procedures 2004, these local procedures must be in accordance with the framework.

This framework has been developed at a national level by the Department of Health, the NHS Confederation, the British Medical Association and the British Dental Association and applies to the NHS in England. It covers:

- action to be taken when a concern about a doctor or dentist first arises;
- procedures for considering whether there need to be restrictions placed on a doctor or dentists practice or suspension is considered necessary
- guidance on conduct hearings and disciplinary procedures
- procedures for dealing with issues of capability
- arrangements for handling concerns about a practitioners health

### **Background**

1. For a number of years there has been concern about the way in which complaints about, and disciplinary action against, doctors and dentists have been handled in the NHS and particularly about the use of suspension\* in such cases. The National Clinical Assessment Authority (NCAA), which was established to improve arrangements for dealing with the poor clinical performance of doctors, has by working with the NHS helped to avoid the suspension, informal suspension and other authorised absences from work of 85% of the cases referred to it where suspension was being contemplated by the NHS Trust. The number of doctors and dentists who have been suspended from work for long periods is a cause for concern. Although the numbers are small the costs to the NHS are substantial.

\* The term exclusion from work is used in this document to replace the word "suspension" which can be confused with action taken by the GMC or GDC to suspend the practitioner from the register pending a hearing of their case or as an outcome of the hearing.

**Table 1. Number of doctors and dentists suspended for six months or more.**

Quarter	2000	2001	2002	2003
1.	33	32	30	27
2.	30	33	33	26
3.	26	33	38	32
4.	27	29	29	24

Changes to NHS disciplinary procedures are necessary as a result of the introduction of Shifting the Balance of Power, the Employment Act 2002 and the Follett report ("A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties" A report to the Secretary of State for Education and Skills, by Professor Sir Brian Follett and Michael Paulson-Ellis, September 2001).

2. Developing new arrangements for handling issues about medical and dental staff performance has become increasingly important both to tackle these concerns and to reflect the new systems for quality assurance and quality improvement which have been introduced in the NHS in recent years.

3. The new approach set out in the framework builds on four key elements:

- appraisal\* and revalidation - processes which encourage practitioners to maintain the skills and knowledge needed for their work through continuing professional development;  
\*Appraisal is a structured process which gives doctors an opportunity to reflect on their practice and discuss, with a suitably trained and qualified appraiser, any issues arising from their work, and their development needs. Appraisal is a contractual requirement for NHS consultants and GP Principals.
- the advisory and assessment services of the NCAA - aimed at enabling NHS Trusts to handle cases quickly and fairly reducing the need to use disciplinary procedures to resolve problems;
- tackling the blame culture - recognising that most failures in standards of care are caused by systems' weaknesses not individuals per se;

- abandoning the "suspension culture" - by introducing the new arrangements for handling exclusion from work set out in part II of this framework.

4. But to work effectively these need to be supported by a culture and by attitudes and working practices which emphasise the importance of doctors and dentists keeping their skills and knowledge up to date; maintaining their competence; and which support an open approach to reporting and tackling concerns about doctors' and dentists' practice. The new approach recognises the importance of seeking to tackle performance issues through training or other remedial action rather than solely through disciplinary action. However it is not intended to weaken accountability or avoid disciplinary action where there is genuinely serious misconduct.

**Maintaining High Professional Standards in the Modern NHS**

***I Action when a concern arises***

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## I. ACTION WHEN A CONCERN ARISES

### INTRODUCTION

1. The management of performance is a continuous process which is intended to identify problems. Numerous ways now exist in which concerns about a practitioner's performance can be identified; through which remedial and supportive action can be quickly taken before problems become serious or patients harmed; and which need not necessarily require formal investigation or the resort to disciplinary procedures.

Concerns about a doctor or dentist's conduct or capability can come to light in a wide variety of ways, for example:

- Concerns expressed by other NHS professionals, health care managers, students and non-clinical staff
- Review of performance against job plans, annual appraisal, revalidation
- Monitoring of data on performance and quality of care
- Clinical governance, clinical audit and other quality improvement activities
- Complaints about care by patients or relatives of patients
- Information from the regulatory bodies
- Litigation following allegations of negligence
- Information from the police or coroner
- Court judgements

2. Unfounded and malicious allegations can cause lasting damage to a doctor's reputation and career prospects. Therefore all allegations, including those made by relatives of patients, or concerns raised by colleagues, must be properly investigated to verify the facts so that the allegations can be shown to be true or false.

### FRAMEWORK FOR NHS PROCEDURES

3. All NHS bodies\* must have procedures for handling serious concerns about an individual's conduct and capability\*\*. These procedures must reflect the framework in this document and allow for informal resolution of less serious problems. Concerns about the capability of doctors and dentists in training should be considered initially as training issues and the postgraduate dean should be involved from the outset.

\*In the Direction and the framework "NHS bodies" means: Strategic Health Authorities, Special Health Authorities, NHS Trusts and Primary Care Trusts.

\*\*A serious concern about capability will arise where the practitioner's actions have or may adversely affect patient care.

4. All serious concerns must be registered with the Chief Executive and he or she must ensure that a case manager is appointed. The Chairman of the

Board must designate a non-executive member "the designated member" to oversee the case and ensure that momentum is maintained. All concerns should be investigated quickly and appropriately. A clear audit route must be established for initiating and tracking progress of the investigation, its costs and resulting action. However the issue is raised, the Medical Director\* will need to work with the Director/Head of HR to decide the appropriate course of action in each case. The Medical Director will act as the case manager in cases involving clinical directors and consultants and may delegate this role to a senior manager to oversee the case on his or her behalf in other cases. The Medical Director is responsible for appointing a case investigator. \*\*In bodies that do not have a Medical Director, the Chief Executive should designate a senior clinical manager to perform the role assigned to the Medical Director in these procedures and ensure that they are appropriately trained.

## **Protecting the public**

5. When serious concerns are raised about a practitioner, the employer must urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings or provide for the exclusion of the practitioner from the workplace. Part II of this framework sets out the procedures for this action.

6. The duty to protect patients is paramount. At any point in the process where the case manager has reached the clear judgement that a practitioner is considered to be a serious potential danger to patients or staff, that practitioner must be referred to the regulatory body, whether or not the case has been referred to the NCAA\*. Consideration should also be given to whether the issue of an alert letter should be requested. \*The GMC or GDC will discuss with the NCAA whether any immediate action is needed by the GMC/GDC or whether the NCAA's consideration should continue.

## **Involving the NCAA**

7. At any stage of the handling of a case consideration should be given to the involvement of the NCAA. The NCAA has developed a staged approach to the services it provides NHS Trusts and practitioners. This involves:

- Immediate telephone advice, available 24 hours
- Advice, then detailed supported local case management
- Advice, then supported local clinical performance assessment
- Advice, then detailed NCAA clinical performance assessment
- Support with implementation of recommendations arising from assessment
- Understanding the issue and investigation

## SUMMARY OF KEY ACTION:

- Clarify what has happened and the nature of the problem or concern;
- Discuss with the NCAA what the way forward should be;
- Consider whether restriction of practice or exclusion is required;
- If a formal approach under the conduct or capability procedures is required, appoint an investigator;
- If the case can be progressed by mutual agreement consider whether an NCAA assessment would help clarify the underlying factors that led to the concerns and assist with identifying the solution.

8. The first task of the case manager is to identify the nature of the problem or concern and to assess the seriousness of the issue on the information available and the likelihood that it can be resolved without resort to formal disciplinary procedures. This is a difficult decision and should not be taken alone but in consultation with the Director/Head of HR and the Medical Director and the National Clinical Assessment Authority (NCAA). The NCAA can provide a sounding board for the case manager's first thoughts. However, the NCAA asks that the first approach to them should be made by the NHS body's Chief Executive or Medical Director. Where there are concerns about a doctor or dentist in training, the postgraduate dean should be involved as soon as possible.

9. The first stage of the NCAA's involvement in a case is exploratory- an opportunity for local managers to discuss the problem with an impartial outsider, to look afresh at a problem, see new ways of tackling it themselves, possibly recognise the problem as being more to do with work systems than doctor performance, or see a wider problem needing the involvement of an outside body other than the NCAA.

10. Having discussed the case with the NCAA, the case manager must decide whether an informal approach can be taken to address the problem, or whether a formal investigation will be needed. Where an informal route is chosen the NCAA can still be involved until the problem is resolved. This can include the NCAA undertaking a formal clinical performance assessment when the doctor, the NHS body and the NCAA agree that this could be helpful in identifying the underlying cause of the problem and possible remedial steps. If the NCAA is asked to undertake an assessment of the doctor's practice, the outcome of a local investigation may be made available to inform the NCAA's work.

11. Where it is decided that a more formal route needs to be followed (perhaps leading to conduct or capability proceedings) the Medical Director must, after discussion between the Chief Executive and Director/Head of Human Resources, appoint an appropriately experienced or trained person as case investigator. The seniority of the case investigator will differ depending

on the grade of practitioner involved in the allegation. Several clinical managers should be appropriately trained, to enable them to carry out this role when required.

12. The case investigator is responsible for leading the investigation into any allegations or concerns about a practitioner, establishing the facts and reporting the findings. The case investigator:

- must formally involve a senior member of the medical or dental staff\* where a question of clinical judgement is raised during the investigation process.  
\*Where no other suitable senior doctor or dentist is employed by the NHS body a senior doctor or dentist from another NHS body should be involved.
- must ensure that safeguards are in place throughout the investigation so that breaches of confidentiality are avoided as far as possible. Patient confidentiality needs to be maintained but the disciplinary panel will need to know the details of the allegations. It is the responsibility of the case investigator to judge what information needs to be gathered and how - within the boundaries of the law - that information should be gathered.
- must ensure that there are sufficient written statements collected to establish a case prior to a decision to convene a disciplinary panel, and on aspects of the case not covered by a written statement, ensure that oral evidence is given sufficient weight in the investigation report.
- must ensure that a written record is kept of the investigation, the conclusions reached and the course of action agreed by the Director or Head of HR with the Medical Director.
- must assist the designated Board member in reviewing the progress of the case.

The case investigator does not make the decision on what action should be taken nor whether the employee should be excluded from work and may not be a member of any disciplinary or appeal panel relating to the case.

13. The practitioner concerned must be informed in writing by the case manager, as soon as it has been decided, that an investigation is to be undertaken, the name of the case investigator and made aware of the specific allegations or concerns that have been raised. The practitioner must be given the opportunity to see any correspondence relating to the case together with a list of the people that the case investigator will interview. The practitioner must also be afforded the opportunity to put their view of events to the case investigator and given the opportunity to be accompanied.

14. At any stage of this process - or subsequent disciplinary action - the practitioner may be accompanied in any interview or hearing by a companion. In addition to statutory rights under the Employment Act 1999, the companion may be another employee of the NHS body; an official or lay representative of the British Medical Association, British Dental Association or defence organisation; or a friend, partner or spouse. The companion may be legally qualified but he or she will not be acting in a legal capacity.

15. The case investigator has wide discretion on how the investigation is carried out but in all cases the purpose of the investigation is to ascertain the facts in an unbiased manner. Investigations are not intended to secure evidence against the practitioner as information gathered in the course of an investigation may clearly exonerate the practitioner or provide a sound basis for effective resolution of the matter

16. If during the course of the investigation it transpires that the case involves more complex clinical issues than first anticipated, the case manager should consider whether an independent practitioner from another NHS body should be invited to assist.

17. The case investigator should complete the investigation within 4 weeks of appointment and submit their report to the case manager within a further 5 days. The report of the investigation should give the case manager sufficient information to make a decision whether:

- there is a case of misconduct that should be put to a conduct panel;
- there are concerns about the practitioner's health that should be considered by the NHS body's occupational health service;
- there are concerns about the practitioner's performance that should be further explored by the National Clinical Assessment Authority;
- restrictions on practice or exclusion from work should be considered;
- there are serious concerns that should be referred to the GMC or GDC;
- there are intractable problems and the matter should be put before a capability panel;
- No further action is needed.

## **Involvement of the NCAA following local investigation**

18. Medical under performance can be due to health problems, difficulties in the work environment, behaviour or a lack of clinical capability. These may occur in isolation or in a combination. The NCAA's processes are aimed at addressing all of these, particularly where local action has not been able to take matters forward successfully. The NCAA's methods of working therefore assume commitment by all parties to take part constructively in a referral to the NCAA. For example, its assessors work to formal terms of reference, decided on after input from the doctor and the referring body.

19. The focus of the NCAA's work is therefore likely to involve performance difficulties which are serious and/or repetitive. That means:

Performance falling well short of what doctors and dentists could be expected to do in similar circumstances and which, if repeated, would put patients seriously at risk.

Alternatively or additionally, problems that are ongoing or (depending on severity) have been encountered on at least two occasions.

In cases where it becomes clear that the matters at issue focus on fraud, specific patient complaints or organisational governance, their further management may warrant a different local process. The NCAA may advise on this.

20. Where an employing body is considering excluding a doctor or dentist whether or not his or her performance is under discussion with the NCAA, it is important for the NCAA to know of this at an early stage, so that alternatives to exclusion can be considered. Procedures for exclusion are covered in part II of the framework. It is particularly desirable to find an alternative when the NCAA is likely to be involved, because it is much more difficult to assess a doctor who is excluded from practice than one who is working.

21. A practitioner undergoing assessment by the NCAA must cooperate with any request to give an undertaking not to practise in the NHS or private sector other than their main place of NHS employment until the NCAA assessment is complete\*. The NCAA has issued guidance on its processes, and how to make such referrals. This can be found at [www.ncaa.nhs.uk/services](http://www.ncaa.nhs.uk/services).

\*Under circular HSC 2002/011, Annex 1, paragraph 3, "A doctor undergoing assessment by the NCAA must give a binding undertaking not to practise in the NHS or private sector other than in their main place of NHS employment until the assessment process is complete."

22. Failure to co-operate with a referral to the NCAA may be seen as evidence of a lack of willingness on the part of the doctor or dentist to work with the employer on resolving performance difficulties. If the practitioner chooses not to co-operate with such a referral, that may limit the options open to the

parties and may necessitate disciplinary action and consideration of referral to the GMC or GDC.

## **Confidentiality**

23. Employers must maintain confidentiality at all times. No press notice should be issued, nor the name of the practitioner released, in regard to any investigation or hearing into disciplinary matters. The Employer should only confirm that an investigation or disciplinary hearing is underway.

24. Personal data released to the case investigator for the purposes of the investigation must be fit for the purpose, nor disproportionate to the seriousness of the matter under investigation. Employers should be familiar with the guiding principles of the Data Protection Act.

## **Transitional arrangements**

25. At the time of the implementation of this framework, a case manager must be appointed for all existing cases and the new procedures followed as far as is practical taking into account the stage the case has reached.

26. Where, in the view of the employer, an existing case could not be effectively resolved using this framework and a disciplinary process began before the Directions came into force, an alternative process may be used.

## Maintaining High Professional Standards in the Modern NHS

### ***II. RESTRICTION OF PRACTICE & EXCLUSION FROM WORK***

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## Restriction of practice and exclusion from work

### Introduction

1. This part of the framework replaces the guidance in HSG (94)49\*. Under the Restriction of Practice and Exclusion from Work Directions 2003 ("the directions"), NHS employers must incorporate these principles and procedures within their local procedures.

\*HSG(94)49- Disciplinary Procedures for Hospital and Community Medical and Hospital Dental Staff. Department of Health, 1994.

2. In this part of the framework, the phrase "exclusion from work" has been used to replace the word "suspension" which can be confused with action taken by the GMC or GDC to suspend the practitioner from the register pending a hearing of their case or as an outcome of the fitness to practise hearing.

3. The Direction requires that NHS bodies must ensure that:

- exclusion from work is used only as an interim measure whilst action to resolve a problem is being considered;
- where a practitioner is excluded, it is for the minimum necessary period of time: this can be up to but no more than four weeks at a time;
- all extensions of exclusion are reviewed and a brief report provided to the Chief Executive and the Board;
- a detailed report is provided when requested to a single non-executive member of the Board (the "Designated Board Member") who will be responsible for monitoring the situation until the exclusion has been lifted.

### Managing the risk to patients

4. When serious concerns are raised about a practitioner, the employer must urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings or provide for the exclusion of the practitioner from the workplace. Where there are concerns about a doctor or dentist in training, the postgraduate dean should be involved as soon as possible.

5. Exclusion of clinical staff from the workplace is a temporary expedient. Under this framework, exclusion is a precautionary measure and not a disciplinary sanction. Exclusion from work ("suspension") should be reserved for only the most exceptional circumstances.

6. The purpose of exclusion is:

- to protect the interests of patients or other staff; and/or
- to assist the investigative process when there is a clear risk that the practitioner's presence would impede the gathering of evidence.

It is imperative that exclusion from work is not misused or seen as the only course of action that could be taken. The degree of action must depend on the nature and seriousness on the concerns and on the need to protect patients, the practitioner concerned and/or their colleagues.

7. Alternative ways to manage risks, avoiding exclusion, include:

- Medical or clinical director supervision of normal contractual clinical duties;
- Restricting the practitioner to certain forms of clinical duties;
- Restricting activities to administrative, research/audit, teaching and other educational duties. By mutual agreement the latter might include some formal retraining or re-skilling.
- Sick leave for the investigation of specific health problems.

8. In cases relating to the capability of a practitioner, consideration should be given to whether an action plan to resolve the problem can be agreed with the practitioner. Advice on the practicality of this approach should be sought from the National Clinical Assessment Authority (NCAA). If the nature of the problem and a workable remedy cannot be determined in this way, the case manager should seek to agree with the practitioner to refer the case to the NCAA, which can assess the problem in more depth and give advice on any action necessary. The NCAA can offer immediate telephone advice to case managers considering restriction of practise or exclusion and, whether or not the practitioner is excluded, provide an analysis of the situation and offer advice to the case manager.

## **THE EXCLUSION PROCESS**

9. Under the Direction, a NHS body cannot require the exclusion of a practitioner for more than four weeks at a time. The justification for continued exclusion must be reviewed on a regular basis and before any further four-week period of exclusion is imposed. Under the framework key officers and the Board have responsibilities for ensuring that the process is carried out quickly and fairly, kept under review and that the total period of exclusion is not prolonged.

## Key features of Exclusion from Work

- **An initial "immediate" exclusion of no more than two weeks if warranted;**
- **Notification of the NCAA before formal exclusion;**
- **Formal exclusion (if necessary) for periods up to four weeks;**
- **Advice on the case management plan from the NCAA;**
- **Appointment of a Board member to monitor the exclusion and subsequent action;**
- **Referral to NCAA for formal assessment, if part of case management plan;**
- **Active review to decide renewal or cessation of exclusion;**
- **A right to return to work if review not carried out;**
- **Performance reporting on the management of the case;**
- **Programme for return to work if not referred to disciplinary procedures or performance assessment.**

## Roles of officers

10. The Chief Executive of the employing organisation has overall responsibility for managing exclusion procedures and for ensuring that cases are properly managed. The decision to exclude a practitioner must be taken only by persons nominated under paragraph 12. The case should be discussed fully with the Chief Executive, the Medical Director, the Director/Head of Human Resources, the NCAA and other interested parties (such as the police where there are serious criminal allegations or the Counter Fraud & Security Management Service) prior to the decision to exclude a practitioner. In the rare cases where immediate exclusion is required, the above parties must discuss the case at the earliest opportunity following exclusion, preferably at a case conference.

11. The authority to exclude a member of staff must be vested in a nominated manager or managers of the NHS body. These managers should be at an appropriately senior level in the organisation and should be the minimum number of people consistent with the size of the organisation and the need to ensure 24 hour availability of a nominated manager in the event of a critical incident. It should include the Chief Executive, Medical Director and the Clinical Directors for staff below the grade of consultant.

12. The Medical Director will act as the case manager or delegate this role to a senior manager to oversee the case and appoint a case investigator to explore and report on the circumstances that have led to the need to exclude the staff member. The investigating officer will provide factual information to assist the case manager in reviewing the need for exclusion and making reports on progress to the Chief Executive or designated Board member.

## **Role of designated Board member**

13. Representations may be made to the designated Board member in regard to exclusion, or investigation of a case if these are not provided for by the NHS body's grievance procedures. The designated Board member must also ensure, among other matters, that time frames for investigation or exclusion are consistent with the principles of Article 6 of the European Convention on Human Rights (which, broadly speaking, sets out the framework of the rights to a fair trial).

## **Immediate exclusion**

14. An immediate time limited exclusion may be necessary for the purposes identified in paragraph 6 above following:

- a critical incident when serious allegations have been made; or
- there has been a break down in relationships between a colleague and the rest of the team; or
- the presence of the practitioner is likely to hinder the investigation.

Such an exclusion will allow a more measured consideration to be undertaken. This period should be used to carry out a preliminary situation analysis, to contact the NCAA for advice and to convene a case conference. The manager making the exclusion must explain why the exclusion is being made in broad terms (there may be no formal allegation at this stage) and agree a date up to a maximum of two weeks away at which the practitioner should return to the workplace for a further meeting. The case manager must advise the practitioner of their rights, including rights of representation.

## **Formal exclusion**

15. A formal exclusion may only take place after the case manager has first considered whether there is a case to answer and then considered, at a case conference, whether there is reasonable and proper cause to exclude. The NCAA must be consulted where formal exclusion is being considered. If a case investigator has been appointed he or she must produce a preliminary report as soon as is possible to be available for the case conference. This preliminary report is advisory to enable the case manager to decide on the next steps as appropriate.

16. The report should provide sufficient information for a decision to be made as to whether:

- the allegation appears unfounded; or
- there is a misconduct issue; or
- there is a concern about the practitioner's capability; or
- the complexity of the case warrants further detailed investigation before advice can be given on the way forward and what needs to be inquired into.

17. Formal exclusion of one or more clinicians must only be used where

a. there is a need to protect the interests of patients or other staff pending the outcome of a full investigation of:

- allegations of misconduct,
- concerns about serious dysfunctions in the operation of a clinical service,
- concerns about lack of capability or poor performance of sufficient,
- seriousness that it is warranted to protect patients;

or

b. the presence of the practitioner in the workplace is likely to hinder the investigation.

18. Full consideration should be given to whether the practitioner could continue in or (in cases of an immediate exclusion) return to work in a limited capacity or in an alternative, possibly non-clinical role, pending the resolution of the case.

19. When the practitioner is informed of the exclusion, there should, where practical, be a witness present and the nature of the allegations or areas of concern should be conveyed to the practitioner. The practitioner should be told of the reason(s) why formal exclusion is regarded as the only way to deal with the case. At this stage the practitioner should be given the opportunity to state their case and propose alternatives to exclusion (e.g. further training, referral to occupational health, referral to the NCAA with voluntary restriction).

20. The formal exclusion must be confirmed in writing as soon as is reasonably practicable. The letter should state the effective date and time, duration (up to 4 weeks), the content of the allegations, the terms of the exclusion (e.g. exclusion from the premises, see paragraph 23, and the need to remain available for work paragraph 24) and that a full investigation or what other action will follow. The practitioner and their companion should be advised that they may make representations about the exclusion to the designated board member at any time after receipt of the letter confirming the exclusion.

21. In cases when disciplinary procedures are being followed, exclusion may be extended for four-week renewable periods until the completion of disciplinary procedures if a return to work is considered inappropriate. The exclusion should still only last for four weeks at a time and be subject to review. The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon the employment, as soon as the original reasons for exclusion no longer apply.

22. If the case manager considers that the exclusion will need to be extended over a prolonged period outside of his or her control (for example because of a police investigation), the case must be referred to the NCAA for advice as to whether the case is being handled in the most effective way and suggestions as to possible ways forward. However, even during this prolonged period the principle of four-week "renewability" must be adhered to.

23. If at any time after the practitioner has been excluded from work, investigation reveals that either the allegations are without foundation or that further investigation can continue with the practitioner working normally or with restrictions, the case manager must lift the exclusion, inform the SHA and make arrangements for the practitioner to return to work with any appropriate support as soon as practicable.

### **Exclusion from premises**

24. Practitioners should not be automatically barred from the premises upon exclusion from work. Case managers must always consider whether a bar from the premises is absolutely necessary. There are certain circumstances, however, where the practitioner should be excluded from the premises. This could be, for example, where there may be a danger of tampering with evidence, or where the practitioner may be a serious potential danger to patients or other staff. In other circumstances, however, there may be no reason to exclude the practitioner from the premises. The practitioner may want to retain contact with colleagues, take part in clinical audit and to remain up to date with developments in their field of practice or to undertake research or training.

### **Keeping in contact and availability for work**

25. As exclusion under this framework should usually be on full pay, the practitioner must remain available for work with their employer during their normal contracted hours. The practitioner must inform the case manager of any other organisation(s) with whom they undertake either voluntary or paid work and seek their case manager's consent to continuing to undertake such work or to take annual leave or study leave. The practitioner should be reminded of these contractual obligations but would be given 24 hours notice to return to work. In exceptional circumstances the case manager may decide that payment is not justified because the practitioner is no longer available for work (e.g. abroad without agreement).

26. The case manager should make arrangements to ensure that the practitioner can keep in contact with colleagues on professional developments, and take part in Continuing Professional development (CPD) and clinical audit activities with the same level of support as other doctors or dentists in their employment. A mentor could be appointed for this purpose if a colleague is willing to undertake this role.

## **Informing other organisations**

27. In cases where there is concern that the practitioner may be a danger to patients, the employer has an obligation to inform such other organisations including the private sector, of any restriction on practice or exclusion and provide a summary of the reasons for it. Details of other employers (NHS and non-NHS) may be readily available from job plans, but where it is not the practitioner should supply them. Failure to do so may result in further disciplinary action or referral to the relevant regulatory body, as the paramount interest is the safety of patients. Where a NHS employer has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer\*.

\*NHS bodies must develop strong co-partnership relations with universities and ensure that jointly agreed procedures are in place for dealing with any concerns about practitioners with honorary contracts. A draft model protocol is available from the Department of Health.

28. Where the case manager believes that the practitioner is practising in other parts of the NHS or in the private sector in breach or defiance of an undertaking not to do so, he or she should contact the professional regulatory body and the Director of Public Health or Medical Director of the Strategic Health Authority to consider the issue of an alert letter.

## **Informal exclusion**

29. No practitioner should be excluded from work other than through this new procedure. Informal exclusions, so called 'gardening leave' have been commonly used in the recent past. No NHS body may use "gardening leave" as a means of resolving a problem covered by this framework.

## **Existing suspensions & transitional arrangements**

30. At the time of implementation of this framework, all informal exclusions (e.g. 'gardening leave') must be transferred to the new system of exclusion and dealt with under the arrangements set out in this framework.

31. A case manager should be appointed for each existing case and a review conducted of the need for the suspension as in paragraph 33 below. In cases where exclusion is considered to be necessary, the new system will apply and the exclusion will be covered by the four-week review rule set out below. The new exclusion will run for four weeks in the first instance.

## KEEPING EXCLUSIONS UNDER REVIEW

### Informing the Board

32. The Board must be informed about an exclusion at the earliest opportunity. The Board has a responsibility to ensure that the organisation's internal procedures are being followed. It should, therefore:

- require a summary of the progress of each case at the end of each period of exclusion, demonstrating that procedures are being correctly followed and that all reasonable efforts are being made to bring the situation to an end as quickly as possible;
- receive a monthly statistical summary showing all exclusions with their duration and number of times the exclusion had been reviewed and extended. A copy must be sent to the Strategic Health Authority.

### Regular review

33. The case manager must review the exclusion before the end of each four week period and report the outcome to the Chief Executive and the Board\*. This report is advisory and it would be for the case manager to decide on the next steps as appropriate. The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon the employment, at any time the original reasons for exclusion no longer apply and there are no other reasons for exclusion. The exclusion will lapse and the practitioner will be entitled to return to work at the end of the four-week period if the exclusion is not actively reviewed.

\*It is important to recognise that Board members might be required to sit as members of a future disciplinary or appeal panel. Therefore, information to the Board should only be sufficient to enable the Board to satisfy itself that the procedures are being followed. Only the designated Board member should be involved to any significant degree in each review. Careful consideration must be given as to whether the interests of patients, other staff, the practitioner, and/or the needs of the investigative process continue to necessitate exclusion and give full consideration to the option of the practitioner returning to limited or alternative duties where practicable.

34. The NHS body must take review action before the end of each 4-week period. After three exclusions, the NCAA must be called in. The table below outlines the various activities that must be undertaken at different stages of exclusion.

### First and second reviews (and reviews after the third review)

Before the end of each exclusion (of up to 4 weeks) the case manager reviews the position.

- The case manager decides on next steps as appropriate. Further renewal may be for up to 4 weeks at a time.

- Case manager submits advisory report of outcome to Chief Executive and the Board.
- Each renewal is a formal matter and must be documented as such.
- The practitioner must be sent written notification on each occasion.
- Third review

If the practitioner has been excluded for three periods:

- A report must be made to the Chief Executive: outlining the reasons for the continued exclusion and why restrictions on practice would not be an appropriate alternative; and if the investigation has not been completed a timetable for completion of the investigation.
- The CE must report to the Strategic Health Authority (SHA) (see paragraphs 36-38 below) and the designate Board member (see paragraphs 41-42 below).
- The case must formally be referred to the National Clinical Assessment Authority (NCAA) explaining:
  - Why continued exclusion is appropriate
  - What steps are being taken to conclude the exclusion at the earliest opportunity
- The NCAA will review the case with the SHA and advise the NHS body on the handling of the case until it is concluded.

## **6 months review**

If the exclusion has been extended over six months,

- A further position report must be made by the Chief Executive to the SHA indicating:
  - the reason for continuing the exclusion;
  - anticipated time scale for completing the process;
  - actual and anticipated costs of the exclusion.
- The SHA will form a view as to whether the case is proceeding at an appropriate pace and in the most effective manner and whether there is any advice they can offer to the Board.

35. Normally there should be a maximum limit of 6 months exclusion, except for those cases involving criminal investigations of the practitioner concerned. The employer and the NCAA should actively review those cases at least every six months.

## **The role of the SHA in monitoring exclusions**

36. When the SHA is notified of an exclusion, it should ensure that the NCAA has also been notified.

37. When an exclusion decision has been extended twice, the Chief Executive of the employing organisation (or a nominated officer) must inform the SHA of what action is proposed to resolve the situation. This should include dates for hearings or give reasons for the delay. Where retraining or other rehabilitation action is proposed, the reason for continued exclusion must be given.

38. The SHA will receive the monthly statistical summary given to Boards and collate them into a single report for the Department of Health.

## **The role of the Board and designated member**

39. The Board has a responsibility for ensuring that these procedures are established and followed. It is also responsible for ensuring the proper corporate governance of the organisation, and for this purpose reports must be made to the Board under these procedures.

40. Board members may be required to sit as members of a disciplinary or appeal panel. Therefore, information given to the Board should only be sufficient to enable the Board to satisfy itself that the procedures are being followed. Only the designated Board member should be involved to any significant degree in each review.

41. The Board is responsible for designating one of its non-executive members as a "designated Board member" under these procedures. The designated Board member is the person who oversees the case manager and investigating manager during the investigation process and maintains momentum of the process.

42. This member's responsibilities include:

- receiving reports and reviewing the continued exclusion from work of the practitioner;
- considering any representations from the practitioner about his or her exclusion;
- considering any representations about the investigation;

## **RETURN TO WORK**

43. If it is decided that the exclusion should come to an end, there must be formal arrangements for the return to work of the practitioner. It must be clear whether clinical and other responsibilities are to remain unchanged or what the duties and restrictions are to be and any monitoring arrangements to ensure patient safety.

**Maintaining High Professional Standards in the Modern NHS**

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## Maintaining High Professional Standards in the Modern NHS

### III. GUIDANCE ON CONDUCT HEARINGS AND DISCIPLINARY PROCEDURES

#### INTRODUCTION

1. Misconduct matters for doctors and dentists, as for all other staff groups, are matters for local employers and must be resolved locally. All issues regarding the misconduct of doctors and dentists should be dealt with under the employer's procedures covering other staff charged with similar matters. Employers are nevertheless strongly advised to seek advice from the NCAA in conduct cases, particularly in cases of professional conduct.
2. Where the alleged misconduct relates to matters of a professional nature, or where an investigation identifies issues of professional conduct, the case investigator must obtain appropriate independent professional advice. Similarly where a case involving issues of professional conduct proceeds to a hearing under the employer's conduct procedures the panel must include a member who is medically qualified (in the case of doctors) or dentally qualified (in the case of dentists) and who is not currently employed by the organisation.<sup>1</sup>
3. NHS bodies must develop strong co-partnership relations with universities and ensure that jointly agreed procedures are in place for dealing with any concerns about practitioners with honorary contracts.

#### Codes of Conduct

4. Every NHS employer will have a Code of Conduct or staff rules which should set out acceptable standards of conduct and behaviour expected of all its employees. Breaches of these rules are considered to be "misconduct". Misconduct can cover a very wide range of behaviour and can be classified in a number of ways, but it will generally fall into one of four distinct categories:

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<sup>1</sup> Employers are advised to discuss the selection of the medical or dental panel member with the appropriate local professional representative body eg for doctors in a hospital trust the medical staff committee or local negotiating committee

- A refusal to comply with reasonable requirements of the employer.
- An infringement of the employer's disciplinary rules including conduct that contravenes the standard of professional behaviour required by doctors and dentists by their regulatory body<sup>2</sup>.
- The commission of criminal offences outside the place of work which may, in particular circumstances, amount to misconduct.
- Wilful, careless, inappropriate or unethical behaviour likely to compromise standards of care or patient safety, or create serious dysfunction to the effective running of a service.

5. Examples of misconduct will vary greatly. The employer's Code of Conduct should set out details of some of the acts that will result in a serious breach of contractual terms and will constitute gross misconduct, and could lead to summary dismissal. The code cannot cover every eventuality. Similarly the ACAS Code of Practice provides a non-exhaustive list of examples. Acts of misconduct may be simple and readily recognised or more complex and involved. Examples may include unreasonable or inappropriate behaviour such as verbal or physical bullying, harassment and/or discrimination in the exercise of their duties towards patients, the public or other employees. It could also include actions such as deliberate falsification or fraud.
6. Any allegation of misconduct against a doctor or dentist in recognised training grades should be considered initially as a training issue and dealt with via the educational supervisor and college or clinical tutor with close involvement of the postgraduate dean from the outset.
7. Failure to fulfil contractual obligations may also constitute misconduct. For example, regular non-attendance at clinics or ward rounds, or not taking part in clinical governance activities may come into this category. Additionally, instances of failing to give proper support to other members of staff including doctors or dentists in training may be considered in this category.
8. Each case must be investigated, but as a general rule no employee should be dismissed for a first offence, unless it is one of gross misconduct.
9. It is for the employer to decide upon the most appropriate way forward, having consulted the NCAA and their own employment law specialist. If a practitioner considers that the case has been wrongly classified as misconduct, he or she (or his/her representative) is entitled to use the employer's grievance procedure. Alternatively or in addition he or she may make representations to the designated board member
10. Many smaller organisations such as Primary Care Trusts, may not have all the necessary personnel in place to follow the procedures outlined in this

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<sup>2</sup> In case of doctors, *Good Medical Practice*. In the case of dentists, *Maintaining Standards*.

document. For example, some PCTs may not employ a medical director or may not employ medical or dental staff of sufficient seniority or from the appropriate specialty. Also, it may be difficult to provide senior staff to undertake hearings who have not been involved in the investigation.

11. Such organisations should consider working in collaboration with other local NHS organisations (eg other PCTs or larger employers) in order to provide sufficient personnel to follow the procedures described. The organisation should be sufficiently distant to avoid any organisational conflict of interest and any nominee should be asked to declare any conflict of interest. In such circumstances the NHS organisation should contact the NCAA to take its advice on the process followed and ensure that it is in accordance with the policy and procedure set out in this document.

## **ALLEGATIONS OF CRIMINAL ACTS**

### **Action when investigations identify possible criminal acts**

12. Where an employer's investigation establishes a suspected criminal action in the UK or abroad, this must be reported to the police. The trust investigation should only proceed in respect of those aspects of the case which are not directly related to the police investigation underway. The employer must consult the police to establish whether an investigation into any other matters would impede their investigation. In cases of fraud, the Counter Fraud & Security Management Service must be contacted.

### **Cases where criminal charges are brought not connected with an investigation by an NHS employer**

13. There are some criminal offences that, if proven, could render a doctor or dentist unsuitable for employment. In all cases, employers, having considered the facts, will need to consider whether the employee poses a risk to patients or colleagues and whether their conduct warrants instigating an investigation and the exclusion of the practitioner. The employer will have to give serious consideration to whether the employee can continue in their job once criminal charges have been made. Bearing in mind the presumption of innocence, the employer must consider whether the offence, if proven, is one that makes the doctor or dentist unsuitable for their type of work and whether, pending the trial, the employee can continue in their present job, should be allocated to other duties or should be excluded from work. This will depend on the nature of the offence and advice should be sought from an HR or legal adviser. Employers should as a matter of good practice explain the reasons for taking such action.

**Dropping of charges or no court conviction**

14. When the Trust has refrained from taking action pending the outcome of a court case, if the practitioner is acquitted but the employer feels there is enough evidence to suggest a potential danger to patients, then the Trust has a public duty to take action to ensure that the individual concerned does not pose a risk to patient safety. Similarly where there are insufficient grounds for bringing charges or the court case is withdrawn there may be grounds for considering police evidence where the allegations would, if proved, constitute misconduct, bearing in mind that the evidence has not been tested in court. It must be made clear to the police that any evidence they provide and is used in the Trust's case will have to be made available to the doctor or dentist concerned. Where charges are dropped, the presumption is that the employee will be reinstated.

**GUIDANCE ON AGREEING TERMS FOR SETTLEMENT ON TERMINATION OF EMPLOYMENT**

15. In some circumstances, terms of settlement may be agreed with a doctor or dentist if their employment is to be terminated. The following good practice principles are set out as guidance for the Trust:

- Settlement agreements must not be to the detriment of patient safety.
- It is not acceptable to agree any settlement that precludes either appropriate investigations being carried out and reports made or referral to the appropriate regulatory body.
- Payment will not normally be made when a member of staff's employment is terminated on disciplinary grounds or following the resignation of the member of staff.
- Expenditure on termination payments must represent value for money. For example, the Trust should be able to defend the settlement on the basis that it could conclude the matter at less cost than other options. A clear record must be kept, setting out the calculations, assumptions and rationale of all decisions taken, to show that the Trust or authority has taken into account all relevant factors, including legal advice. The audit trail must also show that the matter has been considered and approved by the remuneration committee and the Board. It must also be able to stand up to district auditor and public scrutiny.
- Offers of compensation, as an inducement to secure the voluntary resignation of an individual, must not be used as an alternative to the disciplinary process.

- All job references must be accurate, realistic and comprehensive and under no circumstance may they be misleading.
- Where a termination settlement is agreed, details may be confirmed in a Deed of Compromise that should set out what each party may say in public or write about the settlement. The Deed of Compromise is for the protection of each party, but it must not include clauses intended to cover up inappropriate behaviour or inadequate services and should not include the provision of an open reference.<sup>3</sup>

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<sup>3</sup> For the purposes of this paragraph, an open reference is one that is prepared in advance of a request by a prospective employer.

**Maintaining High Professional Standards in the Modern NHS**

***IV Procedures for dealing with issues of capability***

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## Maintaining High Professional Standards in the Modern NHS

### IV. PROCEDURES FOR DEALING WITH ISSUES OF CAPABILITY

#### INTRODUCTION & GENERAL PRINCIPLES

1. The causes of adverse events should not automatically be attributed to the actions, failings or unsafe acts of an individual alone. Root cause analyses of individual adverse events frequently show that these are more broadly based and can be attributed to systems or organisational failures, or demonstrate that they are untoward outcomes which could not have been predicted and are not the result of any individual or systems failure. Each will require appropriate investigation and remedial actions.
2. The National Patient Safety Agency (NPSA) was established to co-ordinate the efforts of all those involved in healthcare to learn from adverse incidents occurring within the NHS. In particular, the NPSA aims to facilitate the development of an open and fair culture, which encourages doctors, dentists and other NHS staff to report adverse incidents and other near misses in a climate free from fear of personal reprimand, where the sharing of experience helps others to learn lessons and in turn improve patient safety.
3. However, there will be occasions where an employer considers that there has been a clear failure by an individual to deliver an adequate standard of care, or standard of management, through lack of knowledge, ability or consistently poor performance. These are described as capability issues. Matters that should be described and dealt with as misconduct issues are covered in part III of this framework.
4. Concerns about the capability of a doctor or dentist may arise from a single incident or a series of events, reports or poor clinical outcomes. Advice from the National Clinical Assessment Authority (NCAA)<sup>4</sup> will help the Trust to come to a decision on whether the matter raises questions about the practitioner's capability as an individual (health problems, behavioural difficulties or lack of clinical competence) or whether there are other matters that need to be addressed. If the concerns about capability cannot be resolved routinely by management, **the matter must be referred to the NCAA before the matter can be considered by a capability panel** (unless the practitioner refuses to have his or her case referred). Employers are also strongly advised to involve the NCAA in all other cases particularly those involving professional conduct.

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<sup>4</sup> or successor body

5. Matters which may fall under the capability procedures include:

**Some examples of concerns about capability**

- out of date clinical practice;
- inappropriate clinical practice arising from a lack of knowledge or skills that puts patients at risk;
- incompetent clinical practice;
- inability to communicate effectively;
- inappropriate delegation of clinical responsibility;
- inadequate supervision of delegated clinical tasks;
- ineffective clinical team working skills.

6. Wherever possible, employers should aim to resolve issues of capability (including clinical competence and health) through ongoing assessment and support. Early identification of problems is essential to reduce the risk of serious harm to patients. The NCAA has a key role in providing expert advice and support for local action to support the remediation of a doctor or dentist and should be consulted. A web based toolkit has been developed and is available at: [www.ncaa.nhs.uk/toolkit](http://www.ncaa.nhs.uk/toolkit)
7. Any concerns about capability relating to a doctor or dentist in recognised training grades should be considered initially as a training issue and dealt with via the educational supervisor and college or clinical tutor, with close involvement of the postgraduate dean from the outset.

## **How to proceed where conduct and capability issues involved**

8. It is inevitable that some cases will cover conduct and capability issues. It is recognised that these cases can be complex and difficult to manage. If a case covers more than one category of problem, they should usually be combined under a capability hearing although there may be occasions where it is necessary to pursue a conduct issue separately. It is for the employer to decide on the most appropriate way forward having consulted with an NCAA adviser and their own employment law specialist.

## **Duties of Employers**

9. The procedures set out below are designed to cover issues where a doctor's or dentist's *capability* to practise is in question<sup>5</sup>. Prior to instigating these procedures, the employer should consider the scope for resolving the issue through counselling or retraining and should take advice from the NCAA.

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<sup>5</sup> see paragraph 3 in Part III concerning clinical academics and paragraphs 9 and 10 in Part III on arrangements for small organisations.

10. Capability may be affected by ill health. Arrangements for handling concerns about a practitioner's health are described in part V of this framework. Employers must follow their own procedure for dealing with ill health – including obtaining advice, usually from a consultant Occupational Health Physician.
11. Employers must ensure that investigations and capability procedures are conducted in a way that does not discriminate on the grounds of race, gender, disability or indeed on other grounds.
12. Employers must ensure that managers and case investigators receive appropriate and effective training in the operation of capability procedures. Those undertaking investigations or sitting on capability or appeals panels must have had formal equal opportunities training before undertaking such duties. The Trust Board must agree what training its staff and its members must have completed before they can take a part in these proceedings.

## **CAPABILITY PROCEDURE**

### **The pre-hearing process**

13. When a report of the Trust investigation (as in Part I<sup>6</sup>) has been received, the case manager must give the practitioner the opportunity to comment in writing on the factual content of the report produced by the case investigator. Comments in writing from the practitioner, including any mitigation, must normally be submitted to the case manager within 10 working days of the date of receipt of the request for comments. In exceptional circumstances, for example in complex cases or due to annual leave, the deadline for comments from the practitioner should be extended.
14. The case manager should decide what further action is necessary, taking into account the findings of the report, any comments that the practitioner has made and the advice of the NCAA. The case manager will need to consider urgently:
  - whether action under Part II of the framework is necessary to exclude the practitioner; or
  - to place temporary restrictions on their clinical duties.

The case manager will also need to consider with the Medical Director and head of Human Resources whether the issues of capability can be

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<sup>6</sup> "Action when a concern arises" - Part I of the framework issued under the Restriction of Practise & Exclusion from Work Directions 2003.

resolved through local action (such as retraining, counselling, performance review). If this action is not practicable for any reason the matter must be referred to the NCAA for it to consider whether an assessment should be carried out and to provide assistance in drawing up an action plan. The case manager will inform the practitioner concerned of the decision immediately and normally within 10 working days of receiving the practitioner's comments.

15. The NCAA will assist the employer to draw up an action plan designed to enable the practitioner to remedy any lack of capability that has been identified during the assessment. The Trust must facilitate the agreed action plan (which has to be agreed by the Trust and the practitioner before it can be actioned). There may be occasions when a case has been considered by the NCAA, but the advice of its assessment panel is that the practitioner's performance is so fundamentally flawed that no educational and/or organisational action plan has a realistic chance of success. In these circumstances, the case manager must make a decision, based upon the completed investigation report and informed by the NCAA advice, whether the case should be determined under the capability procedure. If so, a panel hearing will be necessary.
16. If the practitioner does not agree to the case being referred to the NCAA, a panel hearing will normally be necessary.
17. The following procedure should be followed before the hearing:

***Procedure to be followed prior to capability hearings***

- The case manager must notify the practitioner in writing of the decision to arrange a capability hearing. This notification should be made at least 20 working days before the hearing and include details of the allegations and the arrangements for proceeding including the practitioner's rights to be accompanied and copies of any documentation and/or evidence that will be made available to the capability panel. This period will give the practitioner sufficient notice to allow them to arrange for a companion to accompany them to the hearing if they so choose.
- All parties must exchange any documentation, including witness statements, on which they wish to rely in the proceedings no later than 10 working days before the hearing. In the event of late evidence being presented, the employer should consider whether a new date should be set for the hearing.
- Should either party request a postponement to the hearing the case manager is responsible for ensuring that a reasonable response is made and that time extensions to the process are kept to a minimum. Employers retain the right, after a reasonable period (not normally less than 30 working days), to proceed with the hearing in the practitioner's absence, although the employer should act reasonably in deciding to do so.
- Should the practitioner's ill health prevent the hearing taking place the employer should implement their usual absence procedures and involve the Occupational Health Department as necessary.
- Witnesses who have made written statements at the inquiry stage may, but will not necessarily, be required to attend the capability hearing. Following representations from either side contesting a witness statement which is to be relied upon in the hearing, the Chairman should invite the witness to attend. The Chairman cannot require anyone other than an employee to attend. However, if evidence is contested and the witness is unable or unwilling to attend, the panel should reduce the weight given to the evidence as there will not be the opportunity to challenge it properly. A final list of witnesses to be called must be given to both parties not less than two working days in advance of the hearing.
- If witnesses required to attend the hearing choose to be accompanied, the person accompanying them will not be able to participate in the hearing.

## The hearing framework

18. The capability hearing will normally be chaired by an Executive Director of the Trust. The panel should comprise a total of 3 people, normally 2 members of the Trust Board, or senior staff appointed by the Board for the purpose of the hearing. At least one member of the panel must be a medical or dental practitioner who is not employed by the Trust.<sup>7</sup> As far as is reasonably possible or practical, no member of the panel or advisers to the panel should have been previously involved in the investigation. In the case of clinical academics a further panel member may be appointed in accordance with any protocol agreed between the employer and the university.
19. Arrangements must be made for the panel to be advised by:

- A senior member of staff from Human Resources, and
- A senior clinician from the same or similar clinical specialty as the practitioner concerned, but from another NHS employer.
- A representative of a university if provided for in any protocol as mentioned in paragraph 18.

It is important that the panel is aware of the typical standard of competence required of the grade of doctor in question. If for any reason the senior clinician is unable to advise on the appropriate level of competence, a doctor from another NHS employer in the same grade as the practitioner in question should be asked to provide advice.

20. It is for the employer to decide on the membership of the panel. A practitioner may raise an objection to the choice of any panel member within 5 working days of notification. The employer should review the situation and take reasonable measures to ensure that the membership of the panel is acceptable to the practitioner. It may be necessary to postpone the hearing while this matter is resolved. The employer must provide the practitioner with the reasons for reaching its decision in writing before the hearing can take place.

## Representation at capability hearings

21. The hearing is not a court of law. Whilst the practitioner should be given every reasonable opportunity to present his or her case, the hearing should not be conducted in a legalistic or excessively formal manner.

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<sup>7</sup> Employers are advised to discuss the selection of the medical or dental panel member with the appropriate local professional representative body eg for doctors in a hospital trust the medical staff committee or local negotiating committee.

22. The practitioner may be represented in the process by a friend, partner or spouse, colleague, or a representative who may be from or retained by a trade union or defence organisation. Such a representative may be legally qualified but they will not, however, be representing the practitioner formally in a legal capacity. The representative will be entitled to present a case on behalf of the practitioner, address the panel and question the management case and any witness evidence.

### **Conduct of the capability hearing**

23. The hearing should be conducted as follows:

- The panel and its advisers (see paragraph 19), the practitioner, his or her representative and the case manager will be present at all times during the hearing. Witnesses will be admitted only to give their evidence and answer questions and will then retire.
- The Chairman of the panel will be responsible for the proper conduct of the proceedings. The Chairman should introduce all persons present and announce which witnesses are available to attend the hearing.
- The procedure for dealing with any witnesses attending the hearing shall be the same and shall reflect the following:

- The witness to confirm any written statement and give any supplementary evidence.
- The side calling the witness can question the witness.
- The other side can then question the witness.
- The panel may question the witness.
- The side which called the witness may seek to clarify any points which have arisen during questioning but may not at this point raise new evidence.

## The order of presentation shall be:

- The Case Manager presents the management case including calling any witnesses. The above procedure for dealing with witnesses shall be undertaken for each witness in turn, at the end of which each witness shall be allowed to leave.
- The Chairman shall invite the Case Manager to clarify any matters arising from the management case on which the panel requires further clarification.
- The practitioner and/or their representative shall present the practitioner's case, calling any witnesses. The above procedure for dealing with witnesses shall be undertaken for each witness in turn, at the end of which each witness shall be allowed to leave.
- The Chairman shall invite the practitioner and/or representative to clarify any matters arising from the practitioner's case on which the panel requires further clarification.
- The Chairman shall invite the Case Manager to make a brief closing statement summarising the key points of the case.
- The Chairman shall invite the practitioner and/or representative to make a brief closing statement summarising the key points of the practitioner's case. Where appropriate this statement may also introduce any grounds for mitigation.
- The panel shall then retire to consider its decision.

## Decisions

24. The panel will have the power to make a range of decisions including the following:

### ***Possible decisions made by the capability panel***

- No action required.
- Oral agreement that there must be an improvement in clinical performance within a specified time scale with a written statement of what is required and how it might be achieved.  
*(stays on employee's record for 6 months)*
- Written warning that there must be an improvement in clinical performance within a specified time scale with a statement of what is required and how it might be achieved.  
*(stays on employee's record for 1 year)*
- Final written warning that there must be an improvement in clinical performance within a specified time scale with a statement of what is required and how it might be achieved.  
*(stays on employee's record for 1 year)*
- Termination of contract.

It is also reasonable for the panel to make comments and recommendations on issues other than the competence of the practitioner, where these issues are relevant to the case. For example, there may be matters around the systems and procedures operated by the employer that the panel wishes to comment upon.

25. A record of oral agreements and written warnings should be kept on the practitioner's personnel file but should be removed following the specified period.

26. The decision of the panel should be communicated to the parties as soon as possible and normally within 5 working days of the hearing. Because of the complexities of the issues under deliberation and the need for detailed consideration, the parties should not necessarily expect a decision on the day of the hearing.

27. The decision must be confirmed in writing to the practitioner. This notification must include reasons for the decision, clarification of the practitioner's right of appeal and notification of any intent to make a referral to the GMC/GDC or any other external/professional body.

## APPEALS PROCEDURES IN CAPABILITY CASES

### Introduction

28. Given the significance of the decision of a capability panel to warn or dismiss a practitioner, it is important that a robust appeal procedure is in place. Every Trust must therefore establish an internal appeal process for appeal against decisions of a capability panel. There is no requirement for Trusts to set up a procedure for appeal against exclusion or investigation as these are adjuncts to the stages of the decision making process on what future action to take. The procedure for handling issues about the classification of a case as misconduct is dealt with in paragraph 9 of Part III of this framework.
29. The appeals procedure provides a mechanism for practitioners who disagree with the outcome of a decision to have an opportunity for the case to be reviewed. The appeal panel will need to establish whether the Trust's procedures have been adhered to and that the panel in arriving at their decision acted fairly and reasonably based on:

- A fair and thorough investigation of the issue;
- Sufficient evidence arising from the investigation or assessment on which to base the decision;
- Whether in the circumstances the decision was fair and reasonable, and commensurate with the evidence heard.

It can also hear new evidence submitted by the practitioner and consider whether it might have significantly altered the decision of the original hearing. The appeal panel, however, should not rehear the entire case (see paragraph 31 below).

30. A dismissed practitioner will in all cases be potentially able to take their case to an Employment Tribunal where the reasonableness or otherwise of the Trust's actions will be tested.

### The appeal process

31. The predominant purpose of the appeal is to ensure that a fair hearing was given to the original case and a fair and reasonable decision reached by the hearing panel. The appeal panel has the power to confirm or vary the decision made at the capability hearing, or order that the case is reheard. Where it is clear in the course of the appeal hearing that the proper procedures have not been followed and the appeal panel determines that the case needs to be fully re-heard, the Chairman of the panel shall have the power to instruct a new capability hearing.

32. Where the appeal is against dismissal, the practitioner should not be paid during the period of appeal, from the date of termination of employment. Should the appeal be upheld, the practitioner should be reinstated and must be paid backdated to the date of termination of employment. Where the decision is to rehear the case, the practitioner should also be reinstated, subject to any conditions or restrictions in place at the time of the original hearing, and paid backdated to the date of termination of employment.

## The appeal panel

33. The panel should consist of three members. The members of appeal panel must not have had any previous direct involvement in the matters that are the subject of the appeal, for example they must not have acted as the designated board member. These members will be:

### Membership of the appeal panel

- An independent member (trained in legal aspects of appeals) from an approved pool.<sup>8</sup> This person is designated Chairman.
- The Chairman (or other non-executive director) of the employing organisation who must have the appropriate training for hearing an appeal.
- A medically qualified member (or dentally qualified if appropriate) who is not employed by the Trust<sup>9</sup> who must also have the appropriate training for hearing an appeal.
- In the case of clinical academics a further panel member may be appointed in accordance with any protocol agreed between the employer and the university.

34. The panel should call on others to provide specialist advice. This should normally include:

- A Consultant from the same specialty or subspecialty as the appellant, but from another NHS employer.<sup>10</sup>
- A Senior Human Resources specialist.

<sup>8</sup> See Annex A.

<sup>9</sup> Employers are advised to discuss the selection of the medical or dental panel member with the local professional representative body eg in a hospital trust the medical staff committee or local negotiating committee.

<sup>10</sup> Where the case involves a dentist this may be a consultant or an appropriate senior practitioner.

It is important that the panel is aware of the typical standard of competence required of the grade of doctor in question. If for any reason the senior clinician is unable to advise on the appropriate level of competence, a doctor from another NHS employer in the same grade as the practitioner in question should be asked to provide advice.

35. The Trust should arrange the panel and notify the appellant as soon as possible and in any event within the recommended timetable in paragraph 34. Every effort should be made to ensure that the panel members are acceptable to the appellant. Where in rare cases agreement cannot be reached upon the constitution of the panel, the appellant's objections should be noted carefully. Trusts are reminded of the need to act reasonably at all stages of the process.
36. It is in the interests of all concerned that appeals are heard speedily and as soon as possible after the original capability hearing. The following timetable should apply in all cases:

- Appeal by written statement to be submitted to the designated appeal point (normally the Director of Human Resources) within 25 working days of the date of the written confirmation of the original decision.
- Hearing to take place within 25 working days of date of lodging appeal.
- Decision reported to the appellant and the Trust within 5 working days of the conclusion of the hearing.

37. The timetable should be agreed between the Trust and the appellant and thereafter varied only by mutual agreement. The case manager should be informed and is responsible for ensuring that extensions are absolutely necessary and kept to a minimum.

## **Powers of the appeal panel**

38. The appeal panel has the right to call witnesses of its own volition, but must notify both parties at least 10 working days in advance of the hearing and provide them with a written statement from any such witness at the same time.
39. Exceptionally, where during the course of the hearing the appeal panel determines that it needs to hear the evidence of a witness not called by either party, then it shall have the power to adjourn the hearing to allow for a written statement to be obtained from the witness and made available to both parties before the hearing reassembles.

40. If, during the course of the hearing, the appeal panel determines that new evidence needs to be presented, it should consider whether an adjournment is appropriate. Much will depend on the weight of the new evidence and its relevance. The appeal panel has the power to determine whether to consider the new evidence as relevant to the appeal, or whether the case should be reheard, on the basis of the new evidence, by a capability hearing panel.

## **Conduct of appeal hearing**

41. All parties should have all documents, including witness statements, from the previous capability hearing together with any new evidence.
42. The practitioner may be represented in the process by a friend, partner or spouse, colleague or a representative who may be from or retained by a trade union or defence organisation. Such a representative may be legally qualified but they will not, however, be representing the practitioner formally in a legal capacity. The representative will be entitled to present a case on behalf of the practitioner, address the panel and question the management case and any written evidence.
43. Both parties will present full statements of fact to the appeal panel and will be subject to questioning by either party, as well as the panel. When all the evidence has been presented, both parties shall briefly sum up. At this stage, no new information can be introduced. The appellant (or his/her companion) can at this stage make a statement in mitigation.
44. The panel, after receiving the views of both parties, shall consider and make its decision in private.

## **Decision**

45. The decision of the appeal panel shall be made in writing to the appellant and shall be copied to the Trust's case manager such that it is received within 5 working days of the conclusion of the hearing. The decision of the appeal panel is final and binding. There shall be no correspondence on the decision of the panel, except and unless clarification is required on what has been decided (but not on the merits of the case), in which case it should be sought in writing from the Chairman of the appeal panel.

## **Action following hearing**

46. Records must be kept, including a report detailing the capability issues, the practitioner's defence or mitigation, the action taken and the reasons for it. These records must be kept confidential and retained in accordance with the capability procedure and the Data Protection Act 1998. These records need to be made available to those with a legitimate call upon

them, such as the practitioner, the Regulatory Body, or in response to a Direction from an Employment Tribunal.

## **TERMINATION OF EMPLOYMENT WITH PERFORMANCE ISSUE UNRESOLVED**

47. Where the employee leaves employment before disciplinary procedures have been completed, the investigation must be taken to a final conclusion in all cases and capability proceedings must be completed wherever possible, whatever the personal circumstances of the employee concerned.

48. Every reasonable effort must be made to ensure the employee remains involved in the process. If contact with the employee has been lost, the employer should invite them to attend any hearing by writing to both their last known home address and their registered address (the two will often be the same). The employer must make a judgement, based on the evidence available, as to whether the allegations about the practitioner's capability are upheld. If the allegations are upheld, the employer must take appropriate action, such as requesting the issue of an alert letter and referral to the professional regulatory body, referral to the police, or the Protection of Children Act List (held by the Department for Education and Skills).

49. If an excluded employee or an employee facing capability proceedings becomes ill, they should be subject to the employer's usual sickness absence procedures. The sickness absence procedures take precedence over the capability procedures and the employer should take reasonable steps to give the employee time to recover and attend any hearing. Where the employee's illness exceeds 4 weeks, they must be referred to the Occupational Health Service. The Occupational Health Service will advise the employer on the expected duration of the illness and any consequences it may have for the capability process and will also be able to advise on the employee's capacity for future work, as a result of which the employer may wish to consider retirement on health grounds. Should the employment be terminated as a result of ill health, the investigation should still be taken to a conclusion and the employer form a judgement as to whether the allegations are upheld.

50. If, in exceptional circumstances, a hearing proceeds in the absence of the practitioner, for reasons of ill-health, the practitioner should have the opportunity to submit written submissions and/or have a representative attend in his absence.

51. Where a case involves allegations of abuse against a child, the guidance issued to the NHS in September 2000, called "The Protection of Children Act 1999 – A Practical Guide to the Act for all Organisations Working with Children" gives more detailed information. A copy can be found on the Department of Health website<sup>11</sup>.

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<sup>11</sup> [A Practical Guide to the Act for all Organisations Working with Children](#)

## Maintaining High Professional Standards in the Modern NHS

### Appeal Panels in Capability Cases

### Annex A

#### Introduction

1. The framework provides for the appeal panel to be chaired by an independent member from an approved pool trained in legal aspects of appeals.
2. It has been agreed that it would be preferable to continue to appoint appeal panel chairmen through a separately held national list rather than through local selection. The benefits include:
  - the ability to secure consistency of approach through national appointment, selection and training of panel chairmen; and
  - the ability to monitor performance and assure the quality of panellists.
3. The following provides an outline of how it is envisaged that the process will work.

#### Creating and administering the list

4. The responsibility for recruitment and selection of panel chairs to the list will lie with *the NHS Appointments Commission*. *NHS Employers* will be responsible for administration of the list.
5. Recruitment to the list will be in accordance with published selection criteria drawn up in consultation with stakeholders, including the *BMA*, *BDA*, defence organisations, the *NCAA* and *NHS Employers*. These stakeholders will also assist in drawing up the selection criteria and in seeking nominations to serve.
6. The *Department of Health*, in consultation with *NHS Employers*, *the BDA* and the *BMA* will provide a job description based on the Competence Framework for Chairmen and Members of Tribunals, drawn up by the *Judicial Studies Board*. The framework, which can be adapted to suit particular circumstances sets out six headline competences featuring the core elements of law and procedure, equal treatment, communication, conduct of hearing, evidence and decision making. Selection will be based on the extent to which candidates meet the competences.

7. Panel members will be subject to appraisal against the core competences and feedback on performance provided by participants in the hearing. This feedback will be taken into account when reviewing the position of the panel member on the list.
8. The level of fees payable to panel members will be set by *NHS Employers* and paid locally by the employing organisation responsible for establishing the panel.
9. List members will be expected to take part in and contribute to local training events from time to time. For example, training based on generic tribunal skills along the lines of the Judicial Studies Board competences and /or seminars designed to provide background on the specific context of NHS disciplinary procedures – including the expectations of employers and representatives, could be provided with support from *NHS Employers*, the *National Clinical Assessment Authority* and other stakeholders.

**Maintaining High Professional Standards in the Modern NHS**

***V. Handling concerns about a practitioner's health***

**Contents**

**Introduction**

*Retaining the services of individuals with health problems*

*Reasonable adjustment*

*Handling Health Issues*

## Maintaining High Professional Standards in the Modern NHS

### V. HANDLING CONCERNS ABOUT A PRACTITIONER'S HEALTH

#### INTRODUCTION

1. A wide variety of health problems can have an impact on an individual's clinical performance. These conditions may arise spontaneously or be as a consequence of work place factors such as stress.
2. The principle for dealing with individuals with health problems is that, wherever possible and consistent with reasonable public protection, they should be treated, rehabilitated or re-trained ( for example if they cannot undertake exposure prone procedures) and kept in employment, rather than be lost from the NHS.

#### Retaining the services of individuals with health problems

3. Wherever possible the Trust should attempt to continue to employ the individual provided this does not place patients or colleagues at risk.

#### Examples of action to take

- sick leave for the practitioner (the practitioner to be contacted frequently on a pastoral basis to stop them feeling isolated);
- remove the practitioner from certain duties;
- reassign them to a different area of work;
- arrange re-training or adjustments to their working environment , with appropriate advice from the NCAA and/or deanery , under reasonable adjustment provision in the Disability Discrimination Act 1995.

#### Reasonable adjustment

3. At all times the practitioner should be supported by their employer and the Occupational Health Service who should ensure that the practitioner is offered every available resource to get back to practise where appropriate. Employers should consider what reasonable adjustments could be made to their workplace conditions or other arrangements.

## Examples of reasonable adjustment

- Make adjustments to the premises
- Re-allocate some of the disabled person's duties to another
- Transfer employee to an existing vacancy
- Alter employee's working hours or pattern of work
- Assign employee to a different workplace
- Allow absence for rehabilitation, assessment or treatment
- Provide additional training or retraining
- Acquire/modify equipment
- Modifying procedures for testing or assessment
- Provide a reader or interpreter
- Establish mentoring arrangements

5. In some cases retirement due to ill health may be necessary. Ill health retirement should be approached in a reasonable and considerate manner, in line with NHS Pensions Agency Advice. However, it is important that the issues relating to conduct or capability that have arisen are resolved, using the agreed procedures where appropriate.

## HANDLING HEALTH ISSUES

6. Where there is an incident that points to a problem with the practitioner's health, the incident may need to be investigated to determine a health problem . If the report recommends OHS involvement, the nominated manager must immediately refer the practitioner to a qualified, usually a consultant, occupational physician with the Occupational Health Service.

7. The NCAA should be approached to offer advice on any situation and at any point where the employer is concerned about a doctor or dentist. Even apparently simple or early concerns should be referred as these are easier to deal with before they escalate.

8. The occupational physician should agree a course of action with the practitioner and send his/her recommendations to the Medical Director and a meeting should be convened with the Director or Head of HR, the Medical Director or case manager, the practitioner and case worker from the OHS to agree a timetable of action and rehabilitation (where appropriate)<sup>12</sup>. The practitioner may wish to bring a support companion to these meetings. This could be a family member, a colleague or a trade union or defence association representative. Confidentiality must be maintained by all parties at all times.
9. If a doctor or dentist's ill health makes them a danger to patients and they do not recognise that, or are not prepared to co-operate with measures to protect patients, then exclusion from work must be considered and the professional regulatory body must be informed, irrespective of whether or not they have retired on the grounds of ill health.
10. In those cases where there is impairment of performance solely due to ill health, disciplinary procedures would only be considered in the most exceptional of circumstances, for example if the individual concerned refuses to co-operate with the employer to resolve the underlying situation e.g. by repeatedly refusing a referral to the Occupational Health Service (OHS) or the NCAA. In these circumstances the procedures in part IV should be followed.
11. There will be circumstances where an employee who is subject to disciplinary proceedings puts forward a case, on health grounds, that the proceedings should be delayed, modified or terminated. In such cases the employer is expected to refer the doctor or dentist to the OHS for assessment as soon as possible. Unreasonable refusal to accept a referral to, or to co-operate with, the OHS under these circumstances, may give separate grounds for pursuing disciplinary action.
12. Special Professional Panels (generally referred to as the "three wise men") were set up by District Health Authorities under circular HC(82)13. This responsibility was not transferred to Trusts and the process has fallen into disuse in most parts of the country. This part of the framework replaces HC(82)13 which is cancelled and any existing panels should be disbanded.

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<sup>12</sup> In the absence of a Medical Director organisations should put in place appropriate measures as part of agreed arrangements for small organisations to ensure the appropriate level of input to the process.

Maintaining High Professional Standards  
in the Modern NHS

Guidance on clinical academics

(including an Outline Protocol between University and Trust)

**CLINICAL ACADEMICS****BACKGROUND**

The "*Restriction of Practice and Exclusion from Work Directions 2003*" direct NHS bodies to comply with the framework contained within the document "*Maintaining High Professional Standards in the Modern NHS*". This introduced a new framework for the initial handling and investigation of concerns about the conduct and performance of medical and dental employees. It also introduced a framework for restriction of practice and exclusion from work; it replaces existing guidance on the suspension of doctors and dentists.

In the framework the Department said that NHS bodies must develop strong co-partnership relations with universities and ensure that jointly agreed procedures are in place for dealing with any concerns about practitioners with honorary contracts. This should be achieved by agreeing a protocol. The draft model protocol mentioned in the framework is attached to this guidance note.

**GUIDANCE**

1. The Follett report made a number of recommendations about disciplinary procedures. In particular it said:

"..we are quite clear that here too robust joint working must be the norm. However, we believe that joint working must extend to the prior phase of managing and helping poor performance and seeking remedial measures. It is only when these have run their course without success that formal disciplinary procedures come into play."

2. In discussions with the Universities and Colleges Employers Association (UCEA), Universities UK (UUK), and the Council of Heads of Medical Schools (CHMS), the Department of Health has agreed that the following four key elements are necessary for the successful handling of concerns about a doctor with both an honorary and substantive contract:

- Appraisals are jointly undertaken by the University and the Trust.
- The express permission of the doctor involved is obtained for the exchange of both personal data (for example name, address, registration number, qualifications) and sensitive personal data (for example medical records) between University and Trust.
- Honorary NHS contracts for clinical academic staff contain a clause that states that the employee must have a substantive contract with the University to hold the honorary NHS post, and that, if the University post is terminated, for whatever reason, the Trust reserves the right to review the continuation of the honorary contract (the "inter-dependency clause").

- The Trust and University develop strong, co-partnership relations with each other and ensure jointly agreed procedures are in place for dealing with any concerns about doctors with honorary NHS contracts.
3. Similar arrangements should apply to doctors holding honorary academic contracts with a university.
  4. A Revised Model Statute for universities on dismissal, discipline and grievance procedures for academic staff has been approved by the Privy Council, and recommended to universities. It will be for them to decide on implementation. The UCEA has urged them to implement the provisions within the Revised Model Statute relating to clinical academic staff as soon as possible.
  5. The success of the contracts rests with the joint working of the university and NHS Trust. Although each employer (university or NHS Trust) can only make a decision to discipline or dismiss a member of staff under its own procedures. It is therefore recommended that a protocol should be agreed to permit the joint working necessary to ensure contractual inter-dependence, if both employers choose that route. Implementation of the Revised Model Statute will enable universities to adopt the new procedures.
  6. A draft protocol - "Outline Protocol between University and Trust"- is attached as an appendix. This provides for a good practice way of working, with reference to disciplinary matters and dismissal.

## APPENDIX

### OUTLINE PROTOCOL BETWEEN UNIVERSITY AND TRUST

1. The following general principles and procedure are the result of agreement between the University and such NHS Trust and Provider Units (hereafter called "the Trust") in which University clinical academic staff may hold honorary NHS contracts and is intended to provide a framework for co-operation between University and Trust as employers of the clinical academic staff.

#### General Principles

2. The substantive academic contract and the NHS honorary contract are both contracts of employment. The clinical academic will therefore have two employers, each of whom will have obligations to the employee under its respective contract of employment and arising (for example under statute) from the employment relationship generally.
3. However, the University and the Trust recognise that as far as possible those separate employment relationships should be regarded as a whole, reflecting the fact that the performance of the clinical duties under the honorary NHS contract is essential for the full and proper performance of the duties under the substantive academic contract.
4. The University and the Trust should therefore seek to ensure joint co-operation in their dealings with the member of clinical academic staff, in particular with regard to issues of appraisal, review, dismissal and discipline.

#### Contracts of Employment

5. The University and the Trust will seek to ensure that their contracts (honorary or substantive) contain provisions which facilitate such joint co-operation and shall discuss on a regular basis the contents of the contracts which each will issue to clinical academics.

#### Disciplinary and other Procedures

6. The University and the Trust acknowledge that as employers of the clinical academic member of staff, each may wish, during the employment of the clinical academic concerned, to take action (whether in terms of dismissal or action falling short of dismissal) in respect of matters such as:
  - a) misconduct or alleged misconduct
  - b) performance of the duties of employment to a satisfactory standard
  - c) assessing medical fitness to undertake all or part of the duties of employment (including consideration of the making of reasonable adjustments under the Disability Discrimination Act 1995 where the obligation to make such adjustments applies)
  - d) attendance
  - e) redundancy or other re-organisation
7. The University and the Trust acknowledge that each has the following procedures for determining such issues in respect of its relationship with the member of clinical academic staff:- [list the relevant procedures]

8. The University and the Trust acknowledge that:
- a) there may be occasions on which the University has grounds for considering such action under its appropriate procedure(s), and the Trust does not ( and *vice versa*);
  - b) there may be occasions on which the University has grounds for considering such action under its appropriate procedure(s) and the Trust also has grounds for considering action against the same employee under its own appropriate procedure(s); and
  - c) that if the University or the Trust terminates the substantive or honorary contract (as the case may be), the other will need to consider whether, in the light of that termination, the remaining contract can be continued or ought to be terminated and that, while each case will need to be considered on its own facts, it is appropriate for the University and the Trust to agree in general terms a framework for the handling of such matters.
9. The University and the Trust therefore agree that:
- a) the following issues of conduct are matters which would ordinarily fall to be dealt with under the University's disciplinary procedure(s) [give details];
  - b) the following issues of conduct are matters which would ordinarily fall to be dealt with under the Trust's disciplinary procedure(s) [give details]; and
  - c) in cases where an issue of misconduct arises under both (a) and (b) above, the University and the Trust will need to determine on the facts of each case which procedure will take priority.

## **Potential Dismissal on the Grounds of Misconduct**

10. Where either the University or the Trust has grounds for considering the dismissal of a member of clinical academic staff on the grounds of misconduct:
- a) the party considering the instigation of disciplinary procedures which may result in dismissal shall notify the other of that fact [it would be useful to set out the relevant points of contact eg respective HR Directors] and shall discuss with the other the circumstances which have led it to contemplate initiating proceedings.
  - b) the University and the Trust will co-operate with each other to facilitate any investigation into the alleged misconduct.
  - c) the University and the Trust shall consider whether the case is such that both parties would have grounds for instituting disciplinary proceedings and, if that is the case, agree whether action is to be taken under each of their appropriate disciplinary procedures and the sequence in which those procedures shall be operated.
  - d) any party considering restriction of practice or exclusion from work of the clinical academic shall advise the other of its proposal to restrict or suspend and discuss this prior to the clinical academic being so restricted or suspended, where it is practical to do so.
  - e) the University and the Trust shall liaise with each other on the steps to be taken under the applicable disciplinary procedure or procedures, in particular as regards representation by both employers on any disciplinary panel established under any of their applicable procedures and the facilitation of the calling of witnesses and/or the

production of documentary evidence necessary for the purpose of determining whether misconduct has occurred.

- f) the University and the Trust (as the case may be) shall keep the other informed of the progress and outcome of their respective procedures, including of any appeal.
11. While the University and the Trust shall co-operate with each other as described above, each acknowledges that the other has the ultimate right to determine whether or not disciplinary proceedings should be instigated, to determine whether misconduct has occurred and, if so, whether dismissal is the appropriate sanction to be applied on the facts of that case. Representation of the Trust on the University's disciplinary panels (and *vice versa*) does not mean that that the Trust's representative is deciding whether the Trust's contract with the member of staff concerned is to be terminated (and *vice versa*).

## **Joint Appraisal**

12. The University and the Trust shall agree procedures for the joint appraisal of members of clinical academic staff and ensure that such arrangements are referred to in the terms of the substantive and honorary contracts issued to the member of staff.

## **Dismissal on Performance, Absence or Ill-Health Grounds**

13. In the event that either the Trust or the University considers that there are grounds for considering the dismissal of a member of clinical academic staff on the grounds of performance, absence or health grounds, each will advise the other of that fact [ again it may be useful to specify the points of contact eg HR director] and shall discuss:
- a) whether action is to be taken under the procedures of the University or the Trust or both (and if both, which procedure shall take priority);
  - b) whether it is appropriate to consider the restriction of practice or exclusion from work of the member of staff concerned in relation to either the academic or clinical duties or both. Any party considering restriction of practice or exclusion from work of the clinical academic member of staff shall advise the other if its proposal to restrict or exclude and discuss this prior to the clinical academic member of staff being restricted or excluded where it is practical to do so; and
  - c) (in cases of sickness absence, or medical incapacity) whether it is necessary to obtain a medical report from an Occupational Health adviser or from an independent medical expert on the ability of the employee to perform the duties of his/her employment. The University and the Trust shall discuss the questions/issues to be raised with such medical adviser, in particular any issues arising under the Disability Discrimination Act 1995, including any duty to make reasonable adjustments.
14. The University and the Trust shall keep each other advised of the actions taken under their applicable procedures, including the outcome of any appeal.
15. While the University and the Trust shall co-operate with each other as described above, each acknowledges that the other has the ultimate right, in relation to any matter being dealt with under its procedures, to determine whether or not to dismiss the member of staff concerned. Representation of the Trust on the University panel (and *vice versa*) does not mean that that representative is deciding whether the Trust's contract with the member of staff concerned is to be terminated (and *vice versa*).

## **Dismissal on the grounds of redundancy or re-organisation**

16. In the event that either the Trust or the University is contemplating the dismissal for redundancy or other re-organisational reasons of any member of clinical academic staff it shall advise the other of this fact and shall keep the other regularly informed of the action being taken in this respect.

## **Other general provisions regarding co-operation**

17. The University and Trust shall ensure that:

- a) their respective procedures provide that, while either the University's or the Trust's disciplinary procedure is being applied to a member of clinical academic staff, that individual may not bring any complaint relating to those proceedings under the grievance procedure of the other employer (ie of the Trust or the University, as the case may be).
- b) rights of appeal will be confined solely to the procedure which is being implemented and individual employees may not appeal across procedures to the other party (ie the University or the Trust as the case may be).
- c) their contracts of employment and procedures are as far as possible sufficient to allow the disclosure of information from one to the other (in particular of personal data or sensitive personal data) under the Data Protection Act 1998, whether with or without the consent of the member of staff concerned. The Trust and the University will also discuss and agree guidelines for the disclosure of data regarding third parties, in particular data relating to patients.

18. The University and the Trust shall meet on a regular basis to review this Agreement and its operation.

**This appendix has been drafted at the request of the Universities and Colleges Employers Association by Pinsents, solicitors, 1 Park Row, Leeds, LS1 5AB. In the event of any queries, please contact Chris Mordue, Partner (0113 244 5000 or [christopher.mordue@pinsents.com](mailto:christopher.mordue@pinsents.com))**



Department of

**Health, Social Services  
and Public Safety**

An Roinn

**Sláinte, Seirbhísí Sóisialta  
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PAY AND EMPLOYMENT UNIT**

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of each body

British Medical Association  
British Dental Association  
NI Medical & Dental Training Agency  
NI Regulation & Improvement Authority

**Circular HSS(TC8) 6/2005**

Our Reference: **BP 117/04**

30 November 2005

Dear Colleague

**Maintaining High Professional Standards in the Modern HPSS - A framework  
for the handling of concerns about doctors and dentists employed in the HPSS**

1. The Directions on Disciplinary Procedures 2005 direct HPSS organisations to comply with the framework contained within the attached document "*Maintaining High Professional Standards in the Modern HPSS*". This document introduces a new framework for handling concerns about the conduct, clinical performance and health of medical and dental employees. The new framework is effective from 1 December 2005.
2. As an aid to employing organisations, the document includes two flow charts outlining the main points of both the informal and formal processes described in the framework.
3. HSS Trusts, HSS Boards and Special Agencies are required to notify the Department of the action they have taken to comply with the framework by 31 January 2006.
4. The framework has been agreed with the BMA and BDA.

5. The new disciplinary framework will replace the following guidance:
- HSS (TC8) 3/75 Disciplinary Proceedings in cases relating to hospital medical and dental staff (currently only applies to salaried primary care dental staff);
  - HSS (TC8) 1/84 Health Services Management: Prevention of harm to patients resulting from physical or mental disability of hospital or community medical or dental staff;
  - HSS (TC8) 15/91 Disciplinary Procedures for Hospital and Community Medical and Dental Staff, including the right of certain consultants to appeal to the Department under "Paragraph 190" of the HPSS Terms & Conditions of Service;
  - HSS (TC8) 3/95 Disciplinary Procedures for Hospital and Community Medical and Hospital Dental Staff - Suspensions.

## Further Copies

6. Copies of this circular and framework can be obtained from the Department's website at <http://extranet/dhsspsni.gov.uk>.

## Enquiries

7. Employees should direct enquiries to their employers. Any enquiries that cannot be resolved locally should be directed to Pay and Employment Unit or by e-mail to Irrelevant information redacted by the USI

Yours faithfully

Personal Information redacted by the USI

**ALAN PRESTON**  
Deputy Director

**THE HEALTH AND PERSONAL SOCIAL SERVICES  
(NORTHERN IRELAND) ORDER 1972****THE HEALTH AND PERSONAL SOCIAL SERVICES  
(SPECIAL AGENCIES) (NORTHERN IRELAND) ORDER 1990****THE HEALTH AND PERSONAL SOCIAL SERVICES  
(NORTHERN IRELAND) ORDER 1991****THE HEALTH AND PERSONAL SOCIAL SERVICES ACT  
(NORTHERN IRELAND) 2001****DIRECTIONS ON DISCIPLINARY PROCEDURES 2005**

The Department of Health, Social Services and Public Safety<sup>a</sup> in exercise of the powers conferred on it by Article 17 of the Health and Personal Social Services (Northern Ireland) Order 1972<sup>b</sup>, Article 4(4) of the Health and Personal Social Services (Special Agencies) (Northern Ireland) Order 1990<sup>c</sup>, paragraph 6(2) of Part II of Schedule 3 to the Health and Personal Social Services (Northern Ireland) Order 1991<sup>d</sup>, and of all other powers enabling it in that behalf, hereby directs as follows:

**Citation, commencement, application and interpretation**

1. -(1) This direction is given to all HSS bodies.
  - (2) This direction shall come into force on 1 December 2005.
  - (3) This direction shall be referred to as "Directions on Disciplinary Procedures 2005".
  - (4) In this direction "HSS body" means:
    - (i) a Health and Social Services Board;
    - (ii) a Health and Social Services Trust;
    - (iii) a Special Agency.

**Compliance with Framework**

2. - Each HSS body shall comply with "Maintaining High Professional Standards in the Modern HPSS – A framework for the handling of concerns about doctors and dentists employed in the HPSS"- ("the framework") as set out in the schedule and promulgated in Circular HSS(TC8) 6/2005.
3. – Each HSS body shall notify the Department of the action they have taken to comply with the framework by 31 January 2006.

Personal Information redacted by the USI

A senior officer of the Department of  
Health, Social Services and Public Safety<sup>e</sup>

*29 November 2005*

<sup>a</sup> See Article 3(6) of S.I. 1999/283 (N.I. 1)

<sup>b</sup> S.I. 1972/1265 (N.I.14)

<sup>c</sup> S.I. 1990/247 (N.I.3)

<sup>d</sup> S.I. 1991/194 (N.I.1) as amended by section 44(2) of 2001 c.3 (NI)

<sup>e</sup> See Article 4(3)(b) of S.I. 1999/283 (N.I. 1)

# INDEPENDENT NEUROLOGY INQUIRY

Report  
June 2022

**Volume 1**

[www.neurologyinquiry.org.uk](http://www.neurologyinquiry.org.uk)

# Independent Neurology Inquiry

[www.neurologyinquiry.org.uk](http://www.neurologyinquiry.org.uk)



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**The Independent Neurology Inquiry**

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## THE INQUIRY TEAM

### Chairman of the Inquiry

Mr Brett Lockhart QC was called to the Bar of Northern Ireland in 1982 and to the Inner Bar in 2006. He is a commercial lawyer with extensive experience of working for leading Northern Ireland companies and public bodies and has widespread experience as a commercial mediator. He is also a designated arbitrator for the Motor Insurers Bureau. Actively involved in education, he is a former Chairman of the Board of Governors at Methodist College Belfast and was a member of the Board of De La Salle College Belfast.

### Inquiry Co-Panellist

Professor Hugo Mascie-Taylor was trained as a Consultant Physician and is a revalidated medical practitioner. He has worked at local, regional, national, and international levels, as a provider, a commissioner, and a regulator. He was Medical Director of a large teaching Trust, of the NHS Confederation, of Monitor (NHS national regulator) and Ernst Young. He was appointed by the Secretary of State as Trust Special Administrator in Mid Staffordshire, and by the Deputy Premier in Western Australia to chair the Independent Oversight Committee. He has carried out clinical governance reviews in several organisations and systems across the World.

### Counsel to the Inquiry (from 2020 to 2021)

Christine Smith QC was called to the Bar of Northern Ireland in 1985 and to the Inner Bar in 2011. From 2012 to 2017 she acted as Senior Counsel to the Inquiry into Historical Institutional Abuse and was also Senior Counsel for the Department of Finance in the Inquiry into the RHI scheme in Northern Ireland. She was a Commissioner of the Criminal Cases Review Commission and stepped down from her role as Counsel to the Inquiry to commence her current role as Chair of the Urology Services Inquiry in March 2021.

### Solicitor to the Inquiry

Mr Mark Scott qualified as a Solicitor in 2010 and as a solicitor advocate in 2014. He has experience in the areas of clinical negligence, governance and regulatory law and health and social care law.

### Secretary to the Inquiry

Ms Quinn is a qualified auditor and senior civil servant. She has been a member of the Northern Ireland Civil Service since 1987, having served in a wide range of posts across three government departments.

### Legal team

The Inquiry legal team comprised:

- Mr Andrew Beech BL
- Ms Laura Curran BL
- Ms Emma McIlveen BL and
- Dr Leah Treanor BL

### Secretariat Staff

The Secretariat team comprised:

- Mr William Jordan
- Mr Stephen Magee
- Miss Victoria Mullan
- Ms Stephanie McGall
- Mrs Rose McShane

The Inquiry Panel wish to convey its thanks to the Northern Ireland Assembly Hansard team for provision of transcription services, during the period while the Assembly was dissolved, Gwen Malone Stenography Services, in particular Mrs JoAnne McAlister, and Mrs Rosemary Tollerton for secretarial services.

## INTRODUCTION

The events, which led to Northern Ireland's largest ever patient recall caused, and continue to cause, significant public consternation. This consternation is most acutely felt by the patients and families of those who had their diagnosis and treatment reviewed. The recall involved patients who had been under the care of Dr Michael Watt, formerly a Consultant Neurologist employed by the Belfast Trust. When the outcomes of the patient recall were subsequently published they revealed that a considerable number of patients had been misdiagnosed and/or mistreated.

### **The announcement of the Inquiry:**

The announcement of the recall process was followed shortly afterwards on 10th May 2018 by the announcement by Mr Richard Pengelly, then Permanent Secretary at the Department of Health, of a non-statutory public inquiry. The decision to hold a public inquiry of this type was driven by the fact that the Northern Ireland Assembly was at that time suspended and there was no Health Minister in place. The Inquiry was subsequently converted to a statutory public inquiry by the Minister of Health, Robin Swann MLA, on 11th of December 2020.

### **The Terms of Reference:**

The Terms of Reference are enclosed at appendix A. In essence, the Inquiry was tasked with assessing the extent to which it was known or should have been known prior to November 2016 that there was a problem or potential problem with Dr Watt's practice. The Inquiry was to determine whether the Belfast Trust should have instigated an earlier and more thorough investigation arising out of complaints, concerns or related circumstances which existed prior to November 2016. November 2016 was a significant date because in that month a GP contacted the Belfast Trust identifying concerns about Dr Watt's practice.

The Inquiry was also tasked with reviewing the role of extant governance processes which were in place to maintain standards of professional practice. Appraisal was specifically identified as requiring review and the Inquiry also considered it appropriate to look at the related processes of revalidation. These processes are explained and commented upon in the relevant chapter of in the report.

The Inquiry had to establish what ‘related concerns and circumstances’ existed prior to November 2016. As the evidence to the Inquiry developed, it became clear that work performed by Dr Watt outside the Belfast Trust in the independent sector, regulatory investigation by the General Medical Council, the use of epidural blood patching, and his prescribing of particular treatments were all circumstances that required consideration.

The Inquiry was also to evaluate the corporate governance in the period from November 2016 up to the announcement of the recall in May 2018. The decisions taken in this period included issues relating to restrictions placed on Dr Watt’s practice, investigations into his practice, communicating with other relevant bodies within the healthcare system, and ensuring the ongoing care and treatment of Dr Watt’s patients.

### **Dr Michael Watt:**

The Terms of Reference and, in particular, the preamble, make it clear that the clinical practice of Dr Michael Watt was being investigated by the General Medical Council (GMC) and by his then employer, the Belfast Trust<sup>1</sup>. The preamble explained that the Inquiry “*would consider the role of the Belfast Trust as an employer in terms of professional practice in the context of the Trust’s system of governance*”.

Great care was taken to explain to witnesses that it was not the role of the Inquiry to investigate Dr Watt’s clinical practice. Despite such explanation the Inquiry often had to manage public expectations of its role. Expectations only increased when it became apparent that an application for voluntary erasure by Dr Watt was acceded to by a Medical Practitioner’s Tribunal in 2021. That decision was the subject of a judicial review which was due to be heard in the High Court at the time of this report going to print.

The Inquiry engaged with Dr Watt’s lawyers at various times and documentation was obtained which was of assistance. Further, in March 2021, the Inquiry issued a Notice under the Inquiries Act 2005, directing Dr Watt’s attendance. In response to the Notice, the Inquiry received a detailed medical report advising that Dr Watt was not fit to give evidence. After obtaining a number of further medical reports, the Inquiry reluctantly accepted that Dr Watt would be unable to engage with its work<sup>2</sup>. The Inquiry was still satisfied that it could fulfil its Terms of Reference as the focus was on the relevant governance arrangements. The Inquiry was able to rely on various documents that it had obtained including a transcript of an interview given by Dr Watt as part of an investigation under the Maintaining High Professional Standards framework.

<sup>1</sup> The details in respect of the related reviews and investigations that arose out of the same circumstances as the Inquiry are set out at pages 4-7 of the Guide to the Inquiry Questionnaire. See Appendix E.

<sup>2</sup> The detailed steps taken by the Inquiry in an attempt receive evidence from Dr Watt are set out in a letter of 11th October 2021 sent by the Inquiry Chairman to a number of patients who were concerned about Dr Watt not giving evidence. See Appendix F.

### The work of the Independent Neurology Inquiry:

The Inquiry began its work by identifying organisations that may have held relevant documentary evidence. This included the Belfast Trust, as Dr Watt’s employer and also the independent sector organisations where he worked, namely the Ulster Independent Clinic, Hillsborough Private Clinic and Orthoderm. Collating the documentary and oral evidence proved to be an evolutionary process which included other organisations beyond those referred to previously. This included other health trusts in Northern Ireland, the General Medical Council, the Regulations and Quality Improvement Authority, the Health and Social Care Board<sup>3</sup>, National Clinical Assessment Service<sup>4</sup> and the Northern Ireland Department of Health.

In addition to obtaining relevant documents the Inquiry also identified individuals who could provide oral evidence. This included those who worked in neurology such as the consultants, registrars and nurses along with those who were responsible for managing and governing the healthcare system of which neurology was a part. Relevant individuals from the various organisations, including those referenced above, were identified as the Inquiry progressed.

The Inquiry held its first oral evidence session on 5th September 2018. In total the Inquiry held 214 oral evidence sessions and received in excess of 147,000 pages of documentary evidence. The total cost of the Inquiry is £3.2million<sup>5</sup>.

The standard of proof applied has been the normal civil standard. As appropriate with any non-statutory Inquiry, the evidence obtained was unsworn. By the time that the Inquiry was converted into a public Inquiry it would have been highly problematic to alter the existing methodology given the stage the Inquiry had reached<sup>6</sup>.

### The Involvement of Patients:

From the outset the Inquiry has focused on the importance of the patient voices. A questionnaire was devised for patients and their families in consultation with patient bodies and political representatives. The questionnaire was launched on 8th October 2018 and 240 responses were received. All responses were reviewed. Some contained information which was highly relevant to the Inquiry and others contained information that related to the work

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3 The Health and Social Care Board was dissolved on 1st April 2022 and its functions transferred to other bodies as per the terms of Section 1 of the Health and Social Care Act (Northern Ireland) 2022.

4 Previously known as NCAS and now renamed Practitioner Performance Advice.

5 This includes projected in-year costs along with costs associated with the winding up of the Inquiry.

6 The Inquiry Chairman issued a public statement on 11 January 2021 setting out the significance of the Inquiry being converted from non-statutory to statutory. See Appendix B.

of other organisations. Questionnaires were shared with the GMC on 110 occasions, with the Belfast Trust on 110 occasions, with the RQIA on 5 occasions and with other bodies/Trusts on 5 occasions. 35 patients gave oral testimony to the Inquiry and this is explained and elaborated on in the patient chapter. The evidence provided considerable assistance to the Inquiry Panel in understanding the context and identifying lines of enquiry.

### **Updating Politicians:**

The Inquiry recognised the importance of keeping political representatives apprised of progress. As the Northern Ireland Assembly was suspended the Inquiry Panel met with local politicians who had a responsibility for health care within their parties on 5 separate occasions.<sup>7</sup> Following the restoration of the Assembly, the Inquiry Panel met with members of the Health Committee in July and October 2020. At all times the aim has been to communicate effectively with political representatives as to the work and progress of the Inquiry. It is important, however, to stress, that the Inquiry was able to carry out its work independently and was not subject to interference in its work from any politician or government department.

### **Maxwellisation:**

In accordance with its legal obligations, the Inquiry also ensured that prior to the publication of this report individuals and organisations who were subject to express and significant criticism had the opportunity for comment. The Inquiry took time to carefully consider the comments that were received before finalising this report.

### **Ordering of the Report:**

To make the report as easy to read as possible the approach has broadly been to structure the report around particular issues that became increasingly more relevant as the Inquiry progressed. The chapters start with an explanation of their context and how they fit within the Terms of Reference. In many instances there is overlap between the chapters and particular incidents or events are detailed or referenced multiple times. Where such events or incidents give rise to criticism of individuals or organisations, the repeating of any criticisms in multiple chapters should not be interpreted as increasing the level of criticism. Three specific chapters address periods of time where the Inquiry Panel has concluded that there were missed opportunities to have earlier or more thorough investigations into Dr Watt's practice.

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<sup>7</sup> 27th June 2018; 27th September 2018; 22nd January 2019; 29th May 2019; and 20th November 2019.

### Previous Reviews into the Health and Social Care System in Northern Ireland:

A review of any health trust in Northern Ireland and its governance is by definition a challenging assignment. The Inquiry was immediately conscious of other relevant reports which have been commissioned by the Department of Health or Health Ministers and was at pains to reflect upon these before commencing its work. In a report commissioned by the then Minister for Health, Edwin Poots, MLA by Sir Liam Donaldson entitled *“The Right place, The Right Time”* and published in December 2014, Sir Liam referred to the *“complex interweaving of responsibilities for patient safety amongst the central bodies responsible for the health and social care system in Northern Ireland.”* He concluded:

In the end we believe action is imperative for two reasons. Firstly the present central arrangements are byzantine and confusing; secondly, the overwhelming need is for development of the present system to make it much more successful in bringing about improvement.

On 4th November 2015, the then Minister for Health, Simon Hamilton MLA, announced that in response to recommendation 1 of **The Right Time, The Right Place** report by Sir Liam Donaldson, he would appoint an expert, clinically led panel to consider and lead an informed debate on the best configuration of Health and Social Care services in Northern Ireland. The subsequent Bengoa report was published in October 2016. To the date of going to publication the recommendations of Bengoa remain work in progress and the structural reform of the health and social care system has not taken place as perhaps envisaged. The Inquiry hopes that within the ambit of the Terms of Reference this report can contribute to the evolution of change and ultimately improve patient safety for the benefit of all.

### Recommendations:

The Inquiry has identified numerous learning points and sought to make recommendations. The learning points are interwoven in the commentary throughout the various chapters of the report. The recommendations arise from the totality of the evidence and whereas some are a direct response to a particular single issue others attempt to address broader or more diverse matters. The theme that cuts across all the recommendations, whether expressly or implicitly, is the paramountcy of patient safety in all decisions at every level of healthcare organisations.



## EXECUTIVE SUMMARY

### General Conclusions:

- 1 The systems and processes in place to assure the public in respect of patient safety prior to November 2016 failed. The extent of problems with Dr Michael Watt's practice only began to come to light following a concern being raised with the Belfast Trust by a GP. While one process or system failure may not be critical, the synergistic effect of numerous failures ensured that a problem with an individual doctor's practice was missed for many years and, as this Inquiry finds, opportunities to intervene, particularly in 2006/2007, 2012/2013, and earlier in 2016 were lost.
- 2 Inquiry Panel was asked in the Terms of Reference to determine whether there were complaints, or related concerns and circumstances which should have alerted the Belfast Trust to instigate an earlier and more thorough investigation into the circumstances which led to the recall of patients in May 2018. The Inquiry has concluded that the Trust could and should have intervened earlier but failed to do so.
- 3 The failures identified by this Inquiry Panel are not confined to the Belfast Trust. The Inquiry has concluded that the combined effect of an inadequate investigation into a highly relevant clinical complaint in 2012 by the Regulator (the General Medical Council); the failure to disclose significant complaints by the Ulster Independent Clinic, where Dr Watt had a substantial private practice; alongside failures of other HSC Trusts to identify or communicate concerns, compounded a pre-existing problem in the Belfast Trust. Generally, the inability of the systems then in place to identify a pattern of concern was a conspicuous problem. Information was essentially retained in silos. Communication between different organisations and between management levels within organisations was poor and inadequate.
- 4 The recent response to the global pandemic by the health service, and the esteem in which the caring professions are held by the general public, illustrate just how critical they are to our society. Healthcare professionals deserve to be treated fairly. At the same time, it was universally acknowledged by all witnesses to the Inquiry, that patient safety should be the paramount concern and the standard by which governance and systems are assessed.
- 5 Although not every step taken post November 2016 was correct (especially communicating adequately with patients) the Inquiry Panel believes that the Belfast

Trust got key decisions right after November 2016. The partial restriction of Dr Watt in December 2016 followed by the commissioning of a report into his practice by the Royal College of Physicians<sup>1</sup>, the full restriction on his practice in July 2017 and the decision to initiate a large-scale patient recall in May 2018 were appropriate and served to protect patients. Patients will, however, rightly point to the many years when problems that emerged with Dr Watt were not addressed, opportunities were missed and such inaction was to the significant detriment of patients.

### The Importance of Patient Voices:

- 6 At the outset of this Inquiry, and throughout its deliberations, the Inquiry Panel was determined to hear the voices of patients, many of whom have been deeply affected by the recall process. It is, therefore, appropriate that the chapter addressing the evidence of patients is the first chapter of this report.
- 7 The Inquiry wishes to gratefully acknowledge the many patients who submitted evidence throughout the duration of the Inquiry. The amplification of patient voices was also assisted by various organisations, such as the MS Society and the Patient Client Council, who were invaluable in helping the Inquiry communicate appropriately and effectively with patients. It is significant that patient evidence continued to be submitted right up until the deadline in August 2021.
- 8 It was the desire to focus on patient safety, which led the Inquiry Panel, at the earliest stage of its hearings, to encourage necessary changes to be implemented immediately and on an ongoing basis, rather than await the publication of a report. This was communicated to relevant organisations when the Inquiry was non-statutory, but the aim remained throughout the course of the Inquiry. Such an approach emerged from the wide experience of the Panel Member, Professor Mascie-Taylor, in medical governance and addressing the hospital crisis in Mid-Staffordshire. The Belfast Trust responded positively, and this report will highlight some of the changes that have already been commenced or implemented<sup>2</sup>.

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1 The Royal College of Physicians report identified significant problems with Dr Watt's practice. It was not the role of the Inquiry to make findings of fact in respect of his clinical practice. Nevertheless, the report provided necessary context for the work of the Inquiry in reviewing the relevant governance systems.

2 To assist with investigating complaints the Belfast Trust has now implemented a clinical record review. To protect against the risk of lone working, additional peer review is being incorporated in the Trust through an initiative known as 'Building Effective Teams'. To enable the Medical Director at the Trust to be able to access accurate and useful information on a clinician's practice a live professional governance reporting system has now been put in place.

**The Terms of Reference and Dr Watt:**

- 9 The Inquiry Terms of Reference did not require it to adjudicate on the medical practice of Dr Watt. His practice was being investigated by the General Medical Council (“GMC”) and employer led processes under Departmental Guidance on “Maintaining High Professional Standards in the Modern HPSS” (“MHPS”).<sup>3</sup> Both of those processes came to an end without being able to explore the clinical issues that arose because of the ill health of Dr Watt. Unfortunately, it was not possible for the Independent Neurology Inquiry to fill the gap that emerged. It would, therefore, have been inappropriate for the Inquiry to encroach on the GMC’s remit or employer-led processes referred to in the Terms of Reference.
- 10 This report makes extensive reference to Dr Watt. The Inquiry’s Terms of Reference refer to *“circumstances which led to the recall of patients in May 2018”*. It was clear to the Inquiry that the reference to *“circumstances which led to the recall”* was referring to the practice of Dr Watt. The fact that Dr Watt ultimately was medically unfit to give evidence to the Inquiry was a source of significant and understandable public concern.
- 11 The focus of the Inquiry was properly on systems and governance, the extent to which the extant structures proved effective prior to and after November 2016 and the handling by the Belfast Trust of any previous complaints and concerns. It is, of course, recognised that it would have been preferable to hear directly from Dr Watt. However, the Inquiry did obtain access to the Verita report, which had been commissioned by the Belfast Trust in 2019 as part of the MHPS process. The report contained detailed evidence given by Dr Watt and his response to some of the specific controversies that had emerged, including his use of blood patch procedures. The Inquiry has been able to consider this information and has found that Dr Watt’s comments do assist in understanding the relevant events. The Inquiry has also been able to take evidence from witnesses across the full spectrum of those involved in the matters relevant to the Inquiry’s Terms of Reference at all levels within the Belfast Trust and across the Health and Social Care sector.
- 12 The Inquiry Panel has analysed the information, which was held by the Belfast Trust throughout the period under review. There was sufficient information accessible prior to November 2016 to demonstrate a pattern of potential aberrant practice. Part of this information was collated, but not all. Key information was known to only one or a small number of individuals, who commonly analysed that information in a vacuum and determined that it was a one-off, insufficiently serious, or irrelevant, without the benefit of the broader picture. This resulted in concerns not being

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3 Health & Personal Social Services.

escalated, and when they were, not being analysed in their full and proper context. The problems in the Trust systems are illustrated graphically by the fact that it was a General Practitioner and not someone from within the Belfast Trust, who approached the Medical Director's Office in November 2016 with concerns about Dr Watt's practice.

- 13 A compounding problem from as early as 2006 was the development of a narrative around Dr Watt, which influenced many of those who were tasked to consider issues that arose. The perception that Dr Watt's clinical ability was not in question contributed to a consistent conclusion that Dr Watt's problems were essentially administrative. Consequently, when issues with a clinical dimension were raised, they were often prematurely dismissed without adequate investigation or explained in a manner which ended further investigation. This in turn impeded the ability to discern a pattern when subsequent or further issues arose or were identified. The evidence collated revealed that Dr Watt had a history of either failure to comply with or unreasonable delay in providing or undertaking annual appraisals; reports requested by, for instance, the Coroner, the GMC, insurance companies and patients; and responses to complaints. There was a failure to recognise that a disregard for these matters led to, in some cases, real issues for patients. The delays did not result in managers looking past his 'administrative' issue to appropriately consider if the approach was also mirrored in his clinical practice.
- 14 The Inquiry Panel acknowledges that in reviewing the evidence, it has had the benefit of hindsight. Every effort has been made to prevent this reality from engendering any degree of bias, but there will be a concern that the advantage obtained from what some doctors referred to colloquially as "*the retrospectoscope*" produces a clarity that is removed from what could reasonably have been observed at that time. The Inquiry Panel has sought to take the advantage it had into account when making judgements about a situation. It should be borne in mind that those tasked with making decisions about Dr Watt's practice (particularly prior to November 2016) were doing so in real time, unaware of the full extent of the problems that would subsequently come to light, and without the time or specificity given to this Inquiry in completing its work.
- 15 It should also be stated at the outset that the task of the Inquiry was focused on the governance of the Belfast Trust. The Inquiry Panel was not required to carry out a comparative exercise with other Health and Social Care Trusts, either in Northern Ireland or their equivalents in the UK generally. That said, the Inquiry Panel believes that problems observed will not be unique to the Belfast Trust.

16 It is inevitable that the report criticises individuals as well as systems and processes. The Inquiry observed that some of those it criticises have made substantial contributions and worked tirelessly to enhance healthcare and, in recent times, to mitigate the problems which have arisen. As the chapter on November 2016–May 2018 outlines, it was a GP who raised concerns about Dr Watt’s practice directly with the Belfast Trust Medical Director’s Office. These concerns resulted in a partial restriction on clinical practice being imposed in December 2016 and led to investigations over the subsequent months and a full restriction on clinical practice in July 2017. During the period from December 2016 to May 2018 (when the neurology patient recall was announced) a number of critical actions were taken which addressed the concerns which had arisen with Dr Watt’s practice. These included:

- (i) The commissioning of a report in December 2016 from two Northern Ireland based consultant neurologists who were employed in other NHS Trusts, confirmed problems with other aspects of Dr Watt’s practice beyond the diagnosis of SIH.

The spreadsheet devised and drawn up by Dr Thomas Peukert, on his own initiative, which revealed the number of cases where the diagnosis of spontaneous intracranial hypotension (“SIH”) by Dr Watt had not been accepted by Dr Peukert. Dr Peukert was a consultant neurologist in the Belfast Trust who, in December 2016, had been tasked with approving Dr Watt’s treatment of patients diagnosed with SIH.

- (ii) The decision to invite the Royal College of Physicians to carry out a case note review of a sample of Dr Watt’s practice following receipt of the report at (i) above.
- (iii) The full clinical restriction of Dr Watt’s practice in July 2017.

### **Integrated Governance:**

17 On 29th October 2018, Dr Tony Stevens, the former Medical Director of the Belfast Trust, gave evidence to the Inquiry, which, included the following observation:

You cannot subdivide clinical governance, professional governance and corporate governance.

I have always felt that clinical governance was corporate governance for doctors ... I have always believed firmly in the concept of integrated governance, that there was no simple divide between aspects of corporate governance.

- 18 The Inquiry Panel agrees and believes that a failure by a clinician to take seriously administrative and appraisal obligations may be indicative of an attitude which needed to be challenged more robustly at an earlier stage. Proper enforcement of a medical practitioner's administrative and appraisal obligations is a critical component in the relationship between the Trust, as employer, and the consultant as employee. Although it is much easier to view in retrospect, the combination in Dr Watt's case of lone working, consulting with perhaps the highest number of neurology patients, and persistent administrative failure should also have given rise to questions about the oversight of Dr Watt's clinical practice.

### **Medical Culture & Medical Managers:**

- 19 At the heart of the problems identified in this report was a medical culture, which had not yet come to terms with a managed system. The Inquiry Panel heard from a wide range of witnesses, and it was apparent that the commitment of doctors and other health professionals to their patients is, by any standard, impressive. Medical professionals were, however, apprehensive in raising a concern about the practice of a colleague or querying discrepancies that arose, which did not directly touch upon the welfare of their own patient. It was clear that senior managers were too often reluctant to manage doctors and were easily deflected by the raising of any clinical dimension to an issue of concern. Correspondingly, many doctors who took on a management role were accustomed to operating collegially and consensually and found the responsibilities of management did not easily fit into that extant culture.
- 20 Evidence reveals that clinical directors are expected to fulfil a significant management role at the same time as practising as a doctor. The posts are taken up by busy clinicians, who are given limited hours to carry out the role. The Inquiry Panel's assessment of the evidence is that this resulted in an impoverished understanding of management by doctors and, in some cases, a sense that the focus of the role is to represent the interests of one's specialty. The Inquiry Panel concluded that the role was often taken on by senior doctors out of a sense of duty. As the posts were for a period of 3 years, the perception developed that those senior clinicians have an obligation to take their turn. At the end of the 3-year period, a clinical director will normally go back to full time clinical practice.
- 21 The fact that a consultant may be outstanding as a clinician does not necessarily translate to being competent as a manager. The roles are distinct and require very different skill sets. This has not been adequately understood either by the higher echelons of Trust management, or by the medical profession. In the view of the

Inquiry Panel, an unjustified reliance is placed on the structures created when there is often a disconnect between the policy of the Trust and the managerial approach taken within a specialty. The Inquiry was tasked to consider only the position within Neurosciences but has no reason to believe that the situation is otherwise in different medical specialties.

- 22 The sense within the Trust is that because consultants are highly trained and academically able individuals, they will be able to move easily into a management role. Training for the role needs to be strengthened and an understanding of the accountability aspects of management reinforced. The reality is that for a clinical director or a clinical lead to hold his/her own colleagues managerially to account, in the system that currently operates, is a challenging requirement. For those doctors who have advanced further in medical management and who are more removed from day-to-day interaction with colleagues, the difficulties of managing colleagues are less acute.
- 23 The position of the Medical Director is, in the view of the Inquiry Panel, the critical role in the current structure from a patient safety perspective. The importance of disclosing relevant information to the Medical Director's Office cannot be overstated. In the case of Dr Watt, the Inquiry Panel believes that without the then Medical Director's response in December 2016, to concerns that had been raised, and more particularly in July 2017, there is no guarantee that the problems identified in the recall would have necessarily emerged.
- 24 A pre-existing and deeply rooted medical culture which inhibits a flow of relevant information to the Medical Director's Office was, in the view of the Inquiry Panel, a major factor in failing to identify potential problems with Dr Watt at an earlier stage. Consultants are used to having ultimate personal responsibility for their patients. In relation to clinical care, they are at the head of a clear linear decision-making structure. This contrasts with their role as an employee within a managed organisation where the flow of information is more restricted, and as the Inquiry Panel has found, clinical management roles lack the same clarity. This leads to friction within the broader management framework.
- 25 The evidence received by the Inquiry Panel would suggest that many doctors, by training, impose their own filters and thresholds of proof that often have the unintended consequence of failing to escalate concerns. Such an approach impedes pattern recognition. Information, which, when collated and analysed together may give rise to concern, has been excluded because a doctor has concluded that a concern he or she had, is not sufficiently serious to escalate.

- 26 In a sense, doctors conflate the approach they take to their own practice and the clinical judgements they make on a daily basis, with the view they take if they have a concern about the practice of a colleague. The filter applied seeks to have the maximum degree of investigation and assurance before committing to a position. With their own patient(s), that may not present a difficulty; they have the benefit of full medical notes and records, a detailed examination and full history and a clinician, fully briefed, can consider the appropriate treatment. In contrast, when coming across an issue of concern with a colleague, the doctor sees only in part, rarely has access to the medical notes and records, has not conducted a full examination or taken a full history and is, by definition, not in as good a position to make a judgement.
- 27 In such circumstances, doctors appear wary of committing themselves to a position. A concern identified may fail to meet the threshold in their own mind. Consequently, matters which may urgently need investigation or a further review, are passed over. Such an approach is not the standard imposed by regulators or required by employers. If a concern is reasonable, it should be escalated and checked. It is not the function of the doctor concerned to reach a definitive view or conduct an investigation.
- 28 The current system seeks to model a collective leadership approach. The triumvirate structure with separate medical, general management and nursing lines of authority reporting to a Co-Chair (Medical) and Co-Director (General Manager) under the respective oversight of the Medical Director and a Director at Board level is purposely collegiate. The danger is, however, that when everyone is responsible, no one is responsible, and the evidence given to the Inquiry catalogues a number of occasions where information was shared, and/or lines of accountability appeared not to have been understood.
- 29 A narrative developed following the announcement of the recall process in April 2018, that nothing of substance regarding Dr Watt's practice was known by the Trust until a concern was raised by a GP in November 2016. This Inquiry has found that such an understanding was far removed from the actual position. Information was held, both inside and outside the Belfast Trust, which if it had been properly collated and analysed, could have led to earlier intervention.

### Concerns Raised:

- 30 The Inquiry also considered in detail the question of concerns being raised by various medical personnel including registrars and nursing staff. The Inquiry found

significant evidence that concerns had been raised and had not been appropriately managed or further escalated on numerous occasions. In 2013 a registrar raised a serious concern with the then Clinical Lead in Neurology about a pregnant woman having been diagnosed with epilepsy, and prescribed medication accordingly, when the evidence suggested she should not have been diagnosed. In the same year, another registrar went to the Clinical Director about various aspects of Dr Watt's practice, but the matter was not escalated or recorded. In 2015 the same registrar raised concerns with the Training Programme Director, but again the matter was not properly recorded and in the same year another registrar also gave evidence about raising a concern, albeit that there was confusion as to what had been said or communicated. The reasons for this are multi-factorial but include a failure on the part of those in clinical management to properly understand their role and the actions to be taken upon receipt of a concern.

- 31 Communication problems between those in primary care and those in secondary care were highlighted at the outset of the Inquiry. Some of the main themes that have been outlined in the Medical Culture chapter illustrate the difficulties faced by GPs in raising issues with consultant specialists. It was a matter of surprise that several GP witnesses disclosed that they were unaware of who to raise concerns with, and further alarming that attempts by GPs to raise concerns about Dr Watt floundered because of both reticence by the GP or ignorance by the person receiving the concern as to what should happen to the information. It is the case, however, that it was a GP, who ultimately raised the first series of index cases with the Medical Director's Office in November 2016, thus beginning the chain of events that led to the neurology patient recall in May 2018.

### **The Complaints System:**

- 32 A particular focus of this report is on the complaints system in place and the concerns that were raised but not further escalated or examined. The failure to learn from complaints was one of the more disturbing aspects of the investigation conducted by this Inquiry. Time after time, information was raised in a patient complaint, which needed to be independently investigated. Consistently the answer given to the complainant was obtuse and unhelpful.
- 33 The approach within Neurosciences was that, when a complaint was received from the Belfast Trust Complaints Department, the Service Manager or Assistant Service Manager would then seek the views of the clinician who was the subject of the complaint. In Dr Watt's case, his response was almost invariably to justify the

position he had taken. The Manager would then draw up a detailed chronological list of the patient's attendances with the hospital, treatment prescribed, and advice given, and the letter would be started and finished with a profuse apology for the hurt feelings of the complainant. If there was a clinical component to the complaint the Clinical Director would have been asked to review the response letter. There was confusion as to what extent the Clinical Director was fully analysing the clinical issues raised by the complaint. The letter would then be reviewed by the Co-Director and Director before issue to the complainant.

- 34 When the process was reviewed by the Inquiry, a pattern emerged which raised fundamental questions. Despite the fact that numerous complaints had been made the complaints analysed against Dr Watt did not result in any findings and until February 2016, no independent reports had been commissioned to examine the merits of any clinical complaint against him.
- 35 The results of such an approach were, however, apparent. Information which needed to be analysed and which pointed to aberrant practice was ignored, misunderstood, or did not get to the right person. The Datix system, which was meant to log all complaints often failed to record or log appropriately the complaints against a particular doctor if the person inputting the data was insufficiently specific. It was often difficult for the Medical Director to have a broad overview of a doctor's practice. Information remained in silos, whether in the Datix system, the Complaints Department, the Service Manager's office or, on one occasion, even the Medical Director's Office. The disjointed nature of the extant system was best illustrated by the fact that the Medical Director sought to assure the public in May 2018 that there was no red flag in the complaints relating to Dr Watt. Such a statement, though given in good faith, was demonstrably and clearly wrong when the information obtained by the Inquiry was evaluated.
- 36 What is apparent from the evidence is that there was no consistent method of dealing with clinical complaints and the emphasis remains on timely resolution. The Inquiry Panel has found instances, where the Complaints Department and the appropriate Directorate failed to adequately identify and address the clinical questions raised in the complaint, seek an independent view or learn from any issue of concern that arises.
- 37 The sober reality is that the complaints system within the Belfast Trust was inadequate in terms of identifying patient safety concerns. Little seemed to have been learned, even though, properly analysed, many complaints highlighted concerning patterns of potentially aberrant practice on the part of Dr Watt. It is hard not to conclude

that the system, as operated within the timeframe to be assessed by this Inquiry, made it more difficult to identify problems. Instead of recognising that a well-run complaints system can be perhaps the most effective way of identifying aberrancy, the approach was focused on responding within stipulated time periods and “resolving” complaints. The Inquiry Panel accepts that this focus emanates from the Department of Health complaints handling policy common to all Trusts but, somehow, the opportunity for learning from complaints often seems to have been missed. The Inquiry also recognises that steps have been taken by the Belfast Trust to improving its complaints system and a recommendation has been made which asks the Department to evaluate this initiative and consider extending it to other Trusts if appropriate.

- 38 The Regulator bears a heavy responsibility to ensure that doctors who are practising outside the bounds of clinical norms are identified and appropriate action taken. In this case, a clinical complaint regarding Dr Watt, which was forwarded to the GMC in 2012, was essentially dismissed with general advice and guidance. A GMC internal review of that decision in 2019 concluded that the case had not been properly investigated and recognised that if the matter had been decided again, the outcome would probably have been different. It transpired that the GMC decision in 2012 was influential to the outcome of a parallel investigation within the Belfast Trust on other matters relating to Dr Watt. The series of events is illustrative of the connectedness of various organisations. If information is not shared appropriately, then the opportunity for identifying concerns is correspondingly diminished.

### **Missed Opportunities:**

- 39 In December 2006 / January 2007, Dr Watt came to the attention of the then Medical Director due to a series of administrative concerns. At or about the same time, the Trust, including the Medical Director, was involved in handling two significant and complex clinical complaints relating to Dr Watt. Dr Watt also received a five-year warning from the GMC, but this warning was not communicated to Dr Watt’s line managers in the Trust. There was sufficient information within the Trust, from which a pattern could have been identified and in turn led to a deeper examination of Dr Watt’s practice at this early juncture.
- 40 In January 2012, Dr Watt came to the attention of the then Medical Director after a complaint was received by the GMC from a patient, INI 45, who had seen Dr Watt at Hillsborough Private Clinic. Despite the Belfast Trust carrying out two separate informal investigations into Dr Watt under the “Maintaining High Professional

Standards” procedure, and his practice being under consideration at the Doctors & Dentist in Difficulty Meetings (“DDCRM”), Dr Watt was subsequently revalidated in September 2013. Further, there was relevant information within the Ulster Independent Clinic relating to a complaint which was not brought to the attention of the Belfast Trust. Within Neurosciences in this period registrars had raised concerns about Dr Watt’s practice with management, but these were not escalated to the Medical Director in the Belfast Trust. If the various strands of information, which were available in 2012 and 2013 had been fully analysed, there was every opportunity that aberrant practice could have been spotted and appropriate action taken to assure the safety of patients and perhaps to assist and support Dr Watt.

- 41 In February 2016, the Trust received a concern in relation to the practice of Dr Watt, which was subsequently considered by an independent expert. At the same time, the Medical Director’s Office was aware of administrative issues in relation to appraisal, a report for the coroner and an anonymous complaint. Information was held within Neurosciences which did not reach the Medical Director’s Office. This concerned other complaints and concerns with regards to the prescription of HIG. These concerns were discussed with Dr Watt in August 2016. Concerns in relation to the proliferation of Blood Patching and prescribing of Alemtuzumab which were within the knowledge of a number of individuals, went largely unchallenged and were also not escalated to the Medical Director’s Office. There was sufficient information with the Trust that action could have been taken before a GP raised concerns in November 2016. Further, additional concerns and complaints relating to diagnosis and treatment of Dr Watt’s patients, were known about in other Health Trusts and within the Ulster Independent Clinic but the information was not shared with the Belfast Trust.

### **Appraisal and Revalidation:**

- 42 In the case of Dr Watt, the failure over so many years to promptly undergo appraisal has been the subject of public comment by politicians and others. While the Inquiry Panel shares many of the concerns regarding Dr Watt’s failure to be appraised, it is important to properly grasp the purpose of appraisal and the reassurance that revalidation can offer. While the Inquiry believes that both appraisal and revalidation are useful exercises, which have a significant role to play in terms of raising overall standards, the Inquiry Panel also is of the view that an incorrect public understanding of the purpose behind both appraisal and revalidation can lead to confusion, which ultimately does not serve the interests of patients.

- 43 As far as the public are concerned, great weight is to be afforded to the system of appraisal which was established at the same time as the inquiries into the Shipman case, chaired by Dame Janet Smith. At that time, there was an intense public concern that aberrant practice amongst medical practitioners must be effectively identified and addressed. A system of revalidation every five years was subsequently initiated in statutory form.
- 44 Appraisal for doctors is not a performance management process, where a clinical manager such as a clinical director will set goals and analyse the performance of a subordinate. The process is carried out by a colleague trained as an appraiser who will seek to assist the doctor to self-reflect on his/her clinical practice. The appraiser does not necessarily have to be from the same specialty as the appraisee or even be a doctor. Such a system is undoubtedly beneficial in improving the quality of a doctor's work but no doctor in their evidence to the Inquiry thought the system was designed to identify, or was in any way effective at identifying, aberrant practice.
- 45 Revalidation every 5 years is a much more formal process with a greater emphasis on the views of patients and colleagues. It requires the Responsible Officer to make a formal recommendation to the GMC as to whether the doctor should be revalidated. In the Northern Ireland Health and Social Care Trusts, the Responsible Officer is ordinarily the Medical Director, to whom the doctor is also accountable as an employee. In the view of the Inquiry Panel annual appraisal remains the main building block of revalidation. As set out in the Recommendations, the Department of Health and the GMC should clarify whether in their view these processes are sufficient to ensure that aberrant practice will be identified. If these processes are in themselves inadequate, then the Department and the GMC should specify what mechanisms should be put in place to achieve this necessary objective

### **The Independent Sector:**

- 46 While this report is primarily focused on the Belfast Trust, evidence was obtained which brought into sharp focus the regulation and governance of the independent sector in which Dr Watt practised for many years. The Terms of Reference specifically ask the Inquiry to look at related concerns and circumstances, which should have alerted the Belfast Trust to instigate an earlier and more thorough investigation. In the view of the Inquiry Panel, this includes the independent sector because Dr Watt had a substantial private practice and the communication between the independent sector and the Belfast Trust was relevant at various key junctures.

- 47 Independent sector organisations where Dr Watt worked rely, in most instances, on the Medical Director of the relevant Trust as the Responsible Officer of an individual doctor with practising privileges at their institution. At revalidation and during annual appraisal, a clinician is required to carry out a whole of practice review, which includes any private practice. At the same time, independent sector organisations rely on the submission of a practising privileges document, which requires annual appraisal and revalidation. In Dr Watt’s case, appraisals were missed over various lengthy time periods without sanction by either the Trust or the independent sector providers. Further, relevant clinical complaints were not disclosed by the independent sector provider to the Responsible Officer. It is illogical for an independent sector provider to rely on the approval of a particular doctor by the Responsible Officer, while at the same time failing to ensure that highly relevant matters are not brought to the attention of the same Responsible Officer.
- 48 Critical information at key times was not passed on to the Belfast Trust by the Ulster Independent Clinic. The information may have altered the outcome of an earlier investigation under MHPS, then being conducted in the Belfast Trust. Fundamentally, the independent sector has tended to view itself as providing facilities for consultants to practice, rather than properly recognising its role as a medical hospital or clinic where the public expect the same standards of patient safety and governance as one would find in the National Health Service.

### **Lone Working:**

- 49 While many of the areas investigated by the Inquiry within the ambit of the Terms of Reference required detailed and painstaking analysis, there were other aspects of the review carried out, which highlighted obvious problems. One such example was the inpatient neurology teams to which consultant neurologists were assigned. By reason of the untimely death of one neurologist and the retirement of another, Dr Watt was the sole remaining member of Team A, while Teams B and C both comprised normally five consultant neurologists each. This situation was in place since 2012 and the Inquiry Panel considers it significant that Dr Watt was essentially working on his own for a period between 2012 and July 2017, (when he was clinically restricted). This arrangement does not seem to have been reflected upon or regarded by management as unusual or problematic. The fact is, however, that the Inquiry is satisfied that the isolation of Dr Watt contributed to the problems that developed in his practice. Regular interaction with colleagues tends to prevent deviation from the norm and is one of the main protections which can prevent aberrant practice.

Recommendations have been made, which seek to ensure that team working and peer review amongst specialist consultants is regarded as a priority requirement for all consultants.

**Blood Patching Procedures:**

- 50 A particular focus of public concern related to the extraordinary increase in the treatment of patients by Dr Watt using a blood patch in the period from 2014 to 2017.
- 51 It is not unusual for doctors to develop new or expand existing treatments to address a difficult and chronic problem. While the Inquiry is not in a position to make any definitive assessment in relation to the alleged under-diagnosis of the leakage of cerebrospinal fluid in a person’s spine, the Inquiry does note that some of the medical literature, particularly in the USA, did suggest that the prevalence of SIH in populations is under-diagnosed.
- 52 The Inquiry recognises that the development of evidence-based medicine with a particular focus on MRI and CT-imaging has been a feature of medical practice in the last 20 years. For older neurologists, including Dr Watt, there would have been a greater emphasis on observation of the success of treatment for a working diagnosis as a more common way of establishing a definitive diagnosis in their early practice. The Inquiry Panel was told by almost every neurologist that the practice of neurology is complex and difficult.
- 53 Dr Watt gave a clear explanation to the Verita case investigators who had been carrying out an MHPS investigation on behalf of the Belfast Trust. Dr Watt was fully aware that the guidelines emphasised the importance of imaging evidence in a case of SIH. Although the relevant literature recognised that patients could develop the condition in the absence of imaging evidence, there was a much greater focus on history and examination required before such a conclusion could be reached. Dr Watt noted that it had worked, as he put it, “*like a charm*” with one patient and this had encouraged him to utilise the procedure in many other instances. As Dr Watt explained, the blood patch procedure was being used as essentially “*a diagnostic tool*”. The problem with such an approach was that Dr Watt did this independently and did not consult with other colleagues nor did he have accompanying medical audit to verify and analyse the cases, which had resulted in the procedure. Consequently, at one point, the dramatic rise in blood patch procedures between 2014 and 2017 was truly extraordinary.

- 54 It is also important to stress that the increase in blood patch procedures in Belfast as a result of Dr Watt's initiative was carried out in plain sight of his colleagues and other medical staff. At no point did Dr Watt seek to hide what he was doing and indeed gave three separate presentations during the Neurosciences Grand Round on specific cases, which involved a possible diagnosis of SIH. The Grand Round was attended by consultants, registrars, and student doctors within neurosciences. One of these presentations was after he was partially restricted in 2016. On another occasion at a neurology consultants' meeting, Dr Watt's consultant colleagues were forced to confront the number of blood patch procedures taking place, because of the impact on other elective procedures. Rather than interrogate the diagnosis leading to the need for a blood patch procedure, the number of repeat procedures, or the procedures for which each consultant was responsible, it appears that hypotheses possibly explaining the increase provided reassurance. The focus across doctors and managers in Neurology was on securing sufficient capacity for the procedures and ensuring they did not disproportionately impact other routine procedures, such as lumbar punctures.
- 55 None of the existing management arrangements were effective in querying or questioning the proliferation of blood patch procedures by Dr Watt. The then Assistant Service Manager did ask critical questions, but these were never adequately considered. The Ward Sister also highlighted obvious queries about the procedure because the number of blood patches being carried out by Dr Watt put a significant strain on existing resources, and the arrangements for treatment could only be described as "chaotic". Some personnel, such as Dr Watt's secretary, were put under intolerable pressure to assist and cope with a large volume of patients who were turning up unexpectedly for the treatment.
- 56 It was only when Dr Peukert decided to keep detailed records on a spreadsheet of all the patients he had been asked to review, after concerns regarding blood patching were raised in December 2016, that the true scale of the problem became apparent. Dr Peukert's careful records revealed that the majority of patients who were being proposed for a blood patch procedure, did not have supportive imaging evidence, which would normally be a necessary indicator of the condition. The challenge that arises is how existing systems within the Trust can identify and address a situation where an unusual treatment suddenly increases to an extraordinary degree. The evidence given to this Inquiry suggests that, until Dr Peukert developed his spreadsheet, the Trust had limited understanding of the scale of the problem. In the view of the Inquiry Panel, that failure to understand was compounded by a

medical culture, which discouraged concerns being escalated or the questioning of the actions of such a senior consultant.

### Prescribing:

- 57 The prescribing of disease modifying drugs such as Alemtuzumab for the treatment of multiple sclerosis or the infusion of Human Immunoglobulin (“HIG”) was another area where Dr Watt was a clear outlier. Despite significant budgetary restraints, the pattern of prescription was identifiable and obvious. Management appeared reluctant to challenge a senior consultant’s prescribing pattern when there should at least have been queries raised. The Clinical Director and Clinical Lead adopted a model where consultant consent was a pre-requisite to progress. If one or two doctors refused an initiative proposed, such as a prescribing panel, then no panel could be set up.
- 58 A public health doctor highlighted to the Health and Social Care Board and the Belfast Trust an unusually high prescribing pattern with regard to HIG. This was largely dismissed by the Clinical Director as a naturally occurring variance between the practice of different consultant neurologists and challenged no further. Where the indications for treatment were less clear, a process of approval by a consultant in management was implemented. This became a ‘rubber stamping exercise’ with highly limited practical value, rather than a tool to provide assurance as to the appropriateness of treatment.

### Confidentiality:

- 59 The Inquiry has noted the extent to which concern about compliance with General Data Protection Regulations (“GDPR”), and Data Protection legislation more generally, has strongly influenced administrative action. Insofar as such concerns have obstructed the collation and retention of medical records, then the potential also exists for patient safety to be undermined. The Inquiry is of the view that, in too many instances, decisions are taken which are not required by the relevant legislation.
- 60 A refrain regularly repeated to the Inquiry was that an individual or an organisation had been prevented from sharing information because of confidentiality concerns. This may have been in relation to patient records, appraisal documentation completed by a doctor or access to the electronic care record by medical practitioners working in the independent sector, the storing of complaints data and numerous other scenarios.

- 61 When the Inquiry was non-statutory, it was discovered that the Department of Health had obtained access to a report prepared for the Belfast Trust pursuant to the MHPS process. The Department had no objection to disclosing the detailed report, which included Dr Watt's response to a number of highly relevant matters to the Inquiry. Dr Watt's lawyers, on the instruction of his medical protection organisation, raised strong objection, as a matter of principle, to the Inquiry having sight of the documentation. This was on the grounds that the MHPS process was confidential. Proceedings were subsequently issued in the High Court between Dr Watt and the Department; although the hearing did not proceed, because the Inquiry was then converted to a statutory inquiry with the ability to enforce the production of documents. The issues raised in the proceedings highlighted the importance of confidentiality as a critical consideration in a wide variety of circumstances. The over-reliance on confidentiality norms poses real challenges for the evaluation and governance of clinical practice and for any retrospective analysis such as that conducted by the Inquiry.
- 62 The Inquiry took the view that if patient safety was truly the paramount concern, then confidentiality and issues arising in relation to the sharing and retention of data would need to be more closely examined. Such was the importance of the issue that the Inquiry instructed David Scoffield QC (now Mr Justice Scoffield) and Alistair Fletcher BL to provide an opinion on the legal issues that can arise. A wide variety of possible scenarios focusing on the retention of data by the Responsible Officer of a Trust was considered in the opinion. In each scenario, the opinion found that, subject to certain basic safeguards, data could be retained. The opinion stated in conclusion:
- As a matter of general principle there are justifications for collating and retaining the information that the Inquiry envisages should be made available to, and kept by, the responsible officer. It is likely that the great majority of this information will already be held by the relevant Trust, albeit perhaps not in any centralised or organised manner. If the Trust is permitted to retain the data in the first instance, then there should be no issue with the responsible officer collating it under their auspices, on the basis that the Trust is in reality the controller for GDPR purposes. In our view, the obligations under the 2010 Regulations give additional justification for the retention of data by the Trust through the responsible officer in the cases discussed above.
- 63 The Inquiry Panel believes that, if patient safety is going to genuinely be the paramount concern, much more needs to be done to dismantle some of the impediments to adequate and effective communication between those charged with

ensuring safety. It cannot be right that information is retained in different ‘silos’, and that key personnel, and especially the Responsible Officer, are unable to access highly relevant data for reasons which are in no way persuasive. The Inquiry has uncovered numerous index examples of situations, where, if information has been appropriately shared, those charged with ensuring patient safety would have been able to make an informed decision. As it was, the Responsible Officer/Medical Director was unaware of critical information before November 2016.

**Specific Conclusions:**

- 64 The public and, in particular, patients who were affected, rightly demand to know why the problems in Dr Watt’s practice were not identified and dealt with at a much earlier juncture. This report will give a detailed account of how those problems went unidentified for so many years.
- 65 The evidence obtained by the Inquiry and the report of the Royal College of Physicians revealed problems, including a range of unusual features, in Dr Watt’s practice that went largely unnoticed or unchallenged by other consultants. Such practices included:
- (i) The dramatic increase of blood patch procedures and diagnoses of cases of SIH to the point where Belfast seemed to have an incidence beyond any assessment in the medical literature or in the experience of other neurologists (see chapter on Blood Patching).
  - (ii) Definitive diagnoses being given in the absence of objective imaging without a sufficient patient history to justify a blood patch procedure.
  - (iii) Using blood patch procedures diagnostically and in a manner which was outside the guidelines.
  - (iv) A preference for immediately prescribing second line drugs at the earliest opportunity. An example is the prescription of Alemtuzumab for Multiple Sclerosis.
  - (v) The prescription of HIG treatment in grey area cases to the point where, for many years, Dr Watt was an obvious outlier.
  - (vi) A marked reluctance in some cases to diagnose a functional neurological disorder.
  - (vii) A willingness to circumvent established procedures for transfer between the independent sector and the NHS.
  - (viii) Over confidence in diagnosis and treatment and an unwillingness to change opinion.

- 66 The Inquiry Panel has commended some of the actions taken by the Belfast Trust after November 2016. It rejects, however, a narrative that this was the first time that issues of concern about Dr Watt's practice were apparent. There was sufficient information to give rise to questions and led to a more thorough investigation into his clinical practice much earlier than November 2016. In particular, the Inquiry has concluded significant opportunities were missed to identify a pattern of potential aberrant practice in 2006/2007, 2012/2013 and earlier in 2016.
- 67 The fact that the Trust did not appreciate that there was a great deal in Dr Watt's clinical background that was highly relevant to the issues that emerged in November 2016, was a failing which was contributed to by other organisations, including the UIC, GMC and other Trusts.
- 68 While the Terms of Reference of the Inquiry are focused on the effectiveness of governance, the ultimate purpose of the Inquiry is to establish the facts as to what happened. The Inquiry Panel has, as a result of this detailed process, made 76 recommendations which, if implemented, should significantly reduce the risk of a recurrence of similar events and improve patient safety.

## RECOMMENDATIONS

### NI Department of Health:

- (1) The NI Department of Health and the GMC should issue a joint public statement for the benefit of public and patients making clear the extent to which they consider whether the processes of medical appraisal and revalidation, currently extant, are sufficient to ensure that aberrant practice will be identified. If those processes are in themselves inadequate, the statement should specify what mechanisms should be put in place to achieve this necessary objective.
- (2) The NI Department of Health should remind healthcare organisations that, whilst they should work collaboratively with the GMC, it is the healthcare organisations that remain responsible for the safety of their patients and accountable for managing their employees.
- (3) The NI Department of Health should ensure that healthcare organisations in their management of clinicians, or any other employees, apply the following principles:
  - (i) ‘You cannot unknow what you know’. (Anyone made aware of any patient safety issue must appropriately address it, and not avoid it). Conversations cannot be regarded as “informal” or “off the record”, with no action taken.
  - (ii) Where a healthcare professional raises a concern with a clinical director and lead clinician (or any other manager), then the responsibility for dealing with the concern should rest with the person receiving the concern. The detail of the concern should be discussed with a senior medical manager (Medical Director or Deputy Medical Director).
  - (iii) When a patient safety issue is raised, a comprehensive file note should be retained in a place where it can be easily accessed and interrogated by the relevant personnel, as discussed in the legal advice at Appendix H.
- (4) The NI Department of Health should review its guidance in relation to complaints, to ensure that patient safety is the overriding objective.
- (5) The NI Department of Health’s performance management of Trusts’ response to complaints should not overly focus on timelines and resolution. Greater emphasis should be placed on learning, detecting misconduct or poor practice and improving services.

- (6) The NI Department of Health should make clear how, when investigating complaints, healthcare organisations should detect and investigate poor practice.
- (7) The NI Department of Health should update its guidance to ensure that the view of the clinician who is the subject of a complaint should always be sought and taken fully into account but should never be determinative of the healthcare organisation's response.
- (8) The NI Department of Health should ensure that all employing organisations have in place an appraisal process, which enables them to better assure patient safety, in line with the accountability of the organisation. This process should be the same type of process as for all other employees and should be conducted routinely by the line manager, who should take expert specialist advice if required.
- (9) The NI Department of Health should update appraisal guidance and documentation to ensure that when the line manager conducts the appraisal, the appraisee should certify that they have declared any risk to patient safety of which they are aware. This should include the details of all complaints and concerns in relation to their own practice, but also any concerns they have regarding any other clinician's practice.
- (10) The NI Department of Health should ensure that if any clinician who, as part of their continuing professional development, believes that it would also be beneficial to have a developmental reflective appraisal performed by another clinician within the same specialty or subspecialty, then the employing organisation should encourage, support and facilitate this.
- (11) The NI Department of Health should oversee the putting in place of a formal protocol to assist clarity of understanding and timely sharing of information between Independent Healthcare Providers and Responsible Officers. The overriding objective of the protocol should be to enhance patient safety through a consistent spirit of openness and transparency.
- (12) The NI Department of Health should ensure that all healthcare providers, both NHS and independent sector, will have full and unhindered access to the integrated Electronic Care Record, having sought the relevant permissions from the patient (with an appropriate division of costs).
- (13) The NI Department of Health should ensure that until the electronic care record is available, then there should be direct access to patient notes and records between the NHS and the independent sector to facilitate patient safety, having sought the relevant permissions from the patient.

- (14) The NI Department of Health should review and evaluate the progress made by the Belfast Trust in developing new information gathering and governance processes<sup>1</sup>.
- (15) The NI Department of Health should emphasise to healthcare organisations the potential dangers of lone working and to develop guidance on the many ways in which it can be avoided.
- (16) The NI Department of Health should ensure that the confidentiality dimension of the MHPS process is always subordinate to patient safety considerations.
- (17) The NI Department of Health should review paragraph 39 of MHPS and issue guidance on the appropriate balance between confidentiality for the clinician and safety for the patients.
- (18) The NI Department of Health should oversee the establishment of a group to consider the balance between the fair treatment of clinicians and the safety of patients under MHPS. The group should focus on reducing the complexity of processes and re-evaluating the degree of confidentiality. The group would benefit from input from appropriate experts to include Human Resource expertise and Medical Directors.
- (19) The NI Department of Health should initiate a detailed review in relation to the role of clinical directors and clinical leads to address issues arising from this report and their training needs.
- (20) The NI Department of Health should ensure that Trust Boards have a Safety and Quality Sub-Committee, which has a similar status to the Audit Committee.
- (21) The NI Department of Health should clarify with the Trust Boards the nature of their accountability for patient safety.
- (22) The NI Department of Health should issue guidance to healthcare organisations about the information to be given to patients when a clinician's practice is restricted in any way.
- (23) The NI Department of Health should review (and if necessary, change) the early warning alert process and the serious adverse incident process to assure itself that these processes are clear, well understood and operate in the interests of patients.
- (24) The NI Department of Health should remind commissioners of healthcare that they have a responsibility to commission safe care and, therefore, to be assured of the safety provided by any Independent Healthcare Provider.

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<sup>1</sup> To assist with investigating complaints, the Belfast Trust has implemented a clinical record review. To protect against the risk of lone working, additional peer review is being incorporated in the Trust through an initiative known as 'Building Effective Teams'. To enable the Medical Director at the Trust to be able to access accurate and useful information on a clinician's practice, a live professional governance reporting system has been put in place.

**Healthcare Organisations:**

- (25) Healthcare organisations should collate, store and have readily available all relevant information in relation to a clinician’s practice.
- (26) Healthcare organisations should ensure that if their Medical Director, or any other senior manager, becomes aware of a concern about a clinician in another healthcare organisation, then they should promptly inform the Medical Director of that clinician’s employer, and also the clinician’s Responsible Officer. They are not required to exercise judgement, merely to pass on the information.
- (27) Healthcare organisations should recognise that when it proves necessary to restrict part of a clinician’s practice, then there may or may not be implications for other aspects of his/her practice. Healthcare organisations should take immediate steps to assure themselves that other aspects of the practice are safe, and if in doubt, should restrict the whole practice until the necessary assurance has been gained.
- (28) Healthcare organisations should ensure that in the event of any form of restriction being imposed on a clinician, the GMC is immediately informed of that restriction.
- (29) Healthcare organisations should ensure that when they are asked to disclose information about a clinician’s practice to the GMC, the information is fulsome, accurate and up to date, and no judgement is applied to its likely relevance.
- (30) Healthcare organisations should promptly investigate patient safety concerns. The existence of a separate legal process (such as a Coroner hearing or litigation including criminal proceedings) should not prevent a healthcare organisation from investigating promptly patient safety concerns, including concerns about a clinician’s practice, and without waiting for the outcome of any separate legal process. The paramount concern should always be the safety of patients.
- (31) Healthcare organisations should ensure that when there is a clinical component to the complaint, the response to the complainant should be signed off by the Clinical Director, who should be accountable for the quality of the response. The Clinical Director should determine whether they are competent to assess the quality of the response themselves, or whether they need help and support from elsewhere. They may find the support internally within the Trust, but if the issue appears to be a serious one, or if the expertise does not exist within the Trust, then the Clinical Director, in liaison with the Medical Director, should have the option to seek independent advice from elsewhere.

- (32) Healthcare organisations should ensure that complaints are either upheld, dismissed or appropriately determined and this conclusion shared with all parties including the complainant.
- (33) Healthcare organisations should ensure that any investigation undertaken into patient safety issues has clear terms of reference, a robust process and the findings recorded and kept on file.
- (34) Healthcare organisations should ensure that when it proves necessary to take advice from an external expert, then clear terms of reference should be developed so that all relevant questions are posed and fully addressed.
- (35) Healthcare organisations should share necessary data to ensure patient safety. Data protection concerns should be subordinate to patient safety.
- (36) Healthcare organisations should make clear to their employees or clinicians that when an issue is raised that might have patient safety implications then a robust process needs to be put in place to provide positive assurance that patient safety is secure, rather than assuming that there is an alternative explanation.
- (37) Healthcare organisations should ensure that when a patient or their family are seen following a complaint, then an agreed process needs to be followed. The individuals meeting with the patients, or their carers, should be clear about their roles, about what is to be said to the patients and carers, and the desirable outcomes. A comprehensive note of the meeting should be made and retained.
- (38) Healthcare organisations should clarify their own policies regarding raising concerns and communicate details of these to their employees on a regular basis.
- (39) Healthcare organisations should provide both the appraiser and the appraisee with all relevant information in advance of an appraisal being carried out, with all such information being retained. The appraisal folder should not be treated as confidential to the appraisee.
- (40) Healthcare organisations should ensure that refusal or failure by a clinician, without good reason, to carry out an annual appraisal should result in a careful scrutiny of the clinician's broader practice by the organisation, who should regard the failure to follow policy as a performance issue. The healthcare organisation should also notify the GMC of all such occurrences without delay.
- (41) Healthcare organisations (employers) Boards, or at least one designated non-executive member of a Board, should be made aware of the fact that a consultant

has had their practice partially or wholly restricted. (In some circumstances this requirement may be met by the MHPS process).

- (42) Healthcare organisations should make every effort to provide consultants with opportunities to avoid lone working. It should be made clear that consultants do not have the right of veto, and that complicated “workarounds” are rarely required or acceptable.
- (43) Healthcare organisations should make it clear that all managers have a responsibility to ensure and assure themselves of patient safety. This is a proactive process to be undertaken by general managers as well as clinical managers.
- (44) Healthcare organisations should make it clear that it is the role of all managers to balance competing demands and to be held to account for doing so appropriately.
- (45) Where a healthcare organisation establishes any committee or group to assist with the management of concerns in relation to a clinician’s practice, they should ensure that it has clear terms of reference, robust processes and a widespread understanding of their remit and role. Adequate minutes should be retained detailing the decisions taken and clearly setting out any action points arising. If the role of the Committee is advisory, then this should be made clear in the terms of reference, with particular clarity in relation to whom the Committee is advising and whether, in any circumstances, it has executive responsibility. Any clinician whose practice is being considered at such a group or committee described above should be informed and provided with appropriate details.
- (46) Healthcare organisations should make it clear to clinicians that they are expected to follow national and local patient management guidelines. (If there are pressing reasons in an urgent case then a consultant can prescribe outside the guidelines and explain fully in the notes why they have done so, expecting to be held to account for their decision).
- (47) Healthcare organisations should ensure that if a consultant’s clinical practice is clearly different from that of his or her peer group without immediately obvious explanation, then the matter should be investigated to provide assurance that the practice is safe (the assumption should be that it may not be safe, and this assumption remains until assurance has been gained). Independent Healthcare Providers should inform the Responsible Officer.
- (48) When a healthcare organisation becomes aware, by any means, of an unexplained and marked change in a clinician’s practice, then the management within the

relevant service area should assure themselves that such a change is justified, with the main concern being patient safety.

- (49) Healthcare organisations should have an enforceable process and policy for the introduction of new procedures, which should include the requirement for peer review and signing-off by the Clinical Director / Lead. (The NI Department of Health should assist by developing, in consultation, a specimen policy).
- (50) Healthcare organisations should have a process and policy for the introduction of new drugs, which should include peer review and Pharmacist input, and be summarised in an enforceable formulary.
- (51) Healthcare organisations should ensure that newly introduced therapies are the subject of early clinical audit processes.
- (52) Healthcare organisations should ensure that all patients undergoing procedures of any type should be subject to a standard booking process.
- (53) Healthcare organisations should recognise that, whilst patient consent to review their notes is always desirable, if there are urgent matters of patient safety to be resolved then the need for consent should be overridden. The decision to do this should be endorsed by an appropriate non-executive director.
- (54) Healthcare organisations should make certain that those to whom a clinician is managerially accountable should be made aware of any restriction, sanction or warning in place.
- (55) Healthcare organisations should ensure that when they are asked to disclose information about a clinician’s practice to the GMC, that such information is fulsome, accurate and up to date, and no judgement applied to its relevance.
- (56) Healthcare organisations should liaise when a clinician’s practice is restricted and should follow any restriction that has been imposed.

### **General Medical Council and Regulation:**

- (57) The GMC should work with organisations such as the Faculty of Medical Leadership and Management, experienced Responsible Officers, representatives of the independent sector and lay representatives to review the existing revalidation guidance and determine the minimum data set for every doctor required to enable Responsible Officers to make the necessary judgement about recommendation for revalidation.

- (58) The GMC should update its guidance to Responsible Officers to ensure that they have sufficient information provided directly from independent healthcare providers.
- (59) The GMC should disclose to the Responsible Officer all the information it holds about a doctor to enable the Responsible Officer to make a fully informed judgement about their recommendation for revalidation.
- (60) The GMC should ensure that Responsible Officers are aware that failure by a clinician to engage with appraisal can result in the withdrawal of their licence to practice without engaging Fitness to Practise procedures.
- (61) The GMC should have the name of every doctors' Responsible Officer prominently displayed on their website. They should periodically remind doctors of the need to inform either the Responsible Officer or a senior medical manager (Medical Director or Deputy Medical Director, who should share information with the Responsible Officer) if they have a concern about a doctor's practice.
- (62) The GMC should remind doctors that they have a professional duty to report concerns and have a low threshold for doing so. They are not required to investigate themselves, merely to report.
- (63) The GMC should hold doctors who fail to report concerns to account.
- (64) The GMC should review Paragraph 25(c) of Good Medical Practice to assess the effectiveness of the advice contained within that paragraph and publish its conclusions.
- (65) The GMC should consider establishing a helpline to help doctors in relation to the handling of concerns.
- (66) The GMC should review its practice in relation to the retention of historical information held in relation to individual clinicians, including previous referrals from employers (and others), with a view to strengthening pattern recognition by the GMC itself.
- (67) The GMC should notify every organisation in which a clinician practices of the existence of any warning it issues, clarifying its impact and purpose and the consequences of further issues emerging.
- (68) When the GMC reviews its own decision-making under Rule 12 of its Fitness to Practise Rules, it should publish the outcome of the review.

**Independent Sector:**

- (69) Independent Healthcare Providers should publish the criteria used, which allow clinicians to practice on their premises.
- (70) Independent Healthcare Providers should ensure that full compliance with all these criteria should be continually monitored and enforced. If a clinician fails at any time to fully conform with the criteria, then they should be immediately stopped from practising in the relevant Independent Healthcare Provider and the clinician's Responsible Officer informed.
- (71) Independent Healthcare Providers should require clinicians to immediately notify them of any complaints or concerns received in respect of their work at the private clinic or private hospital.
- (72) Independent Healthcare Providers should, themselves immediately inform the clinician's Responsible Officer of the existence and detail of all complaints or concerns in relation to the clinician.
- (73) Independent Healthcare Providers should ensure that their Boards and Governance Committees keep detailed notes in respect of the investigation, outcome and any action points relating to complaints or concerns about an individual consultant/clinician.
- (74) Independent Healthcare Providers should provide the Responsible Officer with the full report that follows any investigation into a complaint or a concern, as soon as it becomes available. (The fact that litigation or a court hearing is pending does not constitute a valid reason for deferring sending the relevant information to the Responsible Officer).
- (75) Independent Healthcare Providers should accept responsibility for all aspects of patient safety within their organisation. The clinical governance arrangements of all Independent Healthcare Providers, including a named accountable officer, should be clearly stated on their website.
- (76) Healthcare organisations should join the relevant trade association or representative body and follow the standards it sets.



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## CHAPTER 1 – THE EVIDENCE OF DR WATT’S PATIENTS

- 1.1 The Inquiry Panel determined at an early stage that it wanted to hear from Dr Watt’s patients. Although the Inquiry was not tasked with assessing individual patient treatment from a medical perspective, the Terms of Reference were interpreted to give the maximum focus possible on patient experience, even if the main thrust of the Inquiry was to consider the governance systems within the Belfast Trust and beyond.
- 1.2 Ultimately, all the recommendations proposed by this Inquiry are advanced to assist and strengthen patient safety and to try and ensure that potentially aberrant practice can be identified and addressed within the existing systems as early as possible. To exclude or minimise the experience of patients would have been to undermine the purpose of the Inquiry and introduce an artificial dichotomy, which could only further alienate those who had suffered as a result of the misdiagnoses and mistreatment highlighted during the neurology recall process.
- 1.3 When the Inquiry was set up in May 2018, there was no Northern Ireland Assembly in place and, therefore, no Minister of Health. Nevertheless, the Inquiry Panel believed that it was incumbent upon it to engage with politicians, as representatives of the people impacted and to meet with those representatives nominated by their political party as spokespersons on health.
- 1.4 The Inquiry team, with the assistance and input of political representatives and the neurological charities formulated a questionnaire to facilitate patient engagement. A copy of this questionnaire, along with the Guide to the Questionnaire, can be found at Appendix 1. The questionnaire was well received by patients and 240 questionnaires were returned to the Inquiry, all of which were treated as written evidence and reviewed in full.
- 1.5 It is further important to note that the neurological charities greatly helped the Inquiry by providing it with invaluable guidance on how to engage with patients with neurological conditions. Some also assisted patients to fill out questionnaires and promoted the entire process through their office / groups and support networks. This was greatly appreciated.
- 1.6 It was not possible for the Inquiry to receive oral evidence from each of the patients who submitted questionnaires. In deciding who should be called to give evidence, the Inquiry focused on patients who raised concerns about their experience of

Neurology Services prior to the recall being announced in May 2018. There was a particular interest in those patients who had concerns which arose prior to November 2016 (when Dr Watt’s practice started to come under scrutiny following receipt of several index concerns from a General Practitioner – see the Part A chapter for details).

- 1.7 The Inquiry requested that 35 individual patients give oral evidence. 35 patients accepted this invitation and only 2 declined.<sup>1</sup> The summaries have all been anonymised and assigned a designated number. The Inquiry Panel was acutely aware that some patients whose evidence is included would have preferred to be mentioned by name, whereas others did not wish to have their identity revealed. After careful consideration, the Inquiry Panel decided that the best approach was to use designated numbers. Throughout the report there are references ‘INI 1’ etc. The use of such numbers was also necessary for complainants whose complaint was reviewed by the Inquiry but who did not give evidence. It is important that anyone reading the report recognises that every INI number in this chapter refers to a patient (or relative of a patient), and every such individual patient, like every other patient utilising the healthcare system, expected to receive appropriate care and treatment. The use of designation numbers should not be viewed as an attempt to de-personalise the individual patients and their relatives. The Inquiry Panel observed the courage of patients and relatives who came forward and assisted the Inquiry by giving their evidence. The accounts that have been specifically referenced in this chapter have also been sent to the patients (or the relatives of patients) whose evidence has been referenced.
- 1.8 The Inquiry Panel also wishes to acknowledge the value and assistance of the evidence obtained from patients. On numerous occasions, patient testimony provided direction to the Inquiry in terms of opening a line of enquiry and providing critical context to the questions of governance outlined in the Terms of Reference. The examples outlined in this chapter are illustrative and they provide only a sample of the evidence that was obtained.
- 1.9 The issue of greatest interest to patients was their experience and clinical management. A number also gave pertinent evidence in respect of the governance of the system. This added valuable context to the deliberations of the Inquiry Panel and triggered further lines of investigation. Each of the patient accounts below concludes by explaining the relevance of the evidence to the Inquiry.

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<sup>1</sup> The Inquiry did not believe it was appropriate to compel patients to give evidence. In those cases where the patient declined, the Inquiry had full access to the relevant written material which assisted in understanding the governance questions that arose.

- 1.10 It is properly a matter for the Belfast Trust (employer) and the General Medical Council (regulator) to investigate and adjudicate on clinical decision-making and/or professional conduct of individual clinicians. That said, the Inquiry Panel sought and invariably received permission from patients to pass on any relevant evidence to both the Belfast Trust and the General Medical Council (“GMC”) and, where relevant, to the Regulation & Quality Improvement Authority (“RQIA”) and Department of Health. During the Inquiry, relevant information from patients was passed to the GMC on 110 occasions, the Belfast Trust on 110 occasions the RQIA in 8 instances and 5 times with other Trusts or relevant bodies.
- 1.11 In an interview with Radio Ulster on 5th October 2021, INI 124, a patient who had been significantly impacted by the recall, articulated in a most compelling manner, the disappointment and distress of patients who had, the previous day, been informed that the Medical Practitioners Tribunal (“MPT”) had acceded to an application by Dr Watt’s lawyers that Dr Watt be voluntarily erased from the medical register. In a similar interview on BBC Newsline, another patient, INI 106, also cogently expressed the frustrations of patients that they would not have a hearing on the competence and capability of Dr Watt. The effect of this decision by the MPT, which was decided after a private hearing, was to effectively prevent the GMC from presenting its substantive case to the MPT. This included statements of many of the patients involved in the recall process and who had already given evidence to this Inquiry.
- 1.12 INI 124 highlighted in her interview on Radio Ulster the number of times over the preceding years that patients had been informed that regulatory matters were within the domain of the GMC, and that this Inquiry was focused on governance matters. The fact that no hearing took place on Dr Watt’s fitness to practise was extremely unfortunate. The Inquiry understands that it would have been possible to have proceeded in Dr Watt’s absence and notes that it was argued by the GMC that it was in the public interest that the case should have continued in such a manner. Somewhat unusually, the GMC issued a public statement on 4th October 2021 highlighting their “*extreme disappointment*” that a hearing had not taken place. The Inquiry Panel shares that disappointment and believes that the inability of patients to see Dr Watt’s practice assessed by an independent tribunal was a bitter blow to them and brought into sharp focus the fact that there has been no public assessment of Dr Watt’s practice.
- 1.13 Patients are not, and cannot be, responsible for the safety of the health system. That sits with those responsible for governing the system. The fact is, however, that when

patients describe issues that may reflect a lack of safety, they must be heard, and appropriate action initiated. There is a detailed chapter of the report where careful consideration is given to the role of the complaints system. It is vital that the existing system is resourced and properly utilised, where appropriate, particularly in respect of potential patient safety concerns.

#### Accounts from Patient Questionnaires:

- 1.14 It is important to acknowledge that the accounts of patients were many and varied. Inevitably, because one is quoting patients directly, much of the evidence is sharply critical of Dr Watt. While the overwhelming preponderance of the evidence received from patients has been critical, the Inquiry has also received robust and positive testimony from patients and a patient group known as *'We Support Dr Watt'*, who were impressed with Dr Watt's ability as a clinician.
- 1.15 The concerns of the *'We Support Dr Watt'* group were helpfully summarised by the Patient Client Council in a letter to the Inquiry of 10th August 2018:
- That there has been a general lack of support offered to patients affected by the recall and review process.
  - That having been recalled and reviewed there is little follow up by the Trust to cope with a change in diagnosis and to provide information on a forward treatment plan.
  - That some patients contest the new diagnosis and - having had medications and treatment reviewed - feel that this has had a detrimental effect on their health.
  - That patients have already been subject to an unreasonable wait because the Trust took no steps to ensure continuity of care for the period that Dr Watt was suspended.
  - That the Trust is slow to respond to complaints made by patients affected who are at present receiving a standardised response.
- 1.16 The Inquiry also received accounts from the relatives of deceased patients. There is presently a separate review in relation to deceased patients being carried out by the RQIA. Consequently, this category of patients is outside this Inquiry's remit except where circumstances give rise to issues of governance for relevant organisations. The Inquiry noted that family members of deceased patients were often anxious to give evidence to the Inquiry and their determination to do so was impressive.

- 1.17 The Inquiry further observed the frustration that some patients felt prior to the recall. This referred to the period from July 2017 when Dr Watt was fully restricted from clinical practice and, as a result, not seeing any patients. As this occurred before the announcement of the recall in May 2018, the issues raised fell within the Inquiry Terms of Reference.
- 1.18 The question of communication with Dr Watt's patients in the period December 2016 to May 2018 is considered in detail in the Part A chapter. The Inquiry Panel looked in some detail at how patients were informed of difficulties that had emerged and the impact that this had on patients.
- 1.19 The Inquiry also received several comments about the conduct of the recall itself, but as this was outside the Terms of Reference, it was decided by the Inquiry Panel that the evidence was not relevant to the work of the Inquiry.
- 1.20 There were also several patients who were concerned about the non-availability or limited availability of the blood patching service within the Belfast Trust from late 2016 onwards. As this happened prior to the announcement of the recall, this was regarded by the Inquiry Panel as a matter, which needed to be considered by the Inquiry.
- 1.21 A range of issues all relating to epidural blood patching is considered in the specific chapter on Blood Patching.

#### **The Evidence of Individual Patients to the Inquiry:**

- 1.22 As pointed out above, it was not possible to receive oral evidence from each of the patients who submitted questionnaires. That is not, however, to diminish the importance of the written evidence received by the Inquiry in the responses to the questionnaire. In particular, the responses provided considerable context to what had transpired and often eloquently articulated the difficulties that people experienced or in some cases laud the care they had received.
- 1.23 Dr Watt did not give evidence to the Inquiry. The reasons for this are explored in the introduction to the report. The Inquiry has had access to a vast amount of detailed written evidence, and this includes an interview, which touches upon salient issues of concern given by Dr Watt in May 2019, as part of a Maintaining High Professional Standards investigation. While it would have been helpful to hear Dr Watt's response to the issues raised by patients, the Inquiry Panel is confident that the absence of oral testimony to the Inquiry by Dr Watt has not undermined its ability to produce a meaningful report or fulfil its Terms of Reference.

**INI 4:**

- 1.24 On 5th September 2018, INI 4 told the Inquiry Panel that in 2015 his mother was referred to a geriatrician, who arranged further investigations with Dr Watt. She attended the Neurology outpatient clinic at the Belfast Trust. INI 4 described the experience as follows:

... It was clear it was a very busy clinic. She was taken through (a) patient questionnaire by a nurse initially ... When Dr Watt came into the room, he said you have epilepsy straight away. I assume the nurse had taken the questionnaire to him and he'd taken the decision prior to coming into the room. We then naturally were shocked as there was no family history. Dr Watt referred to epilepsy of old age being quite common. He seemed sure and confident of his position ... On leaving, we were shocked but reassured that there was a diagnosis and treatment to bring about improvement.

- 1.25 INI 4 stated in evidence that his mother continued to deteriorate both mentally and physically. As a result, INI 4 contacted his mother's GP in or around January 2016. INI 4 informed the Inquiry Panel that:

A young GP, Dr Claire McNeill of Ballygomartin Practice said, "Oh Michael Watt, we have concerns". That was around January 2016. She also said she didn't like Lamictal for older people or for youngsters and that "we think Dr Watt is rushing to epilepsy diagnosis". She also indicated that the Practice had wider concerns about his diagnoses of epilepsy in other patients and medication, mentioning children in particular.

- 1.26 This patient's family gained the clear impression from Dr McNeill that her practice had broader concerns about Dr Watt's diagnoses:

A family member in conversation with Dr McNeill, got the impression that the Ballygomartin Practice had concern and discussions about Dr Watt's diagnoses. They made it clear to my [family member] that they had held a case review regarding Dr Watt in the practice.

- 1.27 INI 4 said that his mother had a further appointment with Dr Watt in March 2016. He stated:

I wasn't there but my sisters attended with my Mum. My youngest sister put Dr Watt under some pressure. He was insistent Mum had epilepsy but would write a prescription for something else if they wanted. My sister asked him about the MRI scan. He wasn't aware of it. Dr Watt hadn't seen the MRI scan. My sister insisted that he looked at it, which he then appeared to do. He was quite insistent his diagnosis was right and that Lamictal was the right approach.

1.28 After learning about Dr Watt's restriction from clinical practice, INI 4 stated:

When the story broke, I rang the Department [of Health]. My one concern was in relation to deceased patients and that they could have been missed in the review ... When I passed on my concerns, I received a standard complaints response letter from the BHSCCT. I told them I wasn't raising a complaint but rather trying to ensure that deceased patients were not forgotten.

1.29 The evidence of INI 4 led the Inquiry to an important line of investigation into the extent to which concerns about Dr Watt existed outside of the Belfast Trust and more especially among some General Practitioners. More detailed commentary on this is set out in the Concerns chapter.

#### INI 5:

1.30 INI 5 first saw Dr Watt at the Royal Victoria Hospital She told the Inquiry Panel on 21st September 2018:

I explained to Dr Watt that I ... had been having symptoms including forgetfulness, breathless, numbness face, finger and toes along with fatigue.

1.31 Approximately one month later, INI 5 returned to see Dr Watt. She recalled:

I explained how the symptoms were worsening from my last visit ... and Dr Watt said it would be likely that I had an inflammation of the spinal cord caused by either an autoimmune disease or perhaps a virus. He ordered a number of blood tests. He decided that to relieve the numbness he would prescribe a 5-day course of steroids and that this is how he would treat an MS relapse. He said that the symptoms would go away and if they never came back, it was not MS. If within the year it reappeared, then he would query MS again.

1.32 Following the appointment with Dr Watt, INI 5 told the Inquiry Panel:

I received a message from my GP to say he could not give me (the prescription) because he did not recognise this as an appropriate dose and was waiting to hear back from the neurologist to clarify.

1.33 When INI 5 went to pick up her prescription:

... it was not there. The GP called me into his office to ask me what was going on as he hadn't even received any information at all from neurology at this point. He hadn't heard back from Dr Watt since he left the message.

- 1.34 In addition, INI 5 stated that the pharmacist prescribing the medication also queried the dose. Following this experience, INI 5 told the Inquiry Panel that she informed her GP that she:

Was never seeing Dr Watt again ... wanted referred to a different neurologist in a different hospital ... and thought he too readily prescribed a heavy drug.

- 1.35 In November 2010, INI 5 complained to the Belfast Trust. In correspondence to the Belfast Trust on 8th February 2011, INI 5 emphasised:

I spoke at length with you about the incorrect diagnosis made by Dr Watt and his unwillingness to consider any alternative diagnosis even when questioned.

- 1.36 Further details relating to the handling of the INI 5 complaint can be found in the Complaints chapter. As the evidence developed, the Inquiry also established that the investigation and documenting of INI 5's complaint happened in and around the same time as other key events. These events are explored in the 2012-13 Missed Opportunities chapter.

#### INI 46:

- 1.37 INI 46 contacted the Inquiry via email on 8th October 2018. She stated:

I was a private patient of Dr Watt in May 2008. He diagnosed me with epilepsy, but it is something we as a family jokingly questioned over the years. However, in light of recent allegations what was a joke now is a realistic possibility. The major concern with this lies that I was medicated through two pregnancies and there is a possibility I didn't have to be. Both those children have neurological issues now.

The issue I'm having is as I was a private patient, the NHS will not assist me in seeking a review. The Ulster Independent Clinic where I saw Dr Watt are saying that he simply rented a room and as I wasn't under active review with him, I didn't qualify for a recall and so they have said they can't help.

- 1.38 INI 46 attended the Inquiry on 13th November 2018 and informed the Inquiry Panel that she first saw Dr Watt at the Ulster Independent Clinic ("UIC") in 2008 and was diagnosed with epilepsy. When the news of the patient recall broke, INI 46 contacted UIC. She described her experience as follows:

They seemed to give me the impression that they were caught off guard. They didn't really have anything in place as such. They would take my details, and someone would phone me back. Someone phoned me back and the explanation was ... that I was classed as a discharged patient and therefore I didn't qualify

for review, that essentially Dr Watt just rented a room from them, and they didn't have responsibility.

1.39 INI 46 further stated:

I feel like I have fallen through the cracks. I wasn't an NHS patient so I don't fall under the patient recall and the Ulster Independent Clinic say they are only recalling patients under active review which I wasn't and so I have nowhere to turn with my concerns.

1.40 Overall, she described the interaction with UIC as *"a very frustrating process" and in her opinion they were "so unhelpful and dismissive"*. INI 46 described Dr Watt as follows:

Dr Watt, whenever I saw him was a lovely man ... maybe that is how, if there is a problem, maybe that is how it has gone on so long ... I had no reason to question my diagnosis at the time. I never brought it up before because I was respectful of the medical profession. If a doctor tells me something, I go, "yes of course". It is that aspect of authority that goes with the medical profession and I didn't have a real reason to question it.

1.41 The Inquiry Panel was keen to ensure that INI 46 was seen as part of the neurology patient recall. On 14th November 2018, Professor Mascie-Taylor wrote to Dr Adrian Mairs, Public Health Agency, highlighting INI 46's situation and requesting that consideration be given to her inclusion within the recall process. The Inquiry Panel was subsequently informed that INI 46 had been recalled and her diagnosis and treatment reviewed.

1.42 This evidence, combined with other concerns raised by a neurologist who gave evidence to the Inquiry caused Professor Mascie-Taylor to write to the Belfast Trust asking for a review of the prescription of epileptic medication regarding certain patients.

1.43 The evidence of INI 46 also led the Inquiry along an important line of investigation into the responsibilities of the independent sector. More detailed commentary on this and similar issues is set out in the Independent Sector chapter.

#### INI 77:

1.44 On 19th November 2019, INI 77 informed the Inquiry Panel that she saw Dr Watt at UIC in 2013. She described her experience as follows:

[Dr Watt] didn't actually have the actual scan in front of him but he had the letter explaining it. What he said that day was, "no, I don't think it is Multiple

Sclerosis. It depends on the person's interpretation of the scan ... each person could interpret it differently" ... He asked me to walk across the floor and basically that was it. I was so surprised that I wasn't told you would need to have further tests done or anything. It wasn't even brought into it.

1.45 INI 77 gave evidence that she was not happy with Dr Watt's approach. On leaving the consultation, she stated: *"I came out (of the consultation) saying he didn't ask the right questions, he didn't go deep enough"*. She further told the Inquiry Panel that the private consultation with Dr Watt lasted 15 minutes at most.

1.46 INI 77 told the Inquiry Panel that she was subsequently seen by other consultant neurologists who were unsure whether she had multiple sclerosis ("MS"). As a result, INI 77 was referred to see Dr Gavin McDonnell, Consultant Neurologist, at the Belfast City Hospital.

1.47 In or around December 2015, INI 77 stated that Dr McDonnell examined her and came to the view that he thought she did have MS. She recalled:

He was 90% certain on reading the exact same as Dr Watt had read ... he put me through a lumbar puncture and MRI ... he was certain then.

1.48 On 3rd February 2016, INI 77 complained by email to UIC in the following terms:

I contacted your clinic for an appointment in 2013 for a referral with Dr Watt, regarding MRI scans which suggested MS. I then had an appointment with Dr Watt who asked a few questions and then told me I did not have MS.

I would now like you to inform Dr Watt that he was wrong & that after further scans and a lumbar puncture, I do actually have [Relapsing Remitting MS]. I find it appalling that a doctor like him asked so few questions and made his assumptions based on the very little information he asked and a quick review of my own MRI scan. If he had at least asked me to have further tests & came to this conclusion, I could understand this. Taking all this into consideration, I feel that Dr Watt should refund the fee which was paid to him at the time for his appalling diagnosis. I look forward to hearing from you.

1.49 UIC responded:

Further to your recent correspondence which I forwarded to Dr Watt, I write to inform you that Dr Watt is very sorry that you were disappointed with your consultation ... as requested and as a "without prejudice" gesture of goodwill, he has asked that the enclosed cheque be forwarded to you.

1.50 The governance of the Independent Sector, including the management of complaints, is addressed in detail in the Independent Sector chapter. The Inquiry

later established that the timing of INI 77's complaint was especially relevant and further commentary on the failure by UIC to communicate this complaint to Dr Watt's Responsible Officer in the Belfast Trust can be found in the 2016 Missed Opportunities chapter.

#### INI 22:

- 1.51 INI 22 informed the Inquiry Panel on 20th November 2018 that Dr Watt diagnosed her with multiple sclerosis. She described the process of her diagnosis as follows:

When I was first diagnosed by Dr Watt, he simply told me I had MS which I was totally unprepared for ... I had attended the appointment alone and the consultation with Dr Watt lasted no more than 3 minutes.

- 1.52 She described her experience of appointments as follows:

Once I attended an appointment at the [Royal Victoria Hospital] and was seen within 30 minutes, on all other occasions, I waited a minimum of 2 hours 30 mins, even when I did get to see Dr Watt it was never any longer than 5 minutes, generally more like he put his head in the door and said carry on with what you're doing to the nurse.

- 1.53 INI 22 informed the Inquiry Panel that she didn't raise concerns *"because (she) felt that this was simply the level of neurology care that was provided and that was simply the way it was ... I didn't know who to complain to"*.

- 1.54 INI 22 expressed the following view about nurses that worked alongside Dr Watt:

You got shrugs of shoulders and acceptance of the fact that this was the way it was.

- 1.55 INI 22's evidence provided the Inquiry with evidence indicating that there may have been an issue with the volume of patients attending Dr Watt's clinics and was relevant to the chapter on Lone Working and Practice Visibility.

#### INI 106:

- 1.56 INI 106 informed the Inquiry Panel on 3rd December 2018 that she attended her GP in May 2016. INI 106 stated that she was shortly thereafter referred for a consultation with an ENT consultant in UIC. INI 106 told the Inquiry Panel that, at a review appointment, the consultant requested an urgent MRI and walked her down the corridor to Dr Watt who was holding a clinic there. At the time, INI 106 recalled that her head pain was so bad that she was barely able to be upright.

- 1.57 INI 106 gave evidence that Dr Watt saw her immediately and having heard the history of her symptoms diagnosed a Cerebrospinal Fluid (“CSF”) leak. She stated that this diagnosis took approximately 5 minutes. INI 106 went on to say that Dr Watt proceeded to give her his mobile number and told her to WhatsApp him the results of the MRI which was due later that day. That afternoon, INI 106 stated that she messaged Dr Watt to advise him that she had further deteriorated and was completely unable to be upright and that the MRI results were clear. INI 106 stated that Dr Watt advised her to get herself to A&E to be admitted for an Epidural Blood Patch.
- 1.58 Between June and November 2016, INI 106 told the Inquiry Panel that she received four blood patches. INI 106 further told the Inquiry Panel:
- My diagnosis, on the basis of symptomatic low CSF pressure was unable to be confirmed by diagnostic tests ... Also at the start of my blood patches, I was not tested clinically by measuring the opening pressure.
- 1.59 INI 106 also gave evidence that she *“was given an epidural blood patch, which was not recorded in her medical notes”*.
- 1.60 Following her first blood patch, INI 106 said that she noticed a difference in her symptoms. Indeed, after receiving the first blood patch, she stated:
- Within a couple of hours, I was actually sat up in the bed and was able to eat sitting up and was able to leave the bed and go out to the toilet. It made such a difference. Prior to that I wasn’t able to be upright.
- 1.61 However, when asked how long the improvement in her condition lasted, INI 106 responded:
- It is very difficult to be clear about this because immediately after that I had meningitis, clinical meningitis brought on by the blood patch, and after that I had a lot of side effects from that.
- 1.62 In September 2016, following discharge after her third blood patch, INI 106 stated she was unable to get any help when she phoned Ward 4E that she had just left hours earlier. INI 106 felt that she had no way of getting any help or advice so she waited all night and returned to the ward the next morning because she knew Dr Watt was on duty that weekend and would be doing his ward round. INI 106 believed that she had no other option than to present herself directly to the ward.
- 1.63 INI 106 described her third blood patch procedure as follows:
- It was horrendously painful. It was like a red-hot knife going from the top of my head to the bottom of my spine. I screamed aloud repeatedly in terrible pain,

but Dr Watt continued to administer more blood ... Dr Watt stayed with me while I lay flat for an hour afterwards because as I was not an inpatient, I had no nursing care. He said he would not be recording this Blood Patch because it was so close to the previous one 3 days earlier. I went home an hour later and for months I suffered dreadful pain in my brain, which felt like it was burning. I needed ice packs and a fan 24 hours a day for weeks. The other symptoms were also severe and constant, unable to tolerate noise, sudden overheating, bladder dysfunction urinating every 30 minutes, unable to walk any distance, needing a wheelchair to get to hospital appointments, unable to sleep. I was given no pain relief and no way of getting help from Neurology.

- 1.64 Given the fact that her symptoms were continuing, INI 106 sought help from her GP. On 3rd November 2016, INI 106's GP sent a letter to Dr Watt asking for a review and expressing INI 106's concern that another blood patch, possibly a cervical one, was being planned, despite the symptoms she was experiencing.
- 1.65 INI 106 further told the Inquiry Panel that she also attended Dr Watt privately at UIC on 23rd November 2016. At this appointment, INI 106 stated that Dr Watt told her that he was going to do a fourth blood patch as an outpatient at the end of November.
- 1.66 INI 106 described her fourth blood patch as follows:

On 28th November 2016, I was given a 4th Epidural Blood Patch by Dr Watt and an attending nurse in the Programmed Treatment Unit [in the Royal Victoria Hospital] at 8.30am. After this procedure, I was unable to get up to go home because I experienced violent electric shock type pains darting very quickly through my brain, so I had to lie down again. This repeated each time I tried to sit up and I then became nauseous. I was very frightened about what was happening in my brain, and I asked Dr Watt what was happening. He said he didn't know but he didn't like the look of me. He admitted me immediately into the adjoining discharge lounge for patients waiting to go home. Dr Watt left, and I remained there for the rest of that day until the ward was closing for the night. At the end of the evening, I Whatsapped Dr Watt to ask if anyone was coming to see me as the ward was closing. At the last minute, Dr John? from Neurology came to assess me and said I was unfit to be discharged and I was transferred to another adjoining ward which was described to me as a "pop up" ward. I was very frightened about what was happening in my brain, and I was very annoyed that there was no input from Dr Watt or Neurology throughout that day, especially as the reaction to this blood patch was inexplicable and alarming causing an unplanned emergency admission.

1.67 During these months, INI 106 recalled that: *“she must have been in A&E eleven or twelve times”*. On one occasion, INI 106 gave evidence that a clinician said to her, *“you know Michael is just going to patch you again”*. INI 106 stated that she was aware of this and asked for less risky alternatives; the clinician<sup>2</sup> responded, *“do you know how risky this is”?* INI 106 further recalled this clinician having stated that other neurologists *“wouldn’t touch this procedure with a barge pole”*. INI 106 informed the Inquiry Panel that this was the first person who pointed out the risks of the blood patch procedure.

1.68 INI 106 gave further evidence that Dr Watt also considered a fifth blood patch. INI 106 outlined the conversation between herself and Dr Watt as follows:

I was very concerned because Michael had said to me “next time I am going up, I am going to do a cervical” and I said, “really, do you have to”? And he said, “well it’s not working, is it”?

1.69 As an outpatient, INI 106 felt she was repeatedly unable to access advice or help from Neurology about ongoing acute pain and a range of other associated symptoms. Throughout her involvement with Neurology Services, INI 106 stated that she was exasperated by the lack of aftercare, advice or support for blood patch patients. INI 106 also felt isolated and unsupported due to the lack of knowledge among clinicians about her condition. INI 106 was of the view that that the unfamiliarity of GPs with the condition and side effects following the procedure led to a gap in care. INI 106 said the following about her GP:

My GP phoned me after I had my first blood patch and came home, and she said “[patient’s name], I am reading here in your notes that it says you have had an epidural blood patch. What is an epidural blood patch? I have never heard of it. What is it and what is a leak? What is going on”? I am not saying that against her. She is a good doctor. But that is the experience of CSF leak patients throughout.

1.70 During her Inquiry Panel hearing, INI 106 told the Inquiry Panel that she, therefore, turned to Facebook groups to receive support. She stated that there is an international Facebook group for CSF leaks. There is also a specific group for the UK and a separate one for Northern Ireland. When asked whether the blood patches were effective, INI 106 commented:

I think the first blood patch worked ... I don’t know. Nobody even tried to explain that. I think the first blood patch worked and I think it was right. I think

<sup>2</sup> INI 106 believed that this clinician was a registrar in Neurology. Attempts were made to identify the doctor in question but were unable to confirm their identity.

after that successive blood patches were making me worse each time, and the symptoms that I was then coping with were from being over patched.

- 1.71 INI 106 stated that she was due to be reviewed by Dr Watt on 4th November 2017. She described her experience around this time as follows:

With no letter of appointment forthcoming, I made many phone calls to his secretary and was told that Dr Watt was not available. I was not given access to any other neurology consultant. Eventually, I wrote to Dr McDonnell on 23rd January 2018 complaining about the lack of ongoing care due to the continuing absence of Dr Watt and that I had ongoing issues which needed attention. He replied that he had arranged for me to be seen by another neurology consultant. The recall was then announced, and I was seen by Dr Peukert on 15th May 2018.

- 1.72 After the news broke, INI 106 stated that she contacted Dr Watt and said *“I am not sure what is happening to you or what is going on about the investigation into the blood patches, but I feel for you. You have been very kind to me”*.
- 1.73 INI 106 further commented that Dr Watt was *“a nice guy and he is genuinely concerned and genuinely kind and doing whatever he can to alleviate pain and suffering”*. However, from a governance perspective, INI 106 believed that Dr Watt was severely overworked, his caseload was not managed and there was no oversight.
- 1.74 The evidence of INI 106 detailed her experience of blood patching. The issues in respect of the use of this procedure including the involvement of nursing staff and registrars is explored in the chapter on Blood Patching. The concern of patients having limited or no access to blood patches, and communication with those patients by the Trust following the imposition of a partial restriction on Dr Watt in December 2016, is explored further in the Part A chapter.

### INI 3:

- 1.75 INI 3 gave evidence to the Inquiry Panel on 15th November 2018. Following an MRI scan for suspected spontaneous intracranial hypotension (“SIH”), INI 3 was informed that there was no abnormality visible, but that, in any event, Dr Watt wished to proceed with an epidural blood patch, which was carried out on 1st February 2016 by Dr Watt. INI 3 described the procedure as follows:

Dr Watt carried out this procedure on his own, there were no other medical professionals present throughout this procedure, nor did any other medical professional assist Dr Watt in any aspect of this procedure. I was led to believe that this was a fairly routine procedure, with very minimal risks involved.

However, I have subsequently learned that this is not the case. ... During the course of the blood patch procedure, I felt horrendous pressure in my back, hips and legs and my urinary frequency was extremely urgent. I spent over 10 gruelling hours in the [Programmed Treatment Unit] on the day of this procedure, a procedure where I was informed would only last 2 hours at the very most. I was screaming in pain, holding onto the cot rails in extreme agony to the point where my mother had to walk away so that I would not see her distressed or crying. ...My mother sought out a nurse, who then rang for a member of Dr Watt's team to come down to see me as I began to violently shake. They prescribed Tramadol then left. When I was discharged home that evening, I spent the next 5 days in bed.

1.76 INI 3 further told the Inquiry Panel:

At the next review appointment, I informed Dr Watt that since having the blood patch that I was having issues with walking, I kept falling downstairs, my urinary frequency was very urgent. Then in the months that followed, I required the use of walking aids as well as a wheelchair. In May 2016, Dr Watt went back to his initial diagnosis of Hashimoto's Encephalopathy, which was disproved in 2014. I raised this with Dr Watt, however, I was told that the treatment of IVIG would help me and "make me better". I proceeded with the IVIG treatment on 20.5.16.

1.77 INI 3 stated that Dr Watt subsequently:

Stated that the treatment hadn't worked and then went back to the diagnosis of spontaneous intracranial hypotension, and he wanted to do a further blood patch.

1.78 With regards to the proposed second blood patch, INI 3 gave evidence as follows:

I raised concerns again about this with Dr Watt regarding having a second blood patch, especially after the first one left me in so much pain and unable to walk properly. Dr Watt informed me that it can take a few times of having this procedure before it worked. I initially agreed to a second blood patch, this time Dr Watt stated he wanted to inject the blood both into my neck and my spine. After my partner and family raised serious concerns with me regarding how the first blood path had affected me, I then decided against having a further blood patch. I informed Dr Watt of this decision, told him of all of my concerns and reasons for not proceeding, and asked that I was removed from the list. However, Dr Watt ignored my wishes and continually wrote in my clinic file, "arrange further patch", after I especially told him I did not want this treatment.

1.79 INI 3 stated that she had enquired with Dr Watt about pregnancy, and he advised: "*wait until you are fixed*".

- 1.80 INI 3 subsequently received correspondence from the Belfast Trust on 30th November 2017 and in written evidence to the Inquiry, INI 3 stated:

In November 2017, Dr Mark Michelson wrote to me on behalf of the Belfast Trust stating the requirement for Epidural Blood patching was under investigation by the Royal College of Physicians. This concerned me and caused me to be alarmed as I had this procedure. I raised these concerns with my GP, he received the same letter, however, he couldn't offer any further information.

- 1.81 The Inquiry subsequently spoke with INI 3's GP, but his recollection of the conversation was limited. INI 3 further stated:

I also contacted Dr Watt's secretary to relay my concerns on numerous occasions by telephone. I was continually told that Dr Watt was not under investigation, that he was off sick and would be returning in the New Year.

- 1.82 And further:

After obtaining my medical records and attending the review appointment as part of the recall, I again was extremely concerned. A meeting was arranged with [the Belfast Trust] on 15/6/18 I raised various concerns at this meeting, however received very little information or answers.

- 1.83 INI 3 summarised her experience to the Inquiry Panel as follows:

I feel that my whole experience with the Neurology service has been nothing short of appalling. I have been badly let down at every opportunity from the beginning of my care. I have been put through unnecessary treatment, medication as well as a procedure that I should never have had...It took me to get my local MLA involved for me to get any form of response from the Trust, however, even this proved very difficult at times ...

- 1.84 INI 3 provided the Inquiry Panel with minutes from her meeting with the Belfast Trust together with a response from the Belfast Trust to a Freedom of Information request which she submitted. The information obtained on the number of blood patches performed by Dr Watt was of significant value to the Inquiry. The evidence of INI 3 was also useful to the Inquiry in exploring the use and extent of epidural blood patch treatments within the Belfast Trust. These events are explored further in the Blood Patching chapter. The reference at paragraph 76 to the use of IVIG (human immunoglobulin) and the oversight of same, also became of interest to the Inquiry and this is discussed further in the Prescribing chapter.

**INI 104:**

- 1.85 On 6th December 2018, INI 104 informed the Inquiry Panel that Dr Watt diagnosed her with MS during her first appointment with him at UIC. She described the experience as follows:

I went in and gave him the GP referral letter and he read it. He said, "I see here it says on the letter that your mum and your brother both have MS". I said yes. He said, "who are they treated by"? I responded, "actually yourself, that's why I've come to you". He asked me who they were, and I gave him my mum and my brother's name and he knew them straight away. He said, well you know what we're looking at then, don't you? I said, "I am hoping that it is not". He just went through history and things like that ... He just said he was going to arrange for me to have an MRI scan and a lumbar puncture and an evoked response test. He said he felt it was all very expensive, which it was, and he would transfer me over to the NHS waiting list. He said he would put me straight away on the register for disease modifying therapies because it takes three months for you to be approved on that and he felt that by the time the tests all came back that I could just move straight on to therapies ... I specifically asked him, because I knew with my mum's history and stuff, I said to him, "if it is not MS what else could it be if the tests came back clear"? He said he would be "highly, highly surprised if the tests came back clear".

- 1.86 In her questionnaire, INI 104 further stated:

As soon as my MRI came back clear in October/November 2013, I raised a concern as I felt I should have had some lesions on my scan, eventually all tests (lumbar puncture, evoked eye response test) came back clear and once the MS Nurse contacted me to arrange an appointment to start Disease Modifying Therapy I said to her that I felt I may not have had MS. She discussed with Dr Watt who said that- "How did they diagnose patients when they didn't have medical tests?

- 1.87 INI 104 gave evidence to the Inquiry Panel:

I didn't know where I was with him. He wasn't very clear in what he was saying sometimes. We went in and he went through my MRI scan, and he said there's no lesions, but there were white dots which are high density ... he walked on out. The nurse came in and said, right we are going to bring you in to start the treatment. And I said to her, do I have MS? She said, "what did Dr Watt say"? My partner and I both said, "we have no idea what he said". He came back in and said to me "you have MS". I said, "right, ok. are you sure"? And he said "yes". I started the disease modifying therapies and said to [the nurse], "look I don't believe this. Everything has come back clear. How can I possibly have

MS? I actually said to Dr Watt, and he said, what did they do in the days when they didn't have MRIs? He said "your family history".

1.88 INI 104 recalled: *"I always said I did not have MS to (Dr Watt) and the nursing staff at the clinic but was told I was in denial"*.

1.89 INI 104 informed the Inquiry Panel that she specifically stated that she told the nurse that she did not have MS. In response, she stated that the nurse replied, *"Dr Watt was an expert in his field"*. In INI 104's opinion, *"the nurses ... had complete faith in Dr Watt"*. The Inquiry Panel explored INI 104's evidence with the relevant nurse on 10th April 2019. She informed the Inquiry Panel that she only vaguely remembered INI 104. When questioned, she stated that she never had any concerns about any diagnosis of any patient by Dr Watt and, further, could not remember anybody querying their diagnosis.

1.90 INI 104 said that she challenged Dr Watt on several occasions about her diagnosis of MS. She recalled:

Dr Watt stated, *"you're in denial, you are in denial"*. When I wanted to stop the medication, I always got told *"you're going to end up like your mummy"*. My mummy is extremely disabled. Even though I knew in my heart I didn't have it, there was that wee bit of fear if you took a relapse what was going to happen then ... I had to leave my job ... My family were petrified I was going to end up like their nanny.

1.91 INI 104 further informed the Inquiry Panel about a time that she bumped into Dr Watt in the corridor in the Royal Victoria Hospital and he said to her, *"look, another consultant probably wouldn't have diagnosed you as quickly as I did"*.

1.92 When reviewed as part of the recall, INI 104 stated that she was informed that she did not have MS. She described the impact as follows:

Devastated because so much of my life had been put on hold, things I could do, jobs I lost out on. There's so many other ... my career I had ... I lost all that ... I was registered disabled for five years.

1.93 The use of Disease Modifying Treatments is explored in more detail in the chapter on Prescribing. The evidence given by INI 104 is also relevant to issues arising in the Concerns, Lone Working and Practice Visibility and Medical Culture chapters.

#### INI 117:

1.94 INI 117 attended the Inquiry Panel hearing with her mother on 10th December 2018. She told the Inquiry Panel that she had a long complex medical history. She

was initially seen by Dr Paul McMonagle, Consultant Neurologist although whilst under his care she also received treatment from Dr Watt. After having three epidural blood patches Dr Watt then took over her care. She recalled Dr McMonagle saying: *“This has gone beyond the scope of my expertise, so I am going to now transfer you to Dr Watt”*. Upon transfer to Dr Watt’s care, INI 117 stated that he recommended a blood patch. INI 117’s mother described their desperation as follows:

I can remember the conversations ... the turning point when I thought, there’s a wee bit of hope in their conversations now ... When we saw the first consultant, they just said, “too many complications” and then, maybe 10 days later, I was talking to a doctor and she said, “so many complications” And that’s how desperate we were, I said “so many”, “so many” is not “too many”... and that’s when I saw there is a wee chink here that we could start bringing me back to life and that’s how we worked through this, you know ... step by step.

- 1.95 INI 117 gave evidence that she received 5 blood patches between May 2016 and March 2017. In this regard, INI 117’s mother stated:

We were initially happy to go on with [the blood patches] up until blood patch number three really. When four failed, we were starting to get worried about it. And then five came, she was seriously ill. So, we knew that was going to be the end.

- 1.96 INI 117 informed the Inquiry Panel that she received the fifth blood patch on her neck and that was the worst one. She further stated that Dr Watt had also planned to give a sixth blood patch using the Intracranial Pressure monitor, but she refused to have the procedure.

- 1.97 With regards to raising concerns, INI 117’s mother told the Inquiry Panel:

It’s very difficult to say to the doctor, we want to go elsewhere, especially when you have long term health problems, you that you are going to be coming back. We didn’t want to offend anybody.

- 1.98 INI 117 further stated that she travelled to London to get a second opinion within the private sector, where a specialist told her: *“I certainly won’t be doing any more blood patching”*.

- 1.99 INI 117’s mother further stated:

We have never really had any problem with Dr Watt. We liked him and when [my daughter] said stop, he stopped ... and he was always, you know, just I thought he was a bit light-hearted on the blood patch number(s) ... he was in very good form, and he was always optimistic. But we were desperate. We are coming in here, we are expecting now, “Is this going to work”? ... He said

“some people think because I act as if I am unconcerned that I am unconcerned ... but he said, “just because I act as if I am unconcerned doesn’t mean to say I am unconcerned” ... All that suffering and we were sort of grateful at the same time because we were desperate for solutions, and we were worried about offending people because we are going to have to come back to them.

1.100 She went on to say the following about Neurology Services:

So, it’s not so much Dr Watt. We just felt that the whole system up there was a bit, you know. A visitor said to me one day. “Sometimes you get the impression here that one doesn’t know what the other is doing”, and that’s nothing to do with Dr Watt. It was just chaos. It was always busy, and patients were in distress, and there was a lot of noise and especially whenever you would have procedures done you wanted silence. I mean it was a terrible place to be you know.

1.101 Having received INI 117’s evidence, the Inquiry subsequently established that her treatment, including the use of multiple epidural blood patches, had been presented by Dr Watt to his colleagues at a Neurosciences meeting in 2017. The Blood Patching chapter further explores this matter.

#### INI 125:

1.102 On 21st January 2019, INI 125 gave evidence to the Inquiry Panel that she first saw Dr Watt at UIC in February 2017. During her first consultation, INI 125 told the Inquiry Panel that Dr Watt informed her that she had a condition called “*spontaneous intracranial hypotension*” and told her that the only option was a blood patch.

1.103 INI 125 gave evidence to the Inquiry Panel that Dr Watt confirmed SIH at the follow up appointment. INI 125 stated that she explained to Dr Watt that she was frightened and confused and asked whether he could suggest any medication which would alleviate the pain. In response, INI 125 stated that Dr Watt told her to drink plenty of coffee. INI 125 told the Inquiry Panel that at no stage was the blood patch procedure explained to her.

1.104 INI 125 described an appointment at the Royal Victoria Hospital in May 2017 as follows:

I spoke with a nurse that was at the clinic that day and I explained my concerns with her, and I told her how reluctant I was to get the procedure done but felt I had no other option. Her response to me was “don’t tell anyone I told you this, but my advice would be definitely don’t get the blood patch done. I have seen the results”.

INI 125 could not recall the name of the nurse who told her this. She did, however, stress to the Inquiry Panel that: *“We really hope that this nurse doesn't get into any bother over this ... because I thought it was very nice of her what she actually did in the first place ... I thought it was very brave of her to say what she said ... as far as I was concerned, she was doing above and beyond what she had to do”*.

- 1.105 INI 125 told the Inquiry Panel that several weeks later her husband contacted Dr Watt and told him that she felt she had no option but to go ahead with the blood patch as the pain was continuing. She recalled:

My husband rang Dr Watt and confirmed I was going to go ahead with the blood patch even though I was scared and knew nothing about the actual procedure. He told my husband that it now had to be rubber stamped by a second consultant and gave my husband Dr Stephen Hunt's number and I made an appointment to see him on the 3rd April 2017 at UIC. During that appointment with Dr Hunt, I showed him the scan of the brain (which had previously been shown to Dr Watt), he discussed the procedure for the blood patch and following a series of questions, Dr Hunt confirmed that he would not rubber stamp the blood patch.

- 1.106 INI 125 stated that Dr Hunt confirmed that she did not have SIH. In relation to her thoughts about Dr Watt, INI 125 commented:

I put my whole trust in him as you just assume consultants are the experts and in most cases I think they are. I just did not think a top neurologist could get something so badly wrong.

- 1.107 INI 125 told the Inquiry Panel that she was subsequently diagnosed with chronic daily headaches in September 2018. The referral to Dr Hunt and the issues which ensued following the partial restriction imposed on Dr Watt in December 2016 (relating to the diagnosis and treatment of SIH) are discussed in the Part A chapter.

#### **INI 123:**

- 1.108 INI 123 informed the Inquiry Panel on 8th January 2019 that she experienced severe head pain in June 2016. She stated that she was unable to remain upright and had to lie flat. After the pain continued for several days, she attended A&E where a doctor examined her and suspected SIH. She further recalled that a CT scan of her head was carried out and arrangements were made for admission and MRI imaging.
- 1.109 INI 123 gave evidence that she was subsequently informed that the MRI confirmed a diagnosis of SIH and that she would be transferred to the Royal Victoria Hospital

when a bed was available. She was informed that she would be under the care of Dr Watt.

- 1.110 Dr Watt carried out two blood patch procedures. INI 123 described the first blood patch as follows:

Dr Watt carried out the blood patch procedure. He inserted 40 ml of blood. [A registrar] took the blood from my arm for the procedure. This treatment was carried out in a small room no larger than a small storeroom. No other witnesses were present, and it did not appear to be a particularly suitable or sterile environment. I did not sign any consent form and the procedure was carried out within 45 minutes of first meeting Dr Watt. I was not given any instructions about after care and the nurses on duty seemed unaware of how to care for patients after this procedure.

- 1.111 Three days later, INI 123 stated that Dr Watt performed a second blood patch:

Another blood patch procedure was carried out on Monday morning - another 40 mls. This procedure was very painful and difficult. There were repeated attempts to insert the needle in my spine and it caused intense pressure and pain in my head, shoulders and neck. It felt like my head was going to explode and the pressure was unbearable. I remained lying flat for most of the day as I felt very unwell. In the evening, I had an episode of intense pain in my head and neck. It felt like my head and neck were in spasm and I was unable to move my head.

- 1.112 INI 123 commented:

I do feel that, even amongst ... the nursing staff I don't feel like anybody on that ward really had an awareness of why we were there.

- 1.113 With regards to the environment in which blood patch procedures were carried out, INI 123 stated:

That Friday afternoon, Dr Watt arrived by the bedside, spoke for 30 minutes, said, "Come on, we'll go and do it now". You stood and waited ... And I mean, the room was literally down a corridor in - I can only describe it as a store cupboard. I was surprised. I thought, Right Ok, but again, your trust is there.

- 1.114 Following her discharge from hospital, INI 123 told the Inquiry Panel that she experienced intense headaches and daily pain. She stated that she contacted her GP for assistance but her GP had never heard of the condition and was unable to help. Ultimately, INI 123 stated that she returned to A&E as she felt that was the only option to access any information or help from the neurology team. She described this situation as "*psychologically distressing and unfair to be left feeling that there was nowhere to go for medical assistance*".

- 1.115 INI 123 further told the Inquiry Panel that Dr Watt had recommended another blood patch as she still had head pain. She informed the Inquiry Panel that appointments were arranged twice but, on both occasions, she cancelled the appointments as she could not face the procedure again and she suspected that her ongoing symptoms were as a result of the second patch.
- 1.116 INI 123 told the Inquiry Panel that before the news broke about Dr Watt, she was also annoyed about the lack of communication from the Belfast Trust in relation to the situation with regards to Dr Watt being absent. This was the period between July 2017 and May 2018. INI 123 highlighted that she was not given any information about why Dr Watt was not seeing patients and was not given any advice about how to access help. Further, she was not transferred to the care of another neurologist or given an indication as to how long it would be until she would be seen again. Additionally, there was no helpline or information line.
- 1.117 In May 2018, INI 123 stated she was informed by a friend that Dr Watt was being investigated and patients were being reviewed. INI 123 felt that this information should have been relayed to patients first, not announced via the media. In relation to why INI 123 did not raise her concerns, she commented:

I did not raise my concerns about the blood patches and lack of care at the time because I trusted implicitly in the ability, expertise and honourable intentions of those treating me. I was also concerned that because of the rarity of my condition, if I disputed the recommended treatment or was seen as a 'difficult patient', I would not be able to access treatment. I was repeatedly told that it was such a rare condition that not many neurologists knew how to treat or deal with it. I believed all this to be true and desperately needed help. I was not very knowledgeable at that time about my condition and believed everything I was told.

- 1.118 In relation to her diagnosis, INI 123 stated:

I think it was the correct diagnosis because I can't compare the head pain to anything else and the symptoms absolutely fitted. It was Stand up. Bang! Lie down again and there was nothing - no headache tablet, nothing - other than lying flat that made any difference whatsoever.

- 1.119 Overall, INI 123's opinion was that her "*genuine feeling about Dr Watt ... I don't truly believe he was trying to cause harm*". Her evidence was relevant to the chapter on Blood Patching and the Part A chapter.

**INI 124:**

- 1.120 INI 124 informed the Inquiry Panel that she arranged an appointment to see Dr Watt at UIC. INI 124 described her first appointment as follows:

At that first visit, within 10-15 minutes of seeing me, Dr Watt gave me his diagnosis. After he carried out a quick physical examination, we sat down at his desk ... Without hesitation he told me that he believed that I had Motor Neurone Disease, which is one of the most horrible diagnoses that exists ... the diagnosis was pronounced with such surety. There were no “ifs” and “buts”.

- 1.121 INI 124 commented:

How such a diagnosis could be given so easily, without tests being done, is shocking. But this was an experienced consultant neurologist giving me this diagnosis and we believed him.

- 1.122 INI 124 further told the Inquiry Panel that her diagnosis was never questioned:

After that first visit Dr Watt never examined me again. I wondered why he never tested my muscle strength again. My big regret is that I should have questioned this. As a nurse, I should have known better but when you are in the hands of an experienced consultant neurologist you just try to accept his pronouncements.

- 1.123 INI 124 added:

What is very clear is that the power in the word of a consultant is enormous. I and a host of health professionals just accepted Dr Watt’s diagnosis as true. I was at the mercy of the so-called expert. When I saw all the health professionals (MND specialist nurse, the MNDNI Regional Care Development advisor, the Occupational Therapist, the Physiotherapist, and Speech Therapist) swinging into action after Dr Watt’s pronouncement, I never doubted that I had MND.

- 1.124 INI 124 further added:

The specialist nurse comes to your home every three months or so ... you wonder if she wouldn’t have wondered.

- 1.125 Following her diagnosis, INI 124 informed the Inquiry Panel that she “*ended up spending almost £10,000 of (her) own money on ... renovations*” to ensure her home was suitable for someone with an MND diagnosis. She also stated that she banked her voice, discussed peg tube feeding and palliative care decisions and explained the diagnosis to her grandchildren. INI 124 described the impact as follows:

I have been having panic attacks that I have never had in my life before. I have had an irrational fear about being left on my own. I have been angry at myself

for being gullible and believing Dr Watt. I have blamed myself for not asking for a second opinion. At times, I have found it hard to sleep. I feel very anxious. From being someone who never had mental health issues and who had worked hard mentally to come to terms with my MND diagnosis ... I am now mentally fragile and feel very vulnerable.

1.126 INI 124 further stated:

If out of this Inquiry there is better accountability for consultants that would be something good. How could Dr Watt ask for tests to be done and then when a fellow consultant does the tests and gives the results, he ignores the results? And no one in the neurology department picked up on that.

1.127 INI 124 also informed the Inquiry Panel that she had trouble obtaining her medical notes from UIC. She stated:

I've been in touch with the Ulster Independent Clinic to ask could I see what Dr Watt wrote about that first visit ... They said he's holding on to those. He hasn't released them is what they told me.

1.128 The Inquiry followed up with UIC in respect of INI 124's notes. In a letter of 6th February 2019 from lawyers acting on behalf of UIC, it was stated:

As the Inquiry is aware, UIC does not hold the notes & records concerning [INI 124]. Those notes and records are retained by Dr Watt. As evidenced to [INI 124], the Clinic did make repeated requests to Dr Watt for the notes. These have now been made available and were posted to [INI 124].

1.129 The Independent Sector chapter explores relevant issues including the holding of patients' notes and the sharing of information.

**INI 105:**

1.130 INI 105 attended the Inquiry Panel hearing alongside her children on 8th January 2019. Her account of meeting Dr Watt was as follows:

We paid to see Michael Watt at the Ulster Independent Clinic ... he didn't carry out any tests, asked [my husband] to lie on the couch and he looked at [his] stomach. [My husband] showed him the fasciculations on his arms. He told me to help [my husband] up from the couch while he went back and sat at the desk. He said, "He's got Motor Neuron Disease". I asked about what happens now and he said, "If there's anything you really want to do, do it now" ... then he said, "I'll get you into the Royal at the beginning of next week to do some tests, because you're going to need a breathing machine and a feeding tube peg put into your stomach."

- 1.131 She commented: *“We were out of the office and back in the car within ten minutes. His whole attitude was cold and flippant. [My husband] and I were struck dumb, having just been given the devastating news that [my husband] had MND and we knew it was an incurable, terminal condition”*. INI 105 further told the Inquiry Panel:

During our first appointment with Michael Watt, he told us he was the “Northern Ireland Expert” in MND. However, during a home visit from [an] MND nurse ... she advised us to change doctors ... At our next outpatient appointment with Michael Watt, where he again sat behind his desk and didn’t examine [the patient], I told him what the MND nurse had said about [changing doctors] and he said, “if you want to change, change”. We were very quickly dismissed from his office.

- 1.132 During a meeting with Dr Watt, INI 105 told the Inquiry Panel that she explained that the fasciculations weren’t getting any better despite the medication. She recalled Dr Watt’s response: *“he told me, the only time you need to worry about them is when they stop. They stopped on 4th September 2016; the day [my husband] died ... This conversation has haunted me ever since”*. When asked why she didn’t raise concerns, she stated: *“I think, overall, none of us, really, as just ordinary people, would complain about a doctor ... you don’t do it”*. She added:

While I don’t doubt [my husband’s] diagnosis, the manner in which he and his family were treated by Michael Watt was totally unacceptable and less than professional ... While I appreciate that almost 3000 patients who are still alive have had to be reassessed, I appeal to the Inquiry to not forget about those who have already died and their families who are suffering with grief which has been compounded by the need for this inquiry and the ongoing media coverage.

- 1.133 The experience of the INI 105 family, the perception of their role as patient/carer and the difficulty in raising concerns is included as an index example of a particular genre of evidence from some patients.

#### INI 177:

- 1.134 INI 177 told the Inquiry Panel on 25th February 2019:

I asked Dr Watt about a second opinion, and he told me that there was no point in getting another opinion because I was so rare - maybe one in 100,000 or even one in a million so there was no point. Sadly, I listened.

- 1.135 INI 177 further stated:

Then, at the behest of medical friends outside Northern Ireland who were concerned at my condition, we decided that I would get a second opinion in

London and I attended, privately ... at Queen Square in London ... [the doctor] reviewed my MRI scans ... and he was surprised that a CT scan had not also been performed on the area of the lesion, which is an established aid in diagnosing a meningioma where a biopsy cannot be performed. We didn't know that.

- 1.136 INI 177 went on to say that she then attended a further consultation with Dr Watt. She recalled:

I had sent him a medical report and imaging reports from my second opinion in London by post ... so he'd had a little bit of time to look at it before I went. He reluctantly agreed that the Queen Square diagnosis was correct.

- 1.137 INI 177 described the impact as:

I was very upset, obviously, and my husband and myself complained to him that a CT scan should have been carried out at the beginning and that I would not have had a high dose steroid and immunosuppressant treatment for over a year. I don't know what the side effects of that have been.

- 1.138 INI 177 also told the Inquiry Panel about the difficulties in getting an extra contractual referral. The Inquiry Panel was informed by INI 177's husband that the referral to London was never made. INI 177, therefore, had to pay privately for her treatment in London.

- 1.139 INI 177 commented:

I think the key point we will want to make: the system- whether it's a system or its Dr Watt ... the system on attempting to get extra-contractual referrals was not working properly, and either they didn't understand it or they were trying to (avoid it?) ... because of the misdiagnosis. During this period, my condition worsened significantly, and the meningioma had grown.

- 1.140 Her husband further stated:

I wouldn't like the Extra-contractual referral to dominate ... what (we) have given you today. We are much more concerned about the system and how diagnoses come and all that sort of stuff.

- 1.141 The difficulties experienced by patients in getting a second opinion are discussed at various points in the Complaints and Concerns chapters.

#### **INI 87:**

- 1.142 The Inquiry heard from the parents of INI 87, who told the Inquiry Panel on 11th March 2019:

Dr Watt diagnosed our son as having epilepsy. Even though this was a life changing condition, our son was just glad to know what was wrong with him, although he never fully came to terms with it. Dr Watt prescribed medication and reviewed our son on a three-monthly basis, or before this if there were any problems. There was little or no improvement in our son's condition and a scan then revealed an arachnoid cyst on the left temporal lobe of our son's brain. Dr Watt thought the best way forward was to refer our son to Mr Stephen Cooke, neurological surgeon [at the Royal Victoria Hospital].

1.143 INI 87's mother gave evidence that:

Since as far back as early 2005, our son and I had spoken to Dr Watt regarding taking him into hospital and taking him off all the medication and starting from scratch. Dr Watt's reply to this was - but sure he likes his tablets. My son and I were both concerned about the levels of medication with no improvement in his medical condition.

1.144 Sadly, INI 87 died in 2006. INI 87's mother commented:

I feel that basic good practices and procedures were not in place to monitor our son in the community especially with such high levels of medication. In other words, the system failed our son and our whole family ... his symptoms at the time of and well before his sudden death consisted of the following: right side weakness, trailing his leg, purplish discolouration in his arms and especially his hands, sweating, dramatic weight loss, loss of appetite, depression, headaches, pains, seizures, dizziness and visual disturbances. I understand that some of these symptoms can be attributed to side effects of his medication - in other words the medication appeared to be causing more problems than cures.

1.145 The tragic death of INI 87 is commented upon further in the 2006-07 Missed Opportunities chapter.

**INI 286:**

1.146 In the early stages of its work, the Inquiry Panel became aware of a concern raised by three clinicians in the Northern Trust relating to the practice of Dr Watt. It became clear that the concerns arose after a complaint was made by a patient and his family about the care provided in the Northern Trust. To assist with understanding how the complaint arose, the Inquiry made contact with INI 286 (the patient) and his family who had assisted in making the said complaint. INI 286 and his family accepted the invitation and attended the Inquiry to give oral evidence.

1.147 The mother of INI 286 told the Inquiry Panel on 5th November 2019:

My son ... was first admitted to Antrim Area Hospital with what appeared to be seizures on 23rd August 2014 ... Since then, we have been seeking medical attention for him to try and find out exactly what his condition is and what treatment he needs to give him a better quality of life.

1.148 INI 286's mother stated: *"About a week later ... my son took what appeared to be a stroke at home, his face fell on left side, he was disorientated, couldn't lift his arms, didn't know who people were"*.

1.149 The Inquiry Panel was informed that their son first went to see Dr Watt at UIC. INI 286's mother recalled: *"after [Dr Watt] listened to my son's symptoms, he told us he had had a stroke, no doubt about it. He gave us a prescription for Aspirin and another blood thinner"*.

1.150 Subsequently, INI 286's mother stated:

Slow progress was being made until July 2015, my son was very sleepy all week, on the Sunday, he fell and shortly after he couldn't get up, his speech went, he couldn't swallow his spittle, he had pins and needles in head and arms.

1.151 At this stage, INI 286's mother informed the Inquiry Panel that their son was reviewed by a Consultant Geriatrician in the Northern Trust. She did not consider that INI 286 had suffered a stroke and according to INI 286's mother, the plan was for discharge with referral to physiotherapy and psychiatry.

1.152 The complaint raised by INI 286 and the subsequent concerns raised by the consultants in the Northern Trust, led to an independent report being commissioned. The significance of this report and the handling of these concerns is commented upon in the Concerns chapter and the 2016 Missed Opportunities chapter.

### Conclusions:

1.153 The Inquiry Panel was struck by the determination of the patients of Dr Watt to ensure that issues were properly investigated and that lessons will be learned from this Inquiry. At critical junctures, groups of patients of Dr Watt have publicly articulated understandable frustrations at delays and maintained a focus on ensuring the timely publication of the Inquiry report.

1.154 The Inquiry Panel regrets that not every questionnaire response or oral testimony could be included in the actual report. The Inquiry Panel wishes to record its profound gratitude for those who responded to the questionnaire and especially the

patients who gave oral evidence. The information obtained had a genuine impact on the Inquiry and strengthened the determination of the Inquiry Panel to ensure that it produced a meaningful report, which advanced the primary objective of improving patient safety.

- 1.155 Ultimately a decision had to be made on whether the oral evidence was sufficiently germane to the Terms of Reference that it should be included in this chapter. At an early stage, it seemed appropriate to include the testimonies of each patient who was invited to give evidence. On reflection, however, it was decided to restrict patient extracts in the report to those accounts which had led to a specific train of enquiry relevant to the Terms of Reference.
- 1.156 It is the case that it was often patient accounts that led to some of the most critical evidence being evaluated. At every stage, the Inquiry Panel has sought to keep at the forefront of its deliberations, the basic premise that the Inquiry will only have limited value if it does not ultimately result in patient safety being improved. Each process currently relied on to govern the Belfast Trust, and to oversee the activities of its consultants, must be viewed through that lens.
- 1.157 The Inquiry wishes to pay its own tribute to the resilience and determination of so many patients who ensured that the patient voice was never ignored or side-lined. Many patients had been understandably reluctant to question the expertise of a well-respected neurologist. Some stated they did have a concern but felt conflicted raising it with a trusted consultant. The situation was compounded by the complexity of neurological conditions and the additional difficulties sometimes encountered in confidently identifying a specific diagnosis.
- 1.158 The Inquiry Panel also recognises that as with many other sub-specialties, neurology was under the most intense pressure. Waiting list times for an appointment became an increasing problem, to the point where, at times, the situation had become chronic. This state of affairs has only worsened since the advent of this Inquiry, and it is recognised that intense work will be required to ameliorate the situation. In such a highly pressurised environment, it could be tempting to focus almost exclusively on seeing patients and de-prioritising some of the governance concerns raised in this report. That would be a mistake. Concerns that quality and safety improvement initiatives had not been given "*primacy of focus*" were highlighted in Sir Liam Donaldson's report in December 2014. Many of those same issues, including clinical leadership and cultural change, feature prominently in this report. Addressing the current challenges must include at the heart of any co-ordinated response, a particular focus on improving patient safety.



## CHAPTER 2 – COMPLAINTS

### Introduction:

- 2.1 A central aspect of Part B of the Inquiry Terms of Reference was to review the Belfast Trust’s handling of relevant complaints or concerns in relation to Dr Watt, identified or received prior to November 2016. To determine and assess whether the handling of complaints was appropriate, it is necessary to give an overview of how the system in place at the time handled the complaints that it received.

### Department of Health Guidance:

- 2.2 The Health and Social Care Complaints Procedure, *‘Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning’* was developed and published in 2009 by the Department of Health and applies to all Health and Social Care bodies including the Belfast Trust. This document replaced the former Health and Social Care (HSC) Complaints Procedure 1996 that applied equally to all HSC organisations and aimed to provide a streamlined and consistent process. According to the introduction to the revised Guidance in 2019:

The HSC Complaints Procedure (published 2009) was developed in conjunction with HSC organisations and publicly consulted on before being finalised and published. It reflected the changing culture across HSC services and demonstrated an increased emphasis regarding the promotion of and need for safety and quality in service provision as well as the need to be open and transparent; and to learn from complaints and take action in order to reduce the risk of recurrence.

- 2.3 The 2019 revision did not alter the key principles set out in the 2009 Complaints Procedure renamed *‘Guidance in relation to the Health and Social Care Complaints Procedure’* (*“HSC Complaints Procedure”*). The revision set out the aims of the process as:

- A strengthened more robust local resolution stage
- An enhanced role from commissioners in monitoring performance management and learning
- Improved arrangements for driving forward quality improvements across the HSC
- Improved arrangements for the delivery of responses to complaints

2.4 The 8 specific standards of the HSC Complaints Procedure are:

- Accountability
- Accessibility
- Receiving Complaints
- Supporting Complainant and staff
- Investigation of complaints
- Responding to Complaints
- Monitoring
- Learning

2.5 Much of the framework of the 2009 Procedure and 2019 Revision is laudable and coherent. The focus of the Inquiry was, however, on Investigating Complaints and in the Recording of Information. The former is one of the 8 standards for complaint handling. The latter is relevant to a number of the standards and, in particular, monitoring.

2.6 Section 3 of the 2019 Revision sets out the criteria by which organisations must operate in relation to investigation. The purpose of investigation is not only resolution but also to:

- Ascertain what happened or what was perceived to have happened
- Establish the facts
- Learn lessons
- Detect misconduct or poor practice
- Improve services and performance

2.7 Paragraph 3.27 states:

Whoever undertakes the investigation should seek to understand the nature of the complaint and identify any issues not immediately obvious. Complaints must be approached with an open mind, being fair to all parties. The complainant and those identified as the subject of a complaint should be advised of the process, what will and will not be investigated, those who will be involved, the roles they will play and the anticipated timescales. Everyone involved should be kept informed of progress throughout ...

- 2.8 At the completion of the investigation, the investigator should prepare the draft report/response with a view to recording and explaining the conclusions reached following investigation of the complaint. Paragraph 3.33 of the 2009 Guidance notes:

Where the complaint involves clinical/professional issues, the draft response must be shared with the relevant clinicians/professionals to ensure the factual accuracy and to ensure clinicians/professionals agree with and support the draft response.

- 2.9 In section 4, it is noted that each HSC organisation has a legal duty to operate a complaints procedure and is required to monitor how they deal with and respond to complaints.

4.2 HSC organisations are also required to keep a record of all complaints received, including copies of all correspondence relating to complaints. HSC organisations must have effective processes in place for identifying and minimising risk, identifying trends, improving quality and safety and ensuring lessons are learnt and shared. HSC organisations must ensure regular and adequate reporting on complaints in line with agreed governance arrangements...

4.4. The HSC must ensure they have the necessary technology/information systems to record and monitor all complaints. For the purposes of measuring the effectiveness of the procedures, HSC organisations must maintain systems ...

- 2.10 The legal framework in respect of complaints in the Health & Social Care sector is set out at Annex 2 of the 2019 Revision. The Inquiry Panel notes the provisions of the Health & Social Care Complaints Procedure Directions (NI) 2009. Of note is the general duty of the various HSC bodies, including the Trusts, to co-operate, answer questions, attend meetings reasonably required and provide information to the body carrying out the investigation. Regulation 6 requires each HSC body to appoint a senior person within the organisation to take responsibility for ensuring compliance with the arrangements made under the regulations.

- 2.11 A specific requirement at Regulation 11 is that the Complaints Manager shall send to the complainant a written acknowledgement of the complaint within two working days of the date on which the complaint was made. Further, at Regulation 14, the Complaints Manager must ensure a written response is prepared to the complaint which summarises the nature and substance of the complaint, describes the investigation and summarises its conclusions. At Regulation 14(4), it is stated:

The response must be sent to the complainant within 20 working days beginning on the date on which the complaint was made or, where that is not possible, the

complainant must be notified of the delay and the full response issued as soon as reasonably practicable.

### System for Handling Complaints within Belfast Trust:

- 2.12 In considering whether the handling of the complaints by the Trust was appropriate, the Inquiry looked carefully at how complaints received in relation to Dr Watt were dealt with and collated. The system relied on a Complaints Department that received all manner of complaints from car parking to catering. The focus was on ensuring that complaints were answered within 20 days<sup>1</sup>. If it was determined that a complaint was relevant to a particular service area, then the details are forwarded to the relevant Service Manager who, together with the Assistant Service Manager, will investigate the matter.
- 2.13 The draft response was then checked by the Co-Director for the Acute and Unscheduled Services, and ultimately by the relevant Director of Acute Services. The purpose of this exercise was to try and ensure that the response was appropriate and had addressed the issues raised. Information on previous complaints is stored on the Datix system<sup>2</sup>, which is a central record of all complaints in the Trust.
- 2.14 The Inquiry Panel was focused less on the actual outcome of the complaint and more on the methodology utilised and the arrangements made for evaluation and assessment of the issue. In particular, the Inquiry looked at evidence of complaints with a clinical dimension to see to what extent they produced a pattern of concern or enabled learning to take place. Further, the Inquiry Panel looked at the arrangements made to collate the complaints and has sought to address whether the systems utilised permit the relevant decision-makers and, especially the Medical Director to have access in a compendious way to the complete picture regarding a particular doctor.
- 2.15 The aim of the complaints system, in accordance with the Department of Health Guidance, is to satisfy the complainant and ensure that the Trust learns from the complaint. On reflection, the system should also be, if properly evaluated, an early indicator of aberrant practice. It is this aspect, and the importance of Trust learning, that is most relevant to the Inquiry's Terms of Reference. While the satisfaction of a complainant's grievance is undoubtedly an important facet of any process, the Inquiry has not sought to determine such matters as they are outside the Terms

1 This is the response time laid down by Reg 14(4) of the Health and Social Care Complaints Procedure Directions (Northern Ireland) 2009. See 16 *supra*.

2 The Datix system is a computerized record of all complaints received within the Trust. It used by the Health Trusts across the UK.

of Reference. The relevant complaints have, therefore, been assessed with a view to identifying whether, if evaluated, they could have been useful indicators of a developing problem.

- 2.16 The Inquiry has obtained evidence relating to the handling of complaints in Neurology, specifically those relating to Dr Michael Watt. Nevertheless, much of the evidence is, in the Inquiry's view, likely to have a wider significance within the Trust or other Trusts. There is no reason to believe that the practice in other Service Departments materially differs from that which pertained in Neurology.
- 2.17 The ability of the Datix system (referred to at 13 above) to collate information and operate an accessible search facility became a focus of concern, as outlined below in the History of Disclosure to the Inquiry.
- 2.18 If the relevant complaint had a clinical dimension, then the views of the treating clinician would normally have been sought and his/her response included in a prepared draft. Within the Neurosciences Division, the Clinical Director was asked on occasion to check a draft response, especially if there had been a clinical issue raised. In the evidence of the Clinical Director, Dr John Craig, this was to 'sense check' the draft. Without access to the patient's medical notes and records he did not regard the check as a proper review of the case. The then Assistant Service Manager, Clare Lundy, in her evidence of 25th May 2021, described the 'check' in more elevated terms as, "*What's your opinion? What's your thought? Can you review this?*" What is clear at this remove is that there was confusion between the Clinical Director and other managers as to what was required and expected.<sup>3</sup>
- 2.19 In written evidence submitted by the Trust on 4th April 2021, the Trust pointed out that since 2012 the complaints policy of the Belfast Trust was that "*there would be consideration of the proposed complaints response by a similarly qualified clinician to the person complained about*". The Trust submitted that this supported Ms Lundy's understanding of why she was sending complaints identified as having a clinical aspect to Dr Watt's then Clinical Director for review.

#### **Action taken by the Belfast Trust since the commencement of the Inquiry:**

- 2.20 During the first year of the Inquiry, when it was non-statutory, the Inquiry Panel encouraged action to be taken before the publication of the report in areas where problems could be easily identified. Complaints was one such area. Although the

<sup>3</sup> In written evidence from Mrs Bernie Owens dated 19th May 2022 Mrs Owens pointed out that she was surprised to note Dr Craig's description of a "sense check" and that she took a level of assurance of Dr Craig had been involved in checking a response.

Inquiry is not in a position to evaluate the actions taken, the Inquiry Panel strongly welcomes the many initiatives taken partly as a result of early interaction with the Inquiry by the Belfast Trust.

- 2.21 The Belfast Trust also made the point in written evidence of 4th April 2022 that the Departmental Guidance is silent on how one should specifically address clinical complaints. No doubt the Guidance could have addressed this, but the Inquiry Panel notes that the Guidance is replete with standards and aims and the implementation of same is left to the individual Trusts. The Belfast Trust has sought to develop clarity to this aspect of its complaints policy and provided details of the initiative that has been taken.
- 2.22 The Inquiry noted an internal audit report in April 2016 which found that there was a “limited assurance” in respect of the Belfast Trust Management of complaints. The Trust set out in detail the actions that had been taken subsequent to that internal audit report<sup>4</sup>.
- 2.23 An enhancement of the 2020 Belfast Trust Complaint’s policy took place in 2020. This introduced a “Clinical Record Review” which required review by a peer who reported to the relevant Clinical Director for any complaint that related to the quality of treatment or care. In February 2019 a template developed by Dr Jack was piloted for the testing of the Clinical Record Review and in July 2019, 28 complaints made against Dr Watt were reviewed to test the efficacy of the Clinical Record Review. This resulted in a recommendation that the introduction of a Clinical Record Review should be considered for the future management of all clinical complaints within the Belfast Trust. On 8th April 2020 a new 2020 complaints policy entitled Policy and Procedure for the Management of Complaints and Compliments and containing the Clinical Record Review Mechanism was signed off by the Medical Director and the Chief Executive and in May 2020 was formally introduced into the Belfast Trust and had been relaunched in June 2021 following an audit to evaluate compliance. Although the Inquiry is not in a position to evaluate the actions taken, the Inquiry Panel strongly welcomes the initiatives taken partly as a result of early interaction with the Inquiry.

<sup>4</sup> This report triggered the commissioning of a benchmarking review of complaints management systems and processes in October 2016. The review was published in April 2017 and included recommendations for potential improvements to complaints processes. A further review of the Complaints policy was carried out in 2017 and a new policy was adopted in March 2017. The clinical complaint peer review mechanism continued in its original form in a new paragraph 11, which sought to strengthen the investigation process. The Belfast Trust’s Shared Learning Group was expanded to include learning arising from complaints. In April 2017 there was a further review by Internal Audit which reported a finding of satisfactory assurance in relation to the Belfast Trust’s management of complaints. In August 2017 Quality Assurance checklists were developed to assist staff in providing “consistent and robust” complaint responses. In April 2018 the Trust’s weekly governance teleconference was expanded to include discussion and escalation of key governance issues arising from complaints and Northern Ireland Ombudsman cases. In May 2018 the effectiveness and focus of the Belfast Trust Complaints review Group was considered. This resulted in the establishment of a “Service user Experience Feedback Group” to inform learning. In November 2018 the Complaints Department began providing monthly update reports to the Directorates to support greater monitoring and management of complaints and assist Directors to identify trends. In December 2018 a retrospective manual review of complaints files was commenced by the Complaints Department to identify all doctors named in complaints to ensure that medical staff were appropriately linked to the relevant complaint entry in Datix.

### History of Disclosure during the Inquiry:

- 2.24 The Inquiry was announced in May 2018 and, at that stage, in line with the Trust's existing policy, earlier complaints received prior to 2007, would have been destroyed. The Inquiry was able to obtain access to a records tracker, which identified the numbers of those complaints. Using Datix identifiers provided on the records tacker, the Inquiry was able to obtain a brief description of the substance of some of the complaints. It is fair to say that most of the earlier complaints appear to relate to waiting times, both for the appointment to take place and at the clinic itself, together with a lesser number, which had concerns about Dr Watt's attitude.
- 2.25 The Inquiry has no way of knowing as to whether there was information contained within files which would have been relevant. The entries on the Datix system were not detailed and did not permit a proper evaluation of the complaint, or an analysis, which may have been useful in identifying trends. The Inquiry Panel does note, however, that one complaint (INI 409) was deemed important enough to have been raised with the then Medical Director, Dr Michael McBride, by the Patient Liaison Manger, Pauline Webb, in December 2006; the handwritten note of which refers to the lack of physical examination being carried out. There may well have been 'red flags' among these complaints.
- 2.26 Such information must be maintained and retained in an accessible way. Dr McBride stated in his evidence to the Inquiry on 7th November 2019:
- Simply having numbers of complaints on a sheet tells me absolutely nothing. I can understand why the patient elements of a complaint might be destroyed, in terms of – in the interests of the patient – and GDPR, and all the rest of it, and data protection. But in terms of the findings from a complaint or elements, which may be relevant to a doctor's continuing practice, my strong view, although I have not thought about this before, would be that that absolutely should be retained, you know there is intelligence within this which at least the analysis of that and the output of that should be retained, if only from the point of view of learning for the individual doctor in reflective practice.
- 2.27 The Inquiry must also record that following the announcement of the Independent Neurology Inquiry in May 2018, the Permanent Secretary of the Department of Health, Mr Richard Pengelly, wrote to the Chief Executive of the Belfast Trust, Mr Martin Dillon, to ensure *“that the Trust take action to secure all records and communications related to complaints and adverse incidents involving Dr Watt”*. The Trust confirmed on 24th May 2018 that *“action had been taken to secure all records and communications relating to complaints and adverse incidents involving Dr Watt”*.

- 2.28 The Trust subsequently became aware in late 2018 that the Neurosciences Service Manager had disposed of the personal office records relating to neurology complaints in September 2018. An explanation was provided to the Inquiry Panel on 12th February 2019 and an Investigator, independent of the Trust, immediately commenced an inquiry into the destruction of the material. This report was forwarded to the Inquiry on 19th April 2019. The material destroyed was, according to Mr Gerry Atkinson, the then Service Manager, in line with the extant policy that documentation over 10 years old could be destroyed in accordance with the Trust's *Records Retention and Disposal Policy & Schedule*. Mr Atkinson did not believe he had been informed of the directive from Mr Pengelly or anyone discussing the content with him.
- 2.29 The Investigator made various recommendations and the Records Retention Policy is discussed in the conclusion section to this chapter. While the Trust acted swiftly to address the incident that had occurred, it appears that there was a failure by Trust management to properly communicate the contents of the directive from Mr Pengelly, which permitted Mr Atkinson to destroy material that, although not containing patient records, did include Mr Atkinson's personal office records, some of which may have been relevant to the Inquiry. It does appear that as these were not original records that the Inquiry was still able to piece together the relevant evidence. The question of the storage of complaint material remains an important question to be considered.
- 2.30 The Inquiry was anxious to ensure that all the relevant complaint material was provided. Unfortunately, despite strenuous efforts, in particular, by Ms Clare Lundy, the former Assistant Service Manager and now Service Manager, some complaints were still being uncovered in September 2021, over 3 years after the commencement of the Inquiry. As and when information was discovered, it was disclosed immediately. The greater problem, however, was that the systems then in operation did not give confidence that the relevant information could be obtained by the appropriate decision-maker at the right time allowing for pattern recognition.
- 2.31 The Inquiry would often discover, by reference to other documentation, that a complaint had been made, which had not been disclosed by the Trust. By way of example, on 16th May 2019, the Trust's solicitor responded to a query from the Inquiry as to why complaints by INI 284 and INI 440 had not been disclosed. The explanation provided by the Senior Manager in Complaints was as follows:

First of all I would like to give an assurance that every effort was made, and continues to be made by the complaints team to provide any and all information

requested by the Inquiry. I would apologise for any issues regard to these 2 complainants.

The complaints case previously provided by the complaints department regarding MW arose from 2 sources:

a) Listings provided by Ken Fullerton in September 2018 identifying complaints for whom complaints files were to be copied and submitted – see attached emails. Neither [INI 284] or [INI 440] were named on any of these lists and so would not have been included at that time.

b) The Complaints team ran searches on the Datix complaints modules both for BHSC and legacy Trusts to identify all complaints where MW (and the other Neurology Consultants) were specifically linked (via the “Employee screen” option on Datix). None of the complaints associated with [INI 284] or [INI 440] were linked to MW on the system and so would not have been extracted by Datix when the reports were run. There are unfortunately limitations on the ability of Datix to extract complaint cases against specific parameters and given the volume of complaints received each year it would not be practicable to manually review each and every one retrospectively.

2.32 In June 2020, the Inquiry was concerned that an index complaint (INI 87) was not included in the complaints that had been disclosed. An explanation was sought and given by the Trust’s solicitor:

[The parents of INI 87] contacted the Belfast Trust following the coverage of the recall in May 2018. At this time the Medical Director’s office obtained the [INI 87] complaint file from the complaints department in order to review the case and respond to [the parents of INI 87] (as per the reference to Mr Watson on the list which you supplied to me in your email). As a result of this, the [INI 87] complaints file was not with the other complaints files, which Dr Fullerton obtained from the complaints department for the purpose of copying and collating the Trust’s submissions to the Inquiry. Although, as mentioned above, you will note that the fact that there was such a complaint was included in the summary page which you provided to us. The commission of the [INI 87] complaints file from the Trust submissions was an oversight and the Trust would wish to apologise to the Inquiry for this. The Trust had not realised the documentation had been omitted and assumed that the details had gone to the Inquiry, not least in the context of the various discussions there were about the case.

2.33 Subsequently, a further complaint regarding INI 436 was discovered. In a letter of explanation from Mrs Bernie Owens, now the Deputy Chief Executive in the Belfast Trust, it was stated:

The Complaints Department of the Belfast Trust uses an electronic database, Datix, to log complaints. For each complaint entered on Datix there is a significant number of data entry fields available that could be completed by the member of staff inputting the data. One of the available data entry fields is where you can enter the name of a medical professional associated with a complaint. This field was not used by the inputter when the case of [INI 436] was entered on Datix in 2015. Therefore, in 2018, when the Complaints Department carried out an electronic search to identify complaints received by the Belfast Trust relating to Dr Watt, the complaint of [INI 436] did not appear amongst them.

- 2.34 The Belfast Trust's problem with identifying all the complaints relating to Dr Watt was further compounded when, in May 2021, shortly before Ms Lundy appeared again before the Inquiry Panel, it transpired she had uncovered, from her own search, further complaints that had not been disclosed, namely INI 441 and INI 450. The Inquiry Panel wish to acknowledge the careful searches that were carried out by Ms Lundy and accept that there was no question of any attempt to withhold information, although it was disappointing that the Inquiry was into its third year before the information was received. The evidence now obtained, however, reinforces overall concerns about the effectiveness of the complaints system and the ability of the Trust and especially the Medical Director, to be clearly sighted on each of the complaints, which have been made against a specific doctor.
- 2.35 In September 2021, in response to issues flagged by the Inquiry, the Trust disclosed 5 lever arch files holding material relating to 100 complaints identified as potentially relevant, following a manual review of all complaint files within neurosciences. Of these, 21 were identified as directly relevant to the Inquiry Terms of Reference. Mrs Owens explained:

The Belfast Trust recognises that the electronic search of the Datix system (together with the provision of some complaints material from within Neurosciences, such as recently provided by Ms Lundy) is insufficient to provide the Inquiry with a high level of assurance that, as far as possible, all relevant complaints relating to Dr Watt have been provided. Consequently, the Belfast Trust has, amongst other things, put in train a manual review of all complaint files relating to Neurosciences held by the Complaints Department for as long as the Belfast Trust has available records (from circa 1996). This significant piece of work is being carried out urgently. It has involved relevant staff coming in on the weekend to conduct and complete the task. The work is ongoing.

- 2.36 The history of disclosure is important because it demonstrates a more significant problem with the collation of records, the triangulation of data and the ability of

the Trust to obtain information which might identify a pattern of practice. This is commented upon further below.

### Complaints Regarding Dr Watt:

- 2.37 This chapter records chronologically each of those complaints involving Dr Watt within the system, which have been disclosed to the Inquiry and which relate either to the quality of the patient/client relationship, the delay in providing reports and/or questions around clinical diagnoses and treatment.

#### INI 403:

- 2.38 On 26th February 2001, the patient complained about the fact that there was an issue with a diagnostic lumbar puncture, which had been performed by a registrar. The substance of the complaint was the lack of interest allegedly displayed by Dr Watt, who also had not responded to communication.
- 2.39 The letter of complaint composed by the patient's wife, was forwarded to the Chief Executive of the Royal Victoria Hospital on 26th February 2001. The patient's wife stated that the lumbar puncture carried out had caused significant complication and was eventually rectified by a consultant with greater experience. In relation to Dr Watt, the correspondence highlighted the fact that, in the past, Dr Watt had gone out of his way to be helpful to the patient. Attempts, however, to contact Dr Watt to discuss the complications proved problematic. The patient stated:

... I will reiterate my complete disbelief at the lack of interest apparently being displayed by Dr Watt. Between us [INI 403] and I have made at least half a dozen or more phone calls to Dr Watt's secretaries, firstly Pauline and now Katrina. Both girls assured us that Dr Watt would be informed of [INI 403's] situation. If he has received these communications why is he not responding? We just cannot understand any of this, and as we see it, he is the only person with the knowledge of [INI 403's] health record who can help him.

Maybe it is necessary to state this:- If somebody has made an error of judgement regarding the lumbar puncture, surely this is something that can happen anywhere, anytime.

**If the 'mistake' is rectified or attempts are made to retrieve the situation then that mitigates the initial wrong – we are all human. I cannot accept this – I must get something done about it – somehow.**

My only concern, and that of my husband, is that an infection of some kind or another could have set in, with all of the complications that that could bring. There has to be a reason for the pain. I am really worried, and nobody seems to be remotely interested, or care. I need a immediate response to help [INI 403], and this course of action seems to be the only one open to me. I hope and pray that you will do something quickly, before something happens that cannot be fixed ...

- 2.40 The then Associate Medical Director, Mr Peter Walby, intervened and spoke to Dr Watt about the matter developing into a more difficult situation. He suggested, in a letter of 30th October 2001, that a meeting should be set up with the patient, Dr Watt and Mrs Pauline Webb, the Patient Liaison Officer. The matter was eventually resolved when Dr Watt met with the patient and Mrs Webb in January 2002. This is one of the early complaints, which was not destroyed in accordance with Trust policy. The Inquiry Panel noted the difficulty in getting Dr Watt to engage, which resulted in this complaint being escalated to the Medical Director amongst others, and the need to involve the Medical Director to ensure that a response was obtained from Dr Watt.

#### INI 404:

- 2.41 The next complaint of note is that of the husband of INI 404, who on 24th February 2003 wrote to the Chief Executive regarding his wife. In late November 2002, INI 404 consulted Dr Watt at the Hillsborough Private Clinic regarding an ongoing back problem. The complaint stated that Dr Watt had recommended an MRI scan, which took place at Northern MRI on 5th December 2002. The report was posted to Dr Watt on 11th December 2002. Despite numerous efforts to obtain a review appointment from Dr Watt in relation to the contents of the MRI report, Dr Watt did not follow up with his views on the report.
- 2.42 In January 2003, the patient had an accident and required a hip replacement. She was hospitalised for 7 days and was scheduled for surgery on 27th January. When the anaesthetist learned that the patient suffered from spinal stenosis and had undergone a recent MRI scan, he requested a copy of the MRI scan as a matter of urgency. The patient's husband complained that the MRI scan was only delivered to the ward just prior to the surgery and there was no communication from Dr Watt. The complaint was summarised at the end of the letter:
- We paid £125.00 for the initial appointment with Dr Watt, and a subsequent amount of £500.00 for the MRI scan and there has been NO follow-up as promised and agreed.

- My wife continues to suffer with her back and we have had NO consultation regarding any possible treatment or recommendations for future treatment.
- 2.43 The Patient Liaison Office explained to the patient’s husband that, as the complaint emerged from a private consultation, it fell outside the HPSS complaints procedure. The matter was referred to the then Medical Director, Dr Michael McBride, who wrote a note on the memorandum stating: *“1 File re Michael Watt – I need to meet with him. 2 Copy to Jim Morrow/David Adams”*.
- 2.44 The matter had been flagged to Dr McBride by Mrs Webb *“because of the number of similar NHS complaints we have received in this office”*. In his evidence to the Inquiry Panel, Dr McBride could not remember the complaint specifically, but confirmed that the writing on the memo was his. He stated in his evidence of 7th November 2019:
- I had put a lot of confidence – quite rightly so – in the professionalism of **Caroline Lee and Pauline Webb, who, you know, did not sort of, you know, bring these matters** to my attention routinely clearly signalling here that there’d been a number of similar complaints into the office, and, I mean, I acted on the back of that by indicating that I felt I needed to meet with Michael Watt and copied it to his CD and Divisional Director.
- 2.45 Mr David Adams, the then Divisional Director, told the Inquiry on 8th January 2020 that he did not remember the meeting *“but I’m sure it happened because, you know, we were all at Michael, myself and Peter Walby, everybody”*.
- 2.46 The Inquiry Panel accepts at this remove, and in the absence of a contemporaneous note, it is not surprising that neither Dr Adams nor Dr McBride can recall any meeting with Dr Watt. On balance, it is likely to have taken place, given Dr Adams’ statement, but the Inquiry Panel have concluded that even if it had taken place, it had little or no influence on Dr Watt, as evidenced by subsequent events.

#### INI 405:

- 2.47 On 10th October 2003, INI 405 wrote to the hospital. Having got an appointment to see Dr Watt on 12th December 2002, INI 405 presented with complex symptoms and had an interaction with, perhaps, a registrar, who, according to INI 405, was extremely sceptical about the range of symptoms being described. When introduced to the Neurologist, who it would appear was Dr Watt, it was alleged that Dr Watt quickly concluded that INI 405 required an urgent MRI on her neck to ascertain damage.

It was suggested that this could be obtained privately. INI 405 decided to obtain a private MRI and Dr Watt saw her again on 15th May 2003. INI 405 complained at the attitude of Dr Watt, and it transpired eventually that she believed that she may require an operation on her neck. Generally, the handwritten complaint is difficult to decipher. A summary was prepared by an unknown author when the complaint was received, stating as follows:

- The staff attitude of the lady doctor on 12.12.02.
- Dr Watt then saw the patient and requested an urgent MRI scan of the neck.
- She heard nothing and phoned MRI who had no trace of a request for her – she then appears to have arranged a private MRI scan.
- When she attended for this there was no information from the consultant.
- She seen [sic] Dr Watt again on 15.05.03 who laughed all of the time he was giving her a poor diagnosis.
- She wrote to Dr Watt on 10.07.03 and never got a response.
- She now has an apt for 19.11.03.

2.48 Dr Watt, responding to the complaint on 2nd January 2004, in a letter to Mr Peter Watson, then Sub-Divisional Manager in Neurosciences & Fractures, stated:

I am sorry that she found my manner on 15th May 2003 and the attitude of the lady doctor she saw on 12th December 2002 disagreeable. As far as the MRI request if [sic] concerned it would not be unusual for the staff in the MRI unit to be unable to trace the request form. There are several possible explanations for this including difficulty locating the form in the MRI unit, delays in the internal post or a delay at our end in sending the form. Regarding the private MRI, fortunately or unfortunately the speed of response of the private MRI unit means that it can be difficult to get forms to them in time. Regarding the letter of the 10th July I do not generally reply to letters from patients and instead prefer to discuss matters at outpatients. She had an appointment for 19th November 2003 but failed to attend for this.

I can only once more apologise that she was unhappy with our efforts although she [sic] happily she does not appear to have come to any harm as a result.

2.49 A final response issued, signed by the Chief Executive of the Trust, on 26th January 2004. This indicated that Dr Watt had hoped to discuss this matter at an outpatient appointment on 19th November 2003, but that INI 405 failed to attend. The letter indicated that Dr Watt was sorry that his manner was found to be disagreeable and that it would not be unusual for there to be issues with MRI referrals.

**INI 408:**

- 2.50 On 28th April 2005, Mark Robinson MLA wrote to the Chief Executive of the Royal Group of Hospitals Trust (“RVH”), William McKee, in respect of a decision by his constituent’s doctors to discontinue regular doses of Beta Interferon. Mr Robinson stated that INI 408 was in: *“the advanced stages of this debilitating and devastating illness”* (multiple sclerosis) and that INI 408 relied on Beta Interferon to *“sustain even the smallest modicum of what little remains of his quality of life”*.
- 2.51 Mr Robinson had already complained to the then Chief Medical Officer and the Northern Ireland Ombudsman. He informed Mr McKee that INI 408 had obtained a private prescription of the drug and that this had greatly assisted. As his constituent had already spent thousands of pounds on private prescriptions, the essence of the complaint was that the NHS should pay for the treatment.
- 2.52 The Patient Liaison Manager, Pauline Webb, wrote to Mr Peter Watson, then the Manager of the Head and Skeletal Division in the RVH. Dr Hawkins and Dr Watt were contacted for their comments on the complaint. A detailed response from Dr Hawkins was received on 9th June 2005, in which Dr Hawkins set out a detailed medical history and noted that INI 408 had been admitted in October 2003. Dr Hawkins further stated:
- During his admission I spoke many times to his father about the fact that Interferon was probably no longer working ... Interferon was stopped during his admission and then started again from the supply that he had at home during his admission. It was then stopped around the time of his discharge after further and [sic] consultation with his parents.
- Clearly outside the prescribing criteria because he was barely able to stand with help and even with the help of two people he was unable to walk ...
- He was subsequently seen [sic] one of my colleagues Dr Michael Watt and Interferon was prescribed privately. I cannot account for how the Interferon has been prescribed privately since he is well outside the prescribing ABN Guidelines for Interferon as recommended by the ABN.
- 2.53 A letter was forwarded by the Director of Nursing, Mrs KMD O’Brien, on 28th June 2005. This correspondence, drafted by Mr Peter Watson, incorporated the substance of Dr Hawkins’ response. However, while noting that the *“prescribing was ceased given that he was outside of the prescribing criteria”*, the final line of Dr Hawkins’ response, relating to his inability to account for the private prescribing, was omitted.

- 2.54 Following a further letter from Councillor Robinson of 27th July 2005, the Patient Liaison Office wrote to Mr Robinson on 14th September assuring him that the matter was *“still under investigation by the relevant Directorate”*. On 5th October, the Chief Executive responded and after repeating Dr Hawkins’ original comments, stated:
- Given that [INI 408] is now attending Dr Watt privately we are not aware of the current situation.
- 2.55 The matter was then taken up by the Northern Ireland Ombudsman, but it was decided on 7th September 2006 not to proceed further.
- 2.56 From the perspective of the Inquiry Panel, the obvious discrepancy between Dr Hawkins and Dr Watt on the prescription of Beta Interferon was a matter, which required to be investigated, especially as Dr Hawkins was stating clearly that he could not account for how interferon has been prescribed privately since the patient was *“well outside the prescribing ABN guidelines”*. It may also have been early evidence that Dr Watt was prescribing outside the Guidelines. While it is recognised that this might have been clinically justified in the specific case, the issue needed to have been investigated and reassurance obtained.
- 2.57 The papers disclosed make it clear that Dr Watt was asked for his views. There is also reference to correspondence from Dr Watt, but this was, however, no longer in the file that was discovered. This case is commented upon further in the 2006-2007 chapter.

#### INI 396:

- 2.58 A complaint was received on 14th March 2005. The patient had attended Antrim Area Hospital for a suspected TIA in October 2004. He was assured he would see a neurologist within 6 weeks. An appointment was eventually given on 3rd August 2005, which was then postponed until 5th October 2005. The patient could not get cataract surgery until seen by a neurologist. As a result of the complaint, an earlier appointment was arranged for 9th May 2005.

#### INI 406:

- 2.59 INI 406 required a report for the Northern Ireland Compensation Agency. The first request for a report from Dr Watt was made on 26th April 2005. INI 406 wrote again in September 2005 and Jeffrey Donaldson MP then wrote on the patient’s behalf on 4th October 2005. A complaint was made to the Royal Victoria Hospital in September 2005. In her letter of complaint, INI 406 stated:

We have a lot of financial commitments with which I have now fallen behind with payment. It would really help if this claim was to be settled. However the Compensation Agency have informed me that they have received no reply from yourself and they have sent you a reminder. Could I please ask you to reply to them as soon as possible, as the pressure and stress being put on myself by this is affecting my epilepsy and my relationship with my family. As I am currently attending a psychiatric nurse for treatment of depression I hope you understand why I feel the need to contact you on this and will do what you can to reply to the Agency as soon as possible.

- 2.60 Mr Walby, the Associate Medical Director for Litigation, was advised of this complaint. The medical report was eventually forwarded in November 2005 and a letter from the Chief Executive of the Royal Group of Hospitals, Mr William McKee, was forwarded to Mr Donaldson MP apologising for the delay.

**INI 407:**

- 2.61 INI 407 had critical illness cover. She was seen by Dr Watt in July 2005 and the relevant forms from Legal & General were forwarded to Dr Watt at that time. Dr Watt did not respond, and a complaint was made on 28th November 2005. Mr Walby spoke with Dr Watt in March 2006, by which stage Dr Watt indicated that he had sorted the issue some months previously. Investigation found that the forms to the insurance company were completed on 14th February 2006, with a further copy faxed to the insurance company on 9th March 2006. On 6th April 2006, Mr William McKee wrote to INI 407 apologising that the forms had not been completed and stating bluntly: *“the reason for the delay was due to Dr Watt not completing the forms”*.
- 2.62 As discussed in the 2006-2007 chapter, neither INI 406 nor INI 407 were brought to the attention of the GMC, who were investigating Dr Watt at that time. Further, there seems to have been limited attempts by the Trust to identify, investigate or tackle a pattern of behaviour by Dr Watt which was flagged to the Medical Director’s Office years previously by Mrs Webb in relation to INI 404. On 8th January 2020, in his evidence to the Inquiry Panel about the number of early complaints, the Associate Medical Director, Mr David Adams, stated:

... you have the advantage here of seeing all these in one place at one time. We didn’t have that, unfortunately. It’s a very important point because if the system were working properly, they would all be in a file accessible to everyone. And they would say there’s a problem here that needs sorted out.

**INI 411:**

- 2.63 INI 411 attended Dr Watt's clinic on 4th July 2005. When a history was taken of INI 411's unexplained falls, Dr Watt attributed this to "*many years of alcohol abuse*". INI 411 had, in fact, not had a drink problem since 1988. Dr Watt prescribed tablets for epilepsy with a review in two months. INI 411 complained about Dr Watt's attitude. In an internal email of 14th February 2006, Dr Watt stated to Shauna Bradley from the Complaints Department:

What exactly is the complaint? As far as I can understand it is a report of some parts of the consultations. I'm sure what they say is right – I had misunderstood the history regarding her alcohol intake and admitted this when I reviewed her and, as far as I can recall, apologised at the time.

- 2.64 In a letter of 27th February 2006, which addressed additional areas regarding INI 411's care, Mr McKee stated:

The issues surrounding your attendance at the neurology outpatient clinic have also been reviewed. It was not Dr Watt's intention to upset you in any way and I am sorry if you were unhappy with Dr Watt's attitude.

**INI 222:**

- 2.65 The next complaint was intensively examined by the Trust and the Inquiry inspected a substantial amount of documentary evidence relating to it and spoke to a number of witnesses about their involvement with its investigation.
- 2.66 On 20th June 2006, INI 222 wrote to the Chief Executive of the Royal Hospitals, Mr McKee. The significance of the complaint was that it came from a member of the medical staff. This was a clear allegation of misdiagnosis and the manner in which the complaint was dealt with was of interest to the Inquiry.
- 2.67 In her letter of complaint, INI 222 stated:

It is with some professional reluctance that I have decided to formalise in writing my extreme disappointment and discontent at my neurology care over the last two years. I feel the need primarily as a patient, but also as a member of medical staff to vocalise these concerns so that perhaps some lessons may be learnt from my misdiagnosis, unsatisfactory management and the level of communication I experienced under the care of Dr Michael Watt and his team.

After great deliberation and with a certain element of desperation and extreme frustration during a bout of ill health in January 2006, I sought a second opinion. Following further and repeat investigations, I have recently been informed

that I was inaccurately diagnosed with Multiple Sclerosis and inappropriately advised to commence beta Interferon in December 2004. I still don't fit the diagnostic criteria now! ...

- 2.68 INI 222 then set out a detailed list of the issues and questions about her care:
- (i) Following her MRI scan, Dr Watt informed INI 222 that she had a 50% chance of developing MS. This information was delivered in the middle of a corridor in a busy ward.
  - (ii) Outpatient follow-up was arranged for 5 months later without giving timescales for recovery process.
  - (iii) According to INI 222, more prompt assessment would have allowed for consideration of IV immuno-globulin therapy.
  - (iv) INI 222's condition deteriorated towards the end of November 2004. INI 222 believed her symptoms could be attributed to autonomic dysfunction from her brain stem lesion.
  - (v) INI 222's diagnosis of MS was made entirely on temporal separation from two similar episodes with incomplete recovery in between.
  - (vi) Postural hypotension remained a significant problem from November 2004, which was reported at INI 222's clinical appointment in January 2005. Dr Watt's response to this was alleged to be inadequate and there was no suggestion of further treatments.
  - (vii) INI 222 researched drug therapies for postural hypotension and was told by Dr Watt, via a specialist nurse, that she could "*try something if I wanted to*".
  - (viii) No attempt was made to elicit and confirm the clinical signs that INI 222 was reporting. In particular, there was no check of pulse rate, blood pressure and no ECG was requested.
  - (ix) INI 222, who suggested referral to cardiology, was subsequently medically investigated and it was alleged that significant abnormalities entirely in line with what she was reporting were discovered.

- 2.69 The gist of the complaint is set out at paragraph 17 of the letter of complaint:

His premature, incorrect diagnosis has forced me to endure 18 months of side effects from beta-interferon (including significant lymphocytopenia) not to mention the unnecessary expenditure incurred by my parents ... many of the problems relating to my care came down to poor listening of my problems by the neurology service, indeed even to the point of ignoring them. I felt that I was repeatedly dismissed and my genuine and serious symptoms trivialised, perhaps because they did not understand them.

- 2.70 Dr Gavin McDonnell, Consultant Neurologist, and a colleague of Dr Watt, who had not been in any way the subject of complaint, was asked about his involvement. In a letter to Mr Gerry Atkinson, Service Manager, of 5th July 2006, Dr McDonnell felt that this was a difficult and complex case with an unusual presentation. Dr McDonnell stated: *“Because of that, I feel that the criticisms levelled at Dr Watt are unfair. Clinical issues often become clearer, with benefits of hindsight and passage of time”*.
- 2.71 Dr Watt also answered the detailed letter from INI 222 in a letter of 18th July 2006 to Mr Atkinson. Dr Watt believed that INI 222 did have relapsing/remitting multiple sclerosis. He felt that the diagnosis was made on clinical grounds supported by the results of the investigations. Mr Atkinson felt that additional comments were needed from Dr Watt and there was a further delay in response.
- 2.72 On 4th October 2006, the then Clinical Director, Mr Stephen Cooke, emailed the recently appointed Medical Director, Dr Tony Stevens, as follows:
- I had 5 emails regarding this yesterday, but prior to these I had already discussed these matters with Michael and Jim again. I have told him he is going to be in some difficulty if he does not complete the response, and get appraised, but he is adamant that he cannot do so as he still does not have a functional PC! I have suggested that he uses another one but I do not think he appreciates the potential outcome of his position.
- The difficulty is that I don't think there is understanding amongst some medical staff of the need to comply with complaints/appraisal/other organisational procedures and they are seen as non-important. There is a need for us to toughen up our approach in such situations, and be seen to be firm, but as CD I really only have explanation/persuasion to use to resolve such problems.
- Please advise on how to proceed further.
- 2.73 In response, Dr Stevens stated that if local resolution was not successful, the Trust was considering handling the complaint *“down a formal line”*. He went on to state: *“He [Dr Watt] needs to understand this and the implications”*.
- 2.74 By 18th October, Dr Stevens noted that Dr Watt had not responded satisfactorily and stated the following to Mr Adams, the then Divisional Director. He also included the Complaints Department in the email:
- I have spoken to David. Dr Watt has not responded satisfactorily. Can I have a copy of report to date and Dr Watt's input. Can you advise whether he has set date for appraisal.?

- 2.75 Prior to this, Dr Watt had responded to Mr Atkinson’s request for further matters to be addressed by stating in an email to Mr Atkinson on 11th October: *“I have answered what I can”*. There appears to be a limited understanding by Dr Watt of the Trust’s role as his employer.
- 2.76 On 12th December 2006, Mr Adams wrote to Dr Watt stating:
- I understand that despite repeated reminders and requests you have failed to provide a response in relation to the enclosed.
- I must insist that this is provided no later than close of play on Friday 15th December. Given this is a further instance of your failure to comply with the complaint procedure I have copied this correspondence to Dr Stevens and will be discussing with him the action we should take.
- 2.77 A draft letter by Mr Atkinson had been prepared for some months. Eventually Dr Watt answered a number of additional questions, which had been highlighted in red.
- 2.78 On 18th December 2006, a meeting was arranged in Dr Stevens’ office with INI 222 and her parents as well as Mrs Webb from the Complaints Office. The minutes of that meeting record the fact that there was some discussion about the diagnosis, but Dr Stevens had indicated that there *“may finally be a difference in medical opinion in the clinical aspects of this cases and that this may be difficult to resolve entirely through the complaint’s process. He was however committed to resolving the issues as far as possible.”* Dr Stevens felt that there was enough information to prepare a response to INI 222 and he committed to this being available by early January 2007. Dr Stevens also indicated that he would be reviewing the management of the complaints.
- 2.79 The Inquiry notes that on 20th December 2006, Dr Stevens met with Dr Watt and that, prior to the meeting, he had been briefed with a note from Mrs Webb regarding previous complaints. The note is set out below:

04.G.53 [INI 409]	In:	Out:	Response:
	26 Feb 04	16 April 04	33

Issues. Attitude – rude, ‘superior’, breakdown in communications.

No physical examination –

Wishes to attend another consultant.

Dr W **never replied** – Jim Morrow did so as he was the CD.

05.G.414 Jeffrey Donaldson	In:	Out:	Response:
obo [INI 406]	5 Oct 05	25 Nov 05	33

(She wrote to Dr W on 1/9/05)

Issues. Request for report for NI Compensation Agency.

05.G.533 [INI 407]	In:	Out:	Response:
	28 Nov 05	6 April 05	90

Issues. Report re: illness for Legal & General (forms posted 14/2/06).

06.GFL.035 [INI 411]	In:	Out:	Response:
	11.1.06	27.2.06	32

Issue – Doctor’s attitude & behaviour.

(To Division 30.1.06!!)

To PLO 21.2.06

06.G/Z.277 [INI 222]	In:	Out:	Open:
	9.6.06		

Issues. Diagnosis & Care.

Complaint management

(Info to Gerry A. 18.7.06)

06.G.454	[INI 87]	In:
		4 Sept 06

Clinical case – deceased son – [INI 87]

Patient of Dr W

S/B Dr Morrow (privately).

PM report to PLD 19.9.06

28.9.06 – Phone call from sec – this is not Dr W’s patient

Now pp of J Morrow

19.10.06 – email to D Adams from DW – not my pt. at the time of his death.

27.10.06 – reply from J Morrow.

31.10.06 – Another letter from family – very unhappy

8.11.06 - Another letter from family.

7.12.06 – Another letter from family

2.80 By early January, Dr Stevens had corresponded with Dr Gavin McDonnell regarding INI 222’s diagnosis. Dr McDonnell replied:

My dealings and discussions with [the patient] are clearly laid out in the relevant notes. As indicated in those notes, she appears to have had only one attack, she has only one lesion on MRI, no new lesions appeared on follow up MRI, she does not yet meet the criteria for definite MS and therefore DMT would not appear to apply. All of this is obviously a lot easier with hindsight and the follow up MRI.

2.81 Responding to this, on 3rd January 2007, Dr Stevens stated:

Gavin

Thanks for this. I am trying to reconcile the issues in this case to give you a cogent response that reflects the situation. It is difficult for me, as a non neurologist to weight the facts. What you seem to be saying is that with hindsight she does not have MS and that her view that she did not meet the criteria for B interferon has some merit. If this is the case then the trust will have to reflect this in its letter, albeit with the benefit of hindsight.

I recognise that the complaint is not directed at you, but your input is invaluable.

2.82 Arising out of his correspondence with Dr McDonnell, Dr Stevens then contacted Mrs Webb in Complaints on the same day:

Pauline

I am not sure where this leaves us. It may be wise to get some help in a final draft from a 3rd neurologist. What do you think about a meeting with Jim Gilmore?

This is getting into the realms of difference of medical opinion and has med legal overtones. Is it worth also a discussion with Peter Walby?

Can you check is Michael in this week. If so hassle him. If need be I will tell him to respond.

2.83 Earlier that day, Dr Watt had approved the proposed letter to INI 222 and gave a detailed response to Dr Stevens as follows:

I feel the reply is fine. The difference in medical opinion comes down to interpretation of the events after her initial presentation. I felt that she she [sic] had developed new problems which could not be explained by the evolution of the known spinal cord inflammation and could only be explained by a new lesion at a higher level and it was this that led me to conclude that she has MS. I would acknowledge that I believe that in patients who have MS the sooner they start disease modifying therapy the better, but I would not generally start someone on treatment after a single attack. I believed that in starting her on treatment when I did that she would have a better prognosis and that I was treating her as I would have wished myself or my family to be treated in similar circumstances. The fact that she has no [sic] gone on to have further attacks has led to doubt about the diagnosis but it could be argued that this has been due to the interferon treatment. There is ample evidence that treatment with interferon after a single episode of inflammatory demyelination prolongs the time to a further attack and avonex is now licensed for use in this situation, although not yet recommended by the ABN, and there is no evidence of long-term harm from treatment with beta-interferon.

2.84 The letter was eventually sent on 9th January 2007 and responded to each of the paragraphs in the original letter of complaint. The letter did refer to the difference in opinion and included Dr McDonnell's observation that it is easier with the benefit of hindsight and a follow up MRI to come to a more definitive view. The issue of whether INI 222 had been treated unnecessarily with Beta Interferon was not resolved and careful attention was paid to reflecting Dr Watt's own views of the case. At paragraph 17 of the response from Mrs Deirdre O'Brien, Acting Chief Executive, it is stated:

Dr Watt continues to feel that you have relapsing/remitting MS. The diagnosis was made on clinical grounds supported by the results of the investigations. Dr Watt feels that having the Beta-Interferon early in the course of your disease will leave you better off in the long run and, if you are right and you only had a single attack a case could be made for you having taken Interferon anyway as one of the products is now licensed for use after a single attack of inflammatory demyelination.

2.85 The response went on to outline the views of Dr McDonnell as follows:

Dr McDonnell, Consultant Neurologist, was also asked to comment on this case. In his clinical opinion you would appear to have had only one attack, you have only one lesion on MRI, no new lesions appeared on follow-up MRI, you do not yet meet the criteria for definite MS and therefore DMT would not appear to apply. This is clearly a lot easier with the benefit of hindsight and the follow-up MRI.

2.86 In evidence to the Inquiry Panel, it was clear that there had been reflection on this case. Dr Stevens, the then Medical Director, stated in response to a question from the Inquiry Chairman:

**Mr Lockhart QC:** But what I liked about the reflection that you initially gave us was that you got right to the heart of it, because right at the heart of this is the speed of diagnosis, the failure to carry out investigations, and the willingness to prescribe treatment before the criteria are met.

**Dr Stevens:** That's exactly correct. To my mind, in retrospect now, based on what we now know, that was probably the first example I'm aware of where that's expressed.

2.87 Dr Stevens had earlier in his evidence noted:

He was prepared to take the step to a diagnosis of multiple sclerosis ahead of the individual meeting criteria and without necessarily a full range of investigations and then proceed to treatment. Gavin McDonnell's almost last comments that, with the benefit of hindsight, didn't meet the criteria, diagnostic

criteria for MS, and therefore, probably didn't meet the criteria for treatment with disease-modifying drugs, but, at the same time, says but it's easy with the benefit of hindsight ...

... You can see that I was not terribly happy with the earliest drafts of the complaint response and was pushing Gavin and Michael very hard to say that, actually, look, we've got to answer her question about whether she was treated appropriately or inappropriately and insisted on the line that Gavin McDonnell gave us...that she didn't meet the criteria. Because I wanted her to know that I was trying very, very hard at that point to make sure that the complainant knew there was a difference in medical opinion...what I wasn't trying to do was identify that Michael might have been an aberrant doctor or that his decision making was seriously flawed.

- 2.88 Dr Michael McBride, Medical Director prior to Dr Stevens, also reviewed INI 222's complaint:

Knowing what I now know, this was a very important milestone and this is a very significant case in terms of subsequent events. I suppose, looking back on this now with the benefit of hindsight, one would have wanted to ask, perhaps, or now hope that one would've asked, "is this an isolated incident? Could there be other similar cases?"

- 2.89 The Inquiry Panel agrees with Dr McBride. It also notes that he was appointed Chief Medical Officer in September 2006, in the middle of the investigation, which was ultimately completed by Dr Stevens, the new Medical Director.

- 2.90 Dr Gavin McDonnell, in his evidence to the Inquiry Panel, was anxious to highlight that though he disagreed ultimately with the diagnosis of MS in this complaint, he could understand how it was made:

Not all MS attacks are associated with a visible new lesion on MRI, although this would usually be the case. Not all lesions are seen on MRI scans – they may be below the resolution of the scanner or the particular imaging sequences may not be sensitive enough to detect MS lesions. Lesions can also appear and resolve from MRI scans. Therefore, whilst I disagreed with Dr Watt in relation to the diagnosis, I could understand how Dr Watt got to the diagnosis when I was asked to review the case in 2006/7. I noted that the patient had not "yet met the criteria for definite MS.

- 2.91 This complaint was of interest because it involved a patient, who was also a qualified consultant, albeit in a different discipline, and who had a family member in a senior managerial role within the NI Healthcare system. In this respect, it is similar to the INI 5 case discussed below.

2.92 The fact is, however, that the method of dealing with complaints prevented this case from alerting those managing complaints that this was a part of a pattern. It may well be the case that there is in the medical history, a presentation on which reasonable neurologists could disagree in both diagnosis and treatment. This possibility is emphasised several times by Dr McDonnell, who, while clear in his own medical views, is sympathetic to the fact that at the time Dr Watt saw INI 222, the approach taken was not unreasonable. The Inquiry Panel, however, is critical of the fact that there is not an agreed systematic approach to dealing with questions of alleged clinical misdiagnosis and notes the following:

- (1) The focus of those seeking to resolve the complaint is to obtain from Dr Watt his response to the points made. While this was a critical and appropriate step, it should not have precluded obtaining an independent view or views. In this case, and somewhat unusually, Dr McDonnell was asked to give his views. He did disagree with the diagnosis and though he was sympathetic to Dr Watt's earlier predicament, this was a case where a further view might have been helpful as mooted by Dr Stevens in December 2006. The Inquiry Panel agrees with Dr Stevens.
- (2) Dr Stevens clearly had many of the right instincts, and subsequently took action against other doctors. He had a meeting with Dr Watt in December 2006, where he was properly briefed with a note from the Complaints Department about previous complaints. While the note was not especially detailed, there was sufficient information to raise further questions about other complaints, particularly because Dr Watt had not completed his appraisal, which was overdue. This exercise did not appear to have been undertaken although the Inquiry acknowledge that this may have been the first complaint involving an alleged misdiagnosis by Dr Watt
- (3) The points made by Mr Cooke in his email to Dr Stevens of 4th October 2006 at paragraph 67 appear apposite:
  - (i) Medical staff not seeing the need to comply or the importance of complaints (and appraisal).
  - (ii) The need for the Trust to toughen its approach.
  - (iii) What Mr Cooke considered to be the limitations of his role as Clinical Director.

2.93 At this juncture the Inquiry Panel noted that, despite proactivity by Dr Stevens, all the information on relevant complaints was not in front of him. The need to triangulate the available data and present to the Medical Director an accurate picture impeded the ability of the Trust to analyse the situation properly.

## INI 87:

2.94 The parents of INI 87 wrote to the Belfast Trust on 4th September 2006 following the unexpected and sudden death of their son. The letter of 4th September 2006 was addressed to the Chief Executive of the Royal Group of Hospitals. The family sought clarification regarding a number of matters, including identifying who was responsible for reviewing and monitoring their son's medication and progress, the guidelines regarding levels of medication, particularly when drugs were used together and a number of other specific questions about monitoring a patient. The letter concluded:

We would be grateful if you could assist us with this and perhaps any other information you may find which would be of benefit to us in finding answers, which may help us come to terms with [INI 87's] death.

2.95 Dr Watt had seen INI 87 over a number of years and was contacted by the Medical Director's Office. After some delay, Dr Watt responded:

As [INI 87] wasn't my patient at the time of his death, although he had attended me on and off for quite a few years, I don't feel I should be commenting on something I was not responsible for.

2.96 Subsequently, the Medical Director's Office wrote to the Associate Medical Director, Mr Adams, and stated:

I have discussed this case with Mrs Webb. Dr Watt spoke with Pauline two weeks ago indicating that he felt this complaint was not his responsibility, but Dr Morrow's. Pauline explained that Dr Morrow saw [INI 87] once privately and that the questions relate to care, which was given under Dr Watt's management. It was agreed that he would speak with Dr Morrow, perhaps meet with the parents with Pauline in attendance. Dr Morrow, however, may not agree with this – if so, it lies solely with Dr Watt.

2.97 On 19th October 2006, an email from the Medical Director's Office to Dr Watt stated: *"Your response to this complaint was due on 6th October. Please forward or advise of delay. Thank you."*

2.98 This email was immediately followed by a connected email from Mr Adams stating: *"Michael please respond. David Adams."*

2.99 Dr Watt responded within 45 minutes and stated to Mr Adams:

He was not my patient at the time of his death. He had attended Dr Morrow at the UIC and he had arranged to review him in the BCH.

- 2.100 The following day, Mr Adams contacted Dr Morrow and asked him to liaise with Dr Watt and then respond.
- 2.101 On 27th October 2006, Dr Morrow provided a 5-page response to Mrs Webb concerning the complaint. That letter set out in precise detail Dr Morrow's dealings with INI 87. It transpired that Dr Morrow had seen INI 87 on 5th January 2006 when he attended privately at the Ulster Independent Clinic. Dr Morrow noted that INI 87 had been under the care of Dr Watt for some years. He had been referred to Dr Morrow for a review of his epilepsy and medication. A complex history was noted and Dr Morrow undertook to obtain all of the previous notes and review them before suggesting any change of therapy. Dr Morrow then obtained the notes and wrote to INI 87's GP, in some detail on 12th January 2006. Dr Morrow summarised his views as follows:

From the evidence within the notes, albeit that the notes are incomplete and that the early notes appear to be missing, it would appear that this man's original presentation was with psychiatric problems and the diagnosis of epilepsy, originally at least, seems to be based on abnormal ECG and odd behaviour. Certain the description of attacks as conveyed from the letter from Mr Eldridge, Consultant Neurosurgeon in the Walton Hospital, is not at all typical of epilepsy and one wonders why this diagnosis was entertained in the first place. Subsequently there seemed to be compelling evidence that any attacks that had been noted by Dr Pang, who is an experienced epileptologist in the Walton centre for Neurology and Neurosurgery was that the attacks were non epileptic, behaviourally mediated. His subsequent presentation to myself is again very atypical of epilepsy in that he complains mainly of pain and numbness for which there does not appear to be any definite structural or anatomical cause

I feel therefore that the evidence tends to suggest that this young man's problems are certainly in the large part if not completely psychologically mediated. Whether he has an underlying tendency to epilepsy remains uncertain.

- 2.102 On 12th January 2006, an appointment was arranged for 30th January 2006 to discuss Dr Morrow's review of the records. INI 87 unfortunately passed away prior to the date of the subsequent appointment.
- 2.103 Dr Morrow stated in his correspondence of 27th October 2006 that:

To summarise my thoughts at that time, it was clear that [INI 87] had a long and complicated history, which was largely psychiatric in nature. He was felt to have depressive episodes, behavioural disturbances and addictive tendencies. He, however, had an abnormal EEG and was subsequently referred to Dr Watt, who diagnosed epilepsy. His EEG abnormality may have related to an

underlying arachnoid cyst, which was operated on (but I am unsure whether it was ever proven that any seizure activity emanated from this lesion) on the basis of continuing events which were felt to be epileptic.

Despite surgery, he continued to take events which as described to me in the clinic, very unusual [sic] and not at all typical of epilepsy.

On reviewing the notes it would appear that other Epileptologists including those at the Walton Centre for Neurology and Neurosurgery and Dr Pang Consultant Neurophysiologist and indeed, the Neuropsychiatrists that were reviewing [INI 87] also had all felt that most if not all [INI 87's] events were non epileptic in nature.

Following this review it was my intention to review [INI 87] to try to withdraw him from anti-epileptic medication and also to try to address the issue of his pain problems as once again there did not seem to be any structural cause for these complaints. Unfortunately circumstances supervened and [INI 87] died prior to his re-attendance ...

- 2.104 Dr Morrow then sought answers to the specific questions that were raised by INI 87's parents. He felt that Dr Watt was in a better position to address the issues raised and was disappointed that Dr Watt had declined to reply.
- 2.105 Following a letter from INI 87's father, complaining about the length of time to provide a written response, Mrs Webb wrote to INI 87's father and apologised for the delay. The letter indicated that a report had been received from Dr Morrow and that nothing had been received from Dr Watt. Mrs Webb further stated that the matter had been brought to the attention of the Acting Medical Director, Dr Stevens.
- 2.106 Despite efforts to obtain a response from Dr Watt, none was forthcoming. On 7th December 2006, INI 87's parents wrote to the Chief Executive, again concerned about the continuing delay.
- 2.107 On 12th December 2006, Dr Watt responded to Mr Atkinson, the Sub-Divisional Manager. His letter sought to answer the questions raised but was laconic and in sharp contrast to the detailed response from Dr Morrow. The salient extracts are set out below:
- (i) The review time is largely dictated by the frequency of attacks and recent changes to medication. The level of medication is not a factor in deciding when someone is reviewed.
  - (ii) [INI 87] had been attending Dr Watt about his epileptic attacks up until his discharge at his own request on 11th October 2005.

- (iii) The general practitioner is responsible for prescribing outside hospital, guided by the hospital consultants attended as an outpatient.
- (iv) Anti-convulsant levels are not routinely monitored in patients attending neurologists with doses being adjusted depending on the balance between benefits and adverse effects. Levels may be checked if there is doubt about compliance or suspicion of toxicity.
- (v) His treatment outside hospital is largely the responsibility of his GP shared to a degree by the specialists attended.

2.108 Dr Watt concluded his letter by stating that he was shocked and saddened by INI 87's passing and noted that he had a tendency to "*become dependent on analgesic medication*", which his doctors were aware of and attempted to address.

2.109 Subsequent to Dr Watt's letter, a draft response to INI 87's parents was drawn up and circulated based largely on the comments provided by Dr Morrow. Dr Watt was asked to review the letter and stated in an email on 21st December 2006 to Mr Watson:

Pauline [sic]

I feel that it would be better to only answer what has been asked rather than adding details, which might only add to their concerns. I am aware that my reply was felt to be too short, but I did answer the questions and did not raise any other issues. Whether he did or did not have epilepsy has been visited many times over the years and never satisfactorily resolved. I could never persuade his mother that he might not have epilepsy and in the end I felt he had both epileptic and non-epileptic attacks.

Michael

2.110 He followed this up in an email to Mrs Webb of 3rd January 2007 regarding a proposed meeting between the Medical Director and INI 87's parents:

Pauline

I think it would be better if I attended the meeting and would be happier if the reply was closer to mine – all the stuff about the diagnosis makes it look as though we feel vulnerable in that area whereas we had been living with the uncertainty for years and managing his symptoms pragmatically.

Michael.

2.111 The initial draft of the letter, based on Dr Morrow's correspondence noted that INI 87's events were "*very unusual and not at all typical of epilepsy.*" It went on to note the views of other medical professionals that "*most if not all [INI 87's] events were non*

epileptic in nature". The initial draft of the letter concluded by stating as follows:

As stated earlier, Dr Morrow's own review of the case suggested that the use of the drugs may have been somewhat inappropriate in [INI 87's] case, given that the diagnosis of epilepsy was by no means secure and in fact when seen by those most competent in treating epilepsy vis a vis Mr Eldridge, Consultant Neurosurgeon and Dr Pan, Consultant Neurophysiologist, the suggestion was that most if not all of [INI87's] attacks were non epileptic in nature.

- 2.112 In response to the initial draft, Dr Morrow emailed Mrs Webb, and copied in Mr Watson and Dr Watt, on 20th December 2006. Dr Morrow welcomed the opportunity to review the draft and suggested changes as *"there is, I feel a degree of think [sic] diagnostic uncertainty regarding [INI 87's] attacks – but this is not what has been asked in his parents letter and I think to highlight these as graphically as you have is only to invite further criticism"*. There followed a series of amendments to the draft which had the effect of watering down the language of the initial draft and Dr Morrow's views expressed in correspondence of 27th October 2006.
- 2.113 On 17th January 2007, a formal response, based on the advice of Dr Morrow and Dr Watt, was forwarded to INI 87's parents. The letter, which recited extracts from the input of both Dr Morrow and Dr Watt, offered a meeting with INI 87's parents and this was eventually arranged to take place on 1st February 2007 with Dr Stevens, Mrs Webb and Dr Morrow. The Inquiry Panel noted that in summarising the views of Dr Morrow the letter stated:

On reviewing the notes, it would appear that other specialists, including those at the Walton centre for Neurology and Neurosurgery, Dr Morrow, Dr Pang, Consultant Neurophysiologist at the Royal Victoria Hospital and the Neuropsychiatrists that were reviewing [INI 87], had felt that [INI 87's] events **were not all attributable to epilepsy.**

Emphasis Added

- 2.114 This response included no reference to the potentially inappropriate prescription of drugs and the insecure nature of the epilepsy diagnosis as referred to in the initial draft.
- 2.115 The meeting with INI 87's mother, Dr Morrow, Dr Stevens and Mrs Webb took place on 1st February 2007. From the notes of the meeting, it is apparent that the focus of INI 87's parents was on delay in answering the questions raised and criticism also about Dr Watt's attitude and communication and whether INI 87's mediation was appropriate and had been monitored. Dr Morrow in the recorded summary of his view states:

Dr Morrow said [INI 87's] attacks look/sound what were epileptic attacks but that he also had pseudoseizures. **It was difficult to say how much was true epilepsy.**

Emphasis Added

2.116 At the same meeting Dr Stevens was noted as stating:

Dr Stevens indicated that Dr Watt's clinical skills were not causing concern and that the communication issue was being addressed.

2.117 Subsequent to the meeting on 1st February, Mrs Webb liaised with Mr Alphy Maginness from the Directorate of Legal Services. On 14th February, Dr Stevens called an urgent meeting regarding INI 87 at which he required the attendance of Mr Walby, Dr Morrow, Dr Watt and Mrs Webb. Before the meeting could take place, Dr Stevens was informed that the Coroner had instructed the PSNI to gather witness statements on his behalf, following which he would determine whether to hold an inquest. On 16th February, Mr Walby emailed Dr Stevens and indicated that Dr Watt should get his defence organisation to check his statement to the Coroner. The urgent meeting was then deferred by Dr Stevens when it became more apparent that an inquest was likely to take place. In an email of 16th February to Dr Walby, Dr Stevens stated:

As per my earlier email, I feel the likelihood of an inquest clarifies things in terms of how we respond to INI 87 parent. I will talk to Pauline about the phrasing of the letter and ask her to run it past you. I do not feel we need to meet to discuss. I completely agree that Michael (Dr watt) needs advice as proposed. He also needs to abide by action plan that arose from earlier meeting with him. I have written to David Adams on this point and will ask him to ensure the division follows this up.

2.118 Mrs Webb subsequently wrote to INI 87's parents on 27th February 2017, and made them aware that the Trust had been contacted by the Coroner regarding a possible inquest and assured them that the Trust would fully assist the Coroner with his investigations.

2.119 An Inquest did, in fact, take place and a detailed description of the events leading up to same are set out in the 2006-2007 chapter.

2.120 As with the INI 222 complaint, the temptation is to focus on the clinical details and determine whether there was substance to the complaint. That is not the task of the Inquiry. To what extent the diagnosis and treatment of INI 87 was reasonable is a question for others. The Inquiry Panel noted that the epilepsy diagnosis was not considered at the inquest. The Coroner concluded that INI 87 died of drug toxicity.

2.121 The issue of whether the clinical dimension of the INI 87 complaint should have been focused upon to a much greater degree was raised with Dr Tony Stevens when he gave evidence to the Inquiry. Dr Stevens felt that, as a non-neurologist, he was relying upon the view of Dr Jim Morrow, whom he felt had been more nuanced when he met with INI 87's parents on 1st February. Dr Stevens stated:

I, personally, don't think the clinical issue is a big one. And, anyway, Jim Morrow, who was very well sighted on him, was Clinical Director, I think, or at least Clinical Lead, at the time, raised no concerns and, in fact, stepped back at the family meetings, so I don't think I reasonably could have had any clinical concerns. And Michael [Watt] had been the one that had referred to the Walton clinic. His own statement made the point that he didn't think the family would ever accept that this wasn't epilepsy. So, he was probably managing a very complex situation.

2.122 Unfortunately, the Inquiry Panel was unable to hear from Dr Morrow because he was medically unfit to appear but would have liked to have explored with him as to why his views appeared much more nuanced when he met with INI 87's parents.

2.123 What was of interest to the Inquiry and which arose out of this complaint was the following:

- (i) The reaction of management to the delay and reticence by Dr Watt in addressing the issues.
- (ii) There was no consideration given to obtaining an independent view outside the Trust.
- (iii) There was an absence of any look back or review of earlier complaints.
- (iv) A concern that the clarity of Dr Morrow's<sup>5</sup> view, as outlined in his letter to the GP regarding a diagnosis of epilepsy, was toned down when the joint letter to INI 87's parents was written on 17th January 2017 and when he met with INI 87's parents on 1st February.
- (v) Dr Stevens formed the view (which is later repeated in 2013<sup>6</sup>) at the meeting with INI 87's parents on 1st February that he was not concerned about Dr Watt's clinical ability. Arguably, however, there were questions to be addressed, as highlighted by Dr Morrow, which could have given rise to a more thorough

<sup>5</sup> Dr Morrow was unable to attend before the Inquiry Panel because of a documented medical reason and has not had an opportunity to comment on these issues.

<sup>6</sup> See email to Ken Fullerton dated 14th June 2013 with regards to the INI 348 complaint, and after initiating the informal stage of MHPS, which stated 'there is a pattern here that causes me some concern. While I would acknowledge Michael's clinical skills and commitment, there does seem to be an issue about administration and communication that has previously caused him difficulty'.

investigation as to why Dr Watt came to the view that INI 87 should have been treated with drugs based on the diagnosis that he was suffering from epilepsy.

- (vi) While the Coroner subsequently concluded that INI 87 died of drugs toxicity, this should not detract from the fact that the Trust had come across a related concern about possible misdiagnosis, which it could have investigated further.

### Complaints with regards to Waiting Times at Clinics 2006 – 2007:

2.124 Several complaints dating from 30th November 2006 to May 2007 were disclosed, all of which related to the length of waiting times at Dr Watt's clinics at that time.<sup>7</sup>

2.125 All the complaints referred to followed a similar pattern. For example, in preparing a response to the INI 420 complaint, the Inquiry Panel noted a memorandum from Mr Paul Sharpe, Senior Manager in Health Records to Mrs Webb as follows:

Dr Watt's clinic is significantly overbooked. It was originally set up for four patients and he is seeing up to twenty-six. In addition the time slots for the clinics are set for four patients. Consequently patients are being asked to attend at the same times with the inevitable long waits for patients. I understand that Dr Watt has been making efforts within his Division to have his clinics changed to a more appropriate template.

Identical memorandums were prepared by Mr Sharpe with regards to other complaints at this time.

2.126 A response was produced such as that with regards to INI 422, signed by the Acting Chief Executive which indicated as follows:

We have recently introduced a new appointments system, which ensured that patients have an element of choice in selecting a suitable date to attend the hospital. This also helps to reduce the number of occasions when patients do not keep their appointments and contributes to shorter waiting times for appointments on the outpatient waiting list. Unfortunately the subsequent increase in the number of patients who attend also been significant and has led to the delay that you have experienced.

We are therefore reviewing the structure of Dr Watt's clinics. I apologise for any delay or inconvenience that you have experienced as a result of delays at the clinic. Our intention was to increase the efficiency of the clinics by improving attendance rates. However, we are obviously unhappy that achieving the aim has resulted in overbooked clinics where patients face unacceptable delays. We will revise Dr Watt's clinic configurations and achieve a netter balance between

<sup>7</sup> INI 422, INI 420, INI 423, INI 424 INI 425, INI 426 INI 444, INI 427, INI 428, INI 429 and INI 445.

reducing the length of time that patients wait before receiving an appointment and the length of time that they wait at the clinic.

- 2.127 In response to a complaint from INI 444, the description of the clinic on 14th March 2007 was striking. There was also an alternative explanation regarding the number attending:

On that particular day, 36 patients were booked to be seen at the clinic within the allotted 2.5 hours hour clinic session. As is frequently the case due to the varying nature of clinic complaints the clinic did not run on time. All patients are seen in appointment time order and the consultation length may vary according to each patient. The reception and nursing staff have no control over the situation but endeavour to keep patients informed of any delays.

In order to fully utilise each clinic situation there is a degree of overbooking to counteract the 15% DNA rate (did not attend) patients who failed to turn up for scheduled appointment

- 2.128 What was apparent about the cluster of complaints set out above was: (i) the number received over a relatively short period of time; (ii) the identical response given by the Trust on each occasion; (iii) the lack of evidence that the complaints were evaluated by management or acted upon apart from expressing sympathy and concern.
- 2.129 In response to the complaint of INI 428, a reply signed by Dr Stevens, Medical Director, dated 31st May 2007 was a similar to many of the earlier complaints, save that the review promised appeared to have been completed by this time:

We have **since reviewed** the structure of Dr Watt's clinics. I apologise for the distress and inconvenience you have experienced. Our intention was to increase the efficiency of the clinics by improving attendance rates. However, we are obviously unhappy that achieving this aim has resulted in overbooked clinics where patients face unacceptable delays. **We are confident that the revisions to Dr Watt's clinic configurations** will achieve a better balance between reducing the length of time which patients will receive before receiving an appointment and the length of time they have to wait at the clinic.

Emphasis Added

- 2.130 In May 2007, INI 445 contacted the Trust helpline about delays at Dr Watt's clinic. On this occasion the letter of response from the Trust again from Valerie Jackson, Director of Older People, Medicine and Surgery on behalf of William McKee, the Chief Executive, reverted to the original wording of the earlier correspondence. "*We are currently reviewing ... We will revise Dr Watt's clinic configurations*". The inability of the Trust to distinguish between what had occurred or would occur suggested to the Inquiry Panel that the correspondence in response was not being reflected upon

in sufficient depth or there had been no communication with the Patient Liaison Office about the review of Dr Watt's practice template that appears to have been carried out and referred to by Dr Stevens in his response to INI 428.

2.131 On each occasion a complaint was referred to the relevant Service area, which was Neurology, the following advice was given to those charged with investigating the complaint:

The draft response should:

- Address all of the issues raised by the complainant
- Explain what happened and why it happened
- Detail any actions taken to prevent recurrence
- Where appropriate offer an apology

2.132 The Inquiry Panel noted that while apologies for patients' distress were handed out liberally in relation to waiting times, a pattern developed of setting out a narrative, which suggested analysis and action, but in truth bore little relationship to management concern.

#### INI 430:

2.133 This complaint, received on 21st June 2007, related to Dr Watt's attitude. Like other examples above, the complaint itself was not retained, but a response was obtained from Dr Watt, which stated:

Dr Watt regrets not letting you know the reason for his delay in getting back to complete the consultation with you. When he returned he did try to explain what had happened and attempted to apologise. At no time did he intend to upset you in any way. If he appeared abrupt, this was simply that he was anxious to keep the clinic moving as effectively as possible for the sake of all patients who were attending.

#### INI 421:

2.134 The complaint of INI 421 was received by the Trust on 25th October 2007, but a copy of the original complaint letter was not retained. The gist of the concern was that the complainant's husband had been waiting for the insertion of a pump but had been taken off the waiting list. The Patient Liaison Manager, Mrs Webb, wrote in December 2007 to let the patient know that Dr Gray would see them on 20th December 2007.

**INI 446:**

- 2.135 On 18th June 2008, INI 446 complained that she had attended an appointment with Dr Watt at the Ulster Independent Clinic in October 2007. Documentation relating to this complaint is was limited. A draft response to be signed by Patricia O’Callaghan, Director of Head & Skeletal Services, from July 2008 indicated that *“regrettably Dr Watt overlooked arranging an appointment for the MRI scan”*. The draft response noted that an appointment for a further MRI had been made for August 2008 but signposted the complainant to the private practice they attended if they had any further queries.

**INI 417:**

- 2.136 On 9th August 2010, INI 417 wrote to the Trust regarding a recommendation made by a Dr Bahra in London, who had proposed an epidural blood patch. INI 417 had previously been treated with Human Immunoglobulin treatment (“HIG”) and there was a delay in performing the proposed epidural blood patch. Attempts to arrange the procedure as a day-case were objected to by registrars due to their level of experience. There was also a divergence of medical opinion between Dr Bahra and Dr Watt, who wished to repeat the HIG treatment. On being asked for his comment Dr Watt stated:

... her parents seemed to be under the impression that I would follow the instructions from London to the letter and would in some way act as though I was a junior doctor under their direction.

- 2.137 Dr Watt subsequently approved a draft response sent by the Belfast Trust to INI 417, which addressed the allegation of delay on the basis that Dr Watt was on leave, but that he planned to carry out the epidural blood patch on his return and *“had the best interests of the patient at heart and it was not his intention to upset the patient”*. Apologies were proffered for any misunderstanding and a review appointment was organised. The difference in medical opinion was not addressed.
- 2.138 This case was included when an updated Datix search was carried out in 2018. It was classed under category “Y” as a Staff Attitude/Behaviour problem and Graded as – MEDIUM.
- 2.139 Dr Tony Stevens, Medical Director of the Belfast Trust at the time of the complaint, noted in his oral evidence on 3rd September 2019 that he did not believe that the complaint had reached his office and had been dealt with in the Neurosciences Department. The complaint does not appear in the copy of the Medical Director’s Office file disclosed to the Inquiry.

- 2.140 Having reflected, however, on the documentation surrounding the INI 417 complaint, Dr Stevens noted:

... the [INI 417] case, which, again, I believe, was probably a significant case, because, again, it showed some evidence that, although there was a third opinion in that case, he was tending to do – take his own path, do his own thing and also that he treated her with immunoglobulin at a time when, interestingly, there was a focus on the use of the human immunoglobulin. Having read the testimonies in this pack<sup>8</sup>, it was clear that other people saw him as an outlier in the use of immunoglobulin. No doubt, we'll come to that, but that was not something that, while I knew about the issue of overuse of immunoglobulin, it was not known corporately that he might be an outlier in that.

- 2.141 Dr Stevens further stated:

His attitude was dismissive at key times, ... Dr Bahra and I don't know whether Dr Bahra's advice was – I don't know the quality of it – but let's assume it was of good quality. Michael seemed to vary from it, including doing a treatment of immunoglobulin and a proposed second course of immunoglobulin until the family put an end to that based on the advice they got ... we were in the territory here if you look at joining up the dots.

- 2.142 It is noted that the response did not address the difference of opinion between Dr Watt and the view of Dr Bahra about the patient's treatment with HIG and the registrars' concern about performing an epidural blood patch. The issue of Dr Watt's use of HIG is commented upon further in the Prescribing chapter.

#### INI 418:

- 2.143 Following a diagnosis of multiple sclerosis on 6th August 2010, the complainant required a report confirming the diagnosis for critical illness cover to be put in place. On 26th November 2010, a complaint was made by telephone, concerning the length of time the report had taken. The absence of a report ensured that the patient was not able to receive the monthly payment due under the policy. Despite emails and telephone calls, no action was taken and after 4 months a complaint was made.
- 2.144 On 6th December 2010, Katrina Hughes, Assistant Services Manager in Neurosciences emailed a Complaints Officer, having spoken to the Clinical Director. Mr Cooke had confirmed that the completion of such forms was not a part of a consultant's NHS contract.

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<sup>8</sup> Dr Stevens was provided with a bundle of materials including various complaints prior to his appearance at the Inquiry.

- 2.145 On 7th December 2010, it was decided to treat the informal complaint as a formal complaint as the matter was not resolved quickly. In a letter of that date from Maura Quinn the Complaints Manager to INI 418's husband, a Form of Authorisation requiring the patient's signature and a leaflet describing the complaints procedure was forwarded.
- 2.146 On 20th December 2010, a Complaints Officer asked Katrina Hughes if there was any progress with this complaint and was informed that Dr Morrow, the Clinical Lead, had talked to Dr Watt and emphasised the importance of completing such forms.
- 2.147 On 22nd December 2010, Katrina Hughes emailed Dr Morrow, Clinical Lead, Mr Cooke, then Clinical Director, Mr Atkinson, Service Manager and the Complaints Department as follows:

All

I can't answer any more of this complaint but am **being plagued by complaints**.

I can advise complaints to advise the gentleman that this is outside NHS work however this still does not look good from a Trust perspective and Donna has let me know that there are **dozens of calls per week** in relation to this issue with other patients

I would be grateful for advice please

Thanks

Katrina

Emphasis Added

- 2.148 The fact that the Neurosciences Department recognised a pattern of dozens of complaints about the same issue raises the question as to why this was not picked up on by any other recipients of the email.
- 2.149 On 4th January 2011, Legal & General, the relevant insurer of INI 418's policy wrote directly to the Chief Executive of the Royal Victoria Hospital, Colm Donaghy, asking for help in obtaining the necessary information from Dr Watt. The forms eventually appear to have been completed on or about 7th January.
- 2.150 In a letter from the Complaints Department of 27th January 2011, Maura Quinn, Complaints Manager apologised for the inconvenience caused.
- 2.151 The confusion as to the obligations of a consultant in relation to the completion of such forms led to a plethora of complaints in relation to Dr Watt. Clearly, as Dr Morrow had pointed out, neurologists were expected to complete such forms,

whether there was a formal contractual obligation or not. The overriding impression is that, as Mr Cooke had remarked in his email of 4th October 2006 to Dr Stevens with regard to INI 222, there was no understanding among medical staff of the need to comply with complaints procedures. The Clinical Director felt he could only use explanation/persuasion to resolve problems with colleagues. This reality permeated the complaints process. Instead of management recognising that there was a problem with Dr Watt not filling in standard forms for patients and addressing the situation, if necessary by referring the matter to the GMC, the confusion persisted and those in the complaints department were left trying to make up creative excuses, pleading with doctors, or suggesting to complainants that it was a private matter between them and the consultant. The situation needed griped and the behaviour addressed. In reality, the opposite occurred.

#### INI 419:

2.152 A case analogous to INI 418 was received by the Complaints Department on 15th December 2010. The complainant's driving licence had been revoked on 29th November 2010 and it was alleged that Dr Watt had failed to provide the necessary medical evidence to the Driving Vehicle Agency ("DVA"). The relevant forms had been provided to Dr Watt in August 2010 and the matter had been discussed further at an appointment with Dr Watt on 3rd November 2010. The complainant stated that she had contacted Dr Watt's secretary on numerous occasions in September, October and November. The complainant had written directly to Dr Watt on 28th November 2010 expressing disappointment that Dr Watt had not contacted the medical section of the DVA. In her letter to Dr Watt, the complainant stated:

... I have also arranged for the completed form to be collected by my sister at your earliest convenience, preferably today, so that she can drive it to the DVA in Ballymena. You will appreciate that I am technically banned from driving; otherwise I would collect it myself. My biggest concern is that I may have to apply for a new licence which means that I could be without transport for up to one month which is most inconvenience, especially for my work ...

2.153 On 15th December, the complainant wrote to the Complaints Department at the Belfast Trust. At that point, the complainant had been unable to drive for two weeks and had been informed by the DVA that any new application for a driving licence may take up to four weeks to process following receipt of relevant medical information. This letter of complaint was acknowledged by Maura Quinn, the Complaints Manager, on 16th December 2010. The letter of acknowledgement sought to reassure the complainant that the matter would be investigated.

- 2.154 In a subsequent letter of 14th January 2011, Ms Quinn explained that there had been a delay into the investigation for reasons, which were not explained.
- 2.155 On 20th January 2011, Ms Quinn indicated that Dr Watt’s secretary had advised her that the forms had been completed and sent prior to Christmas.
- 2.156 Subsequently, an Officer in the Complaints Department telephoned the complainant and was informed that she required a formal response from the Trust as the length of time she had had to wait was unacceptable. This explanation was provided to the Neurology Services Manager, Mr Atkinson, on 24th January 2011.
- 2.157 On 26th January 2011, Mr Atkinson indicated to the Complaints Department that *“something like the following would suffice: ‘I am sorry to hear that you have experienced some difficulties in relation to a private matter between yourself and Dr M Watt. I understand that the documentation you require has since been processed and I hope that this matter has been resolved to your satisfaction’.”* Ms Quinn responded indicating that *“I am not sure this will suffice given that she had her licence revoked”*. On considering the same, Mr Atkinson indicated he had made a few amendments but *“I’m not sure that there is anything else to add. We have apologised for the delay and you have invited the complainant to contact you if required”*.
- 2.158 A formal response from the Director of Acute Services, Ms Patricia Donnelly, was sent to the complainant on 31st January 2011, which stated as follows:
- Dear [INI 419]
- Thank you for your letter of 16 December 2010 regarding your request for medical information from Dr M Watt, Consultant Neurologist, which was required for the completion of forms.
- I am sorry to hear that you have experienced some difficulties in relation to what is a private matter between yourself and Dr M Watt. I am happy to note that the documentation you require has since been processed and I hope that this matter has been resolved to your satisfaction.
- I apologise for all the inconvenience caused to you by this delay.
- Should you require any further information, please contact Ms Maura Quinn, Complaints Manager on 028 90630025.
- 2.159 The complaint appears to have been forwarded to the Northern Ireland Ombudsman’s Office in October 2011 but does not seem to have been the subject of any formal ruling or decision. This complaint was not on the January 2012 Datix entry but was one of the complaints sent to Dr Fullerton on 26th July 2013, when

he was reviewing the situation regarding Dr Watt's revalidation. The matter was included in the updated 2018 Datix and graded as "low" and classified as "other contracted service". It was noted that an apology was given, for what was "a private matter between complainant and consultant". The fact that Dr Watt had imposed upon him a 5-year warning by the GMC in 2007 does not appear to have been grasped or known about. If a doctor failed to fulfil a professional obligation, which may have been outside his strict contractual obligation then the matter could and should have been referred to the GMC.

2.160 In oral evidence, Ms Clare Lundy, the then Assistant Services Manager, stated to the Inquiry Panel on 21st January 2019:

... there's no other consultants that I'm aware of within neurology or even in the other specialties that I've worked in where there has been that number of reports being requested ...

2.161 In his evidence to the Inquiry Panel on 3rd September 2019 Dr Stevens reflected as follows:

... should we have fired some of those back to the GMC, there's an argument, ... a lot of these complaints were not getting up the line. They were being dealt with at a local level, and they weren't being triggered. They didn't trigger a Clinical Director or an Associate Medical Director to bring them to the doctors' and dentists' case review meetings, which started in 2009, which would've been an obvious place if they had concerns to bring them ...

... in retrospect, it would be reasonable to have flagged with the GMC that these were matters of concern, or these were issues that were causing us a problem: "Over to you". I think there are two reasons. One is I'm not sure anybody senior enough in the organisation was really being pestered with them and, therefore, it didn't become an issue. The second is it goes to the heart of the relationship with the GMC and ... whether the GMC would've acted on it ...

2.162 The Inquiry Panel noted that the GMC warning given in 2007 for a period of 5 years was still in force at the time of both the INI 418 and INI 419 complaints. This is further commented upon in the GMC chapter. Complaints like this one and the preceding one illustrate how a tardy approach to responding to requests for reports can lead to more time and resources being spent in an already stretched service area; the issue has real life consequences as patients are being delayed in claiming of insurance policies or clarifying their driving status; and ultimately it appears that, yet again, delay by Dr Watt was tolerated.

**INI 5:**

- 2.163 On 16th December 2010, a non-executive director of the Health & Social Care Board made a formal complaint about her diagnosis and treatment under the care of Dr Watt and more general complaints about her inpatient care. Following two consultations with Dr Watt, the patient had been prescribed a five-day course of oral steroids, which required the patient to be admitted for treatment in the Royal Victoria Hospital.
- 2.164 INI 5 met directly with the Chief Executive of the Belfast Trust, Mr Colm Donaghy, after which Mr Donaghy prepared and circulated a summary of the issues. On 23rd December 2010, Ms Maura Quinn wrote to INI 5 acknowledging the correspondence with Mr Donaghy.
- 2.165 Following receipt of the complaint, a draft response directly from Mr Donaghy was drawn up, which was more detailed than usual. This response received input from Dr Watt on 17th December 2010. He indicated that he had discussed the differential diagnosis with INI 5 and that psychosis was a recognised but infrequent complication of the steroids.
- 2.166 On 12th January 2011, Mr Donaghy wrote to INI 5 indicating that there had been a Trust investigation into the issues raised and stating that they would need some further time to complete their formal response. This was forwarded on 31st January 2011 and the Chief Executive offered to meet with the patient to discuss the issues arising.
- 2.167 In response to Mr Donaghy's letter of 31st January 2011, the patient replied on 8th February 2011, in detail, complaining in essence that the investigation and response from the Trust had not addressed the issues raised and was also full of inaccuracies. With regards to her diagnosis, INI 5 indicated as follows:

I spoke at length with you about the incorrect diagnosis made by Dr Watt and his unwillingness to Tegretol any alternative diagnosis even when questioned after seeing him briefly in his clinic on the day I was humiliated in his waiting room for an hour and 40 minutes. I suggested that nothing had gotten better with the steroids, that every symptom and more was multiplied by 100 in severity and I asked the question "What is it was something else?" As I now have been diagnosed (and now treated twice) for Lyme disease, I question how his reply could have been so certain "It's definitely an inflammation of the spinal cord." How could he be so wrong and not have cast his diagnostic mind wider after the negative MRI. He also knew the travel history as I gave it on the first visit. Additionally, I have been informed since that every so often the DoH sends

out reminders to doctors not to forget to consider Lyme Disease. As he is a consultant neurologist, I would have expected a more thorough and thoughtful approach. I am afraid he failed to listen to me. I think you will find that within your response this too is left unanswered.

2.168 In the concluding paragraphs of this correspondence, the patient stated:

... You conclude your response with a sincere apology for how I felt, rather than for the poor and inappropriate treatment I received. There is no admission of wrongdoing and no apparent lessons learned from my and others' experience on that ward or along the entire journey. You do realise that had I not had £700 to pay for an MRI, I would have still been waiting with neurological Lyme disease running rampant and who knows what else. Equally, I would have been psychologically distressed to say the least thinking I was dying of a brain tumour and all of the eventualities that coincide with that. How many patients are currently waiting for urgent tests like this that somehow become 'non-urgent'? How many people can't get through on the switchboard? How many people wait around for hours and at what cost to their employers? To the taxpayer? How many patients' urgent calls go unanswered and inadequately dealt with by staff? How many patients, at their most vulnerable, are mistreated and shouted at in the A&E department at the RVH? How many people are maltreated and have their human rights infringed in Ward F? And is this endemic? Have we lost all common sense from clinical care stretching to the investigative and complaints realm?

These questions are why a proper response would have been so important to me.

**I felt extremely concerned for any complainants if this is the level/standard of investigation. I am so saddened that the Trust has not admitted to any wrongdoing and that there appears to be nothing learned.** Even the Department of Health states in its guidance that it is better to be honest and admit where mistakes have been made and apologise.

My husband implored me to try and forget about it, saying that nothing will change no matter how I might like it to – that it's too big of a machine. Maybe he is right. But based on what I have seen so far including the unbelievably inaccurate and inappropriate response, I cannot help but respond further. I met you in my capacity as a non-executive director because I feel I have a duty and that includes being able to feel confident in the services we commission. That is why I came to meet you and I explained that in full. Based on the response I received, I am still not confident that things aren't just the same. I feel it would be remiss of me to let this go, even if it were only for patient safety reasons – the fact that Ward 2F is potentially extremely unsafe from my experience; but indeed there is so much more. I believe a more considered investigation and

answers to the questions outlined in my original complaint to you and here again is warranted. The answers to which have implications for the public and the services they use and rely on heavily.

Emphasis Added

- 2.169 As INI 5 was dissatisfied with the initial response by the Trust, Mr Donaghy offered a further meeting with himself and the Medical Director, Dr Stevens, in a letter to the patient of 16th February 2011.
- 2.170 In preparation for the meeting, Dr Stevens sought to meet with Dr Watt and Dr Sara Hedderwick, Infectious Disease Consultant employed by the Belfast Trust. Dr Hedderwick had considered a differential diagnosis of Lyme disease and concluded that it was unlikely. Dr Stevens had also received a summary of the steps taken by the Complaints Department to prepare a response. In an email of 22nd February 2011, Ms Maura Quinn informed Dr Stevens that the response had been composed from information received by the following staff:
- Neuro – Gerry Atkinson
  - ED – Bernie Glover/Linda Linford/Brendan Sinnott
  - Outpatient wait – Lorna Mercer
  - 2F – Siobhan Donald/Sr Irwin
  - Telecoms – Annemarie Perry
- 2.171 A meeting between the patient, Dr Stevens and Mr Donaghy was arranged for 28th March 2011. Dr Stevens met separately with Dr Watt, Dr Hedderwick and Sister Irwin.
- 2.172 Following the meeting on 28th March, Dr Stevens drew up an action plan to deal with matters arising. The actions were as follows:

ACTION	BY
Review success of introduction of clinical template	AS
Guidance on inpatients attending outpatient clinics to see a consultant	AS/BC
Use [INI 5's] experience to improve practice in 2F	BC
Feedback to Dr Watt	AS
Feedback to ED and 2F on [INI 5's] experience	AS/RC
Follow up on nurse who shouted [INI 5]	BC
Maintenance of call logs by secretaries	
[INI 5] involvement in patient experience	BC

- 2.173 On 3rd May 2011, Mr Donaghy wrote to the patient summarising the meeting that had taken place. Mr Donaghy indicated that the Trust was keen to maintain an ongoing dialogue with the patient *“to ensure that all matters are appropriately and*

*finally dealt with*". The patient had declined the opportunity to meet with Dr Watt, but Mr Donaghy was anxious that the patient would be involved in Trust initiatives on patient experience. The letter concluded:

... Can I repeat my wholehearted apology for the difficulties and distress you have experienced. Please accept my promise that we will make every effort to learn from your experiences. I look forward to further dialogue on these matters.

2.174 Dr Stevens met with Dr Watt on 17th June 2011 and followed this up with a letter dated 21st June 2011. In that correspondence, Dr Stevens stated:

I understand from our conversation that your clinics are now running effectively to the clinic template which is reducing waiting times, at the clinic, for patients.

Regarding communication with patients, particularly in respect of the differential diagnosis, I am pleased that you have reflected on [INI 5's] experience. I recognise that you have used this opportunity to consider how you communicate differential diagnosis to patients particularly where such diagnosis may cause alarm.

2.175 In his oral evidence to the Inquiry Panel on 3rd September 2019, Dr Stevens stated in relation to this complaint:

I have no note of it, but I have a clear memory of it, and I – or reasonably clear. I actually thought I would have spoken to John Craig, and I double-checked it with John, and he has no recall, so I went back and looked at who was the Clinical Lead, or Clinical Director, at the time, and it was Jim Morrow, and I concluded that I would have spoken to Jim. I definitely spoke to a neurologist ... I was given an assurance at the time that outpatient treatment of a large dose of steroids for a putative diagnosis of myelitis is reasonable ...

The challenge with [INI 5] was that she was extremely angry ... Misdiagnosis was not where she started in this. Her biggest concern had been around waiting for Michael Watt's clinic; the issue around the MRI; the issue around the diagnosis, which didn't include Lyme, but that he was suggesting it was a tumour or a syringomyelia or myelitis ... My concern about the Lyme disease issue and the breakdown in her relationship with Michael Watt was to ensure that she was being cared for appropriately by somebody she had confidence in. And my meeting with Michael and Sara, in a way, was to try and resolve some of the issues but also to make absolutely certain that we were all settled on who was going to care for her and where the care lay ...

On the issue which we're here today about, which is, "Was this a red flag about Michael's practice?", there were so many interplaying issues ...

2.176 INI 5 gave evidence to the Inquiry Panel at an early stage of evidence gathering. Significant time was taken to consider what a multi-layered complaint was. Occasionally the focus was on the question of diagnosis and whether, the patient had or had not suffered from Lyme disease or whether Dr Watt should have prescribed steroids when he did. While it is difficult to understand the context without averting in some measure to the medical details of this complaint, the Terms of Reference do not permit the Inquiry Panel to come up with conclusions on the medical treatment of particular individuals. This complaint is, however, of interest to the Inquiry for the following reasons:

- (1) INI 5 was a non-executive director of the Health & Social Care Board and within her own profession had a significant understanding of health and governance issues. The complaint lodged was taken extremely seriously by the Trust. The complainant secured two meetings with the Chief Executive, one of which included the Medical Director. The Trust was clearly anxious to resolve this complaint. In addition, the Medical Director, following his meeting with the patient and the Chief Executive, drew up an action plan, which included direct feedback to Dr Watt. While this approach was detailed and systematic, its effectiveness and the degree to which informal conversations were not noted and relied upon for reassurance, undermined the ability of the investigation to achieve any objective outcome. Any structured and ordered investigation needs a clarity about the issues raised and the methods used to determine whether concerns are justified.
- (2) This patient highlights in an articulate and insistent manner the problems she perceived with the responses that had been drawn up by the Complaints Department and the Medical Director. This case is a good example of the methods utilised by the Complaints Department, which could be summarised as follows:
  - (i) A careful attention paid to the history of dealings with the service within the Trust. When attended, treatment given, drugs prescribed, and other factual material collated into what in most cases amounted to a chronology of the patient's treatment.
  - (ii) A consistent theme of apology and recognition of distress for the complainant's perceptions without a commensurate evaluation of the extent to which complaints were objectively legitimate.
  - (iii) Liaison with the doctor, who was the subject matter of the complaint. Insofar as other medical practitioners were consulted, the discussions were often informal and not written down. In this case, the Medical Director appears to have reassured himself about

certain aspects of the treatment by talking informally to the Clinical Lead without any note or record being kept of that conversation, leaving it difficult to know exactly what was discussed and agreed.

- (iv) Significant reliance was placed on input from the relevant service area within the Trust. In most cases, a draft response to a complaint was drawn up by the Service Manager. Any response sought to collate the patient's interaction with Trust Services and a summary often included the comments of the clinician, who was the subject of the complaint. The Clinical Director may have been asked to sense check the response letter. Dr Craig, the Clinical Director since 2013, in his evidence to the Inquiry Panel on 6th February 2020, made it clear that he did not evaluate complaints or review the patients' medical records. The Service Manager is not a clinician. Their view of a complaint, which highlighted treatment and diagnosis concerns was of limited value and yet appear to be the person who was relied upon to give the necessary input. The system appeared to be so ingrained and longstanding, that it was difficult for those responsible for same to envisage an alternative.
  - (v) The absence of an appropriate investigation negated the possibility of any learning.
- (3) In her response to the detailed correspondence from Mr Donaghy, the patient trenchantly pointed out that the subject matter of the complaint had not been addressed and that the sincere apology was for how the patient felt *"rather than for the poor and inappropriate treatment I received"*. The patient's conclusion was that the level or standard of investigation was inadequate.

2.177 While this complaint was recalled in some detail by many of the people involved, including the Medical Director, the focus tended to remain on the merits and demerits of the patient's complaint about diagnosis, rather than about the methods utilised in order to get to a proper assessment of the complaint. The Inquiry Panel recognised that Dr Stevens had sought the advice of Dr Sarah Hedderwick, a specialist in infectious diseases specifically in relation to the query about Lyme Disease. Dr Stevens believed that Dr Hedderwick had provided an independent opinion but in her evidence to the Inquiry Panel on 9th April 2019, Dr Hedderwick stated:

**Mr Lockhart QC:** The substance of her complaint is that she was given high-dose steroids for the condition that he had — the differential diagnosis that he had made. To some extent, whether or not she ultimately had Lyme disease, the question is *"Was it reasonable to give a high dose of steroids on the presentation that he —?"*. That seems to be the critical question.

**Dr Hedderwick:** You're also taking to the wrong person about to answer that question, because, mostly I am a doctor for whom when I see steroids, its usually they were given at the for the wrong thing or they were given and now they've got an infection as a consequence of them. So, I'm very careful with steroids.

- 2.178 In the view of the Inquiry Panel, the reference to Dr Hedderwick, though helpful and appropriate was not the obtaining of an independent view on the critical issue of differential diagnosis and the prescription of steroids.

**INI 431:**

- 2.179 On 23rd September 2011, Gregory Campbell MP wrote to the Trust on behalf of his constituent, who had been a patient of Dr Watt. In order to substantiate INI 431's fitness to return to work, the DVA required a report from INI 431's treating physician. This had been outstanding for 3 months when Mr Campbell complained to the Chief Executive of the Belfast Trust.

- 2.180 The correspondence between the Public Liaison Service and the Service Manager within Neurology is instructive:

Josephine

The provision of a medical report is a private matter between Dr Watt and the Driver and Vehicle Agency. It is not part of Dr Watt's contract of employment with the Trust, however I have forwarded this correspondence to Dr Watt's attention and I hope this matter can be resolved soon.

Gerry

Hi Gerry

Thanks for this. Are you happy that I use this info as the basis of our response?

Josephine

Josephine

Yes that's OK. Medical reports are provided by consultants when requested. This is private work for which Dr Watt will receive a payment.

Gerry

- 2.181 The Inquiry noted that this complaint, as with the INI 418 and INI 419 complaints referred to above, was within the 5-year warning period imposed by the GMC in 2007 in respect of delays in preparing a report.

## INI 447:

- 2.182 On 14th March 2012, INI 447 complained to the Trust about the delay in obtaining an MRI scan and an appointment. INI 447 was also concerned that he had not been prescribed the correct medication. Following a routine ENT operation, INI 447 developed neck spasms and he was advised by his GP and by Dr Primrose at the ENT clinic that he had developed dystonia<sup>9</sup> for which he was prescribed medication. Frustrated by the lack of progress, INI 447 arranged a private appointment with Dr Watt at the Ulster Independent Clinic, who, after confirming the diagnosis of a form of dystonia, prescribed trihexyphenidyl and undertook to review INI 447 at the RVH at his NHS clinic.
- 2.183 According to the email complaint from his wife, INI 447 developed significant side-effects from the medication including extreme dizziness, hallucinations difficulty passing urine and memory lapse. The email asked for an early consultation, given the symptoms being manifested. In a draft response prepared by Mr Gerry Atkinson *"from a neurology perspective"*<sup>10</sup> the position was summarised as follows:
- I understand that an appointment with Dr Watt was arranged and your husband attended this on 29th March. Dr Watt felt that treatment with botulinum toxin would help your husband's symptoms and arrangements were made to progress this. Your husband next attended the RVH on 5th April when he was seen by Dr A Fulton and Dr S Kearney, consultant neurologists specialising in movement disorders. A CT scan of your husband's neck was undertaken at this time and it was decided that treatment with botulinum would not proceed at this stage. A further appointment at the Movement Disorder clinic at BCH was arranged for 11th April and botulinum toxin was administered.
- 2.184 The position summarised by Mr Atkinson above was reflected in the formal response of 23rd May 2012 from Mrs Patricia Donnelly, Director of Acute Services, sent on behalf of the Chief Executive, Colm Donaghy, to INI 447's wife.
- 2.185 Reflecting on this complaint, the following questions now seem obvious to the Inquiry Panel:
- (i) What steps were taken by the Trust to investigate if there were significant prescribing differences between Dr Watt and Dr Kearney and Dr Fulton?
  - (ii) Noting that a CT scan was carried out, why did there not appear to have been tests carried out by Dr Watt?

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<sup>9</sup> Dystonia is a movement disorder in which your muscles contract involuntarily, causing repetitive or twisting movements.

<sup>10</sup> Mr Atkinson was commenting "from a neurology perspective" because ENT, Imaging and ED were other service involved in responding to the complaint.

- (iii) Why was botulinum toxin administered when a week earlier it had been decided not to proceed with it?

The impression from the documentation is that it rarely seemed to have occurred to those summarising issues, collating a response or drafting a formal reply, that there was or may have been a clinical issue which needed to have been investigated.

#### INI 448:

- 2.186 On 3rd September 2012, INI 448's insurer complained that Dr Watt had failed to complete a medical report for an insurance company on critical illness. According to Legal & General, in an email of 5th December 2012, the information had been outstanding since 6th January 2012. The Complaints Manager eventually wrote to Legal & General on 14th January 2013 indicating that the report required had been completed. Although the documentation is incomplete, it appears that no one had questioned the fact that this was another example of delay in providing reports and that, while expired, Dr Watt had previously been given a 5-year warning by the GMC about not providing reports. The focus was on obtaining the report and closing the file. However, there was still a delay of several months from the complaint being made to the report being received.

#### INI 347:

- 2.187 This case arises out of a letter of complaint of 20th February 2013. The patient was referred to the TIA clinic in September 2007 and had been assessed by Dr Mark Magorrian, Consultant Geriatrician employed by the Belfast Trust and a colleague of Dr Watt, as having suffered a migraine. Dr Watt was present at the same clinic and was asked by Dr Magorrian to consider. Having gone through the same questions as Dr Magorrian, Dr Watt, according to the complaint submitted, had suggested as a precaution that they would do the same test as would be the case with a TIA *"to completely rule out any problems such as stroke, brain haemorrhage, TIA, brain injury/ tumour or heart problem"*.
- 2.188 The patient duly went for the relevant tests and heard nothing further. In 2010, an insurance policy with Scottish Provident was due for renewal and the patient discovered via her GP that Scottish Provident believed she had suffered a TIA based on a report prepared by Dr Watt of 2nd October 2007. The patient was indignant that no one had said that to her at the time.

- 2.189 It transpired that Dr Magorrian had, in fact, written to the patient's GP in October 2007. This letter was not seen by the patient at that time. Dr Magorrian stated:

I discussed this lady with Dr Watt today and Dr Watt also spoke with [INI 347]. On review of the symptoms the main feature is really a brief episode of right arm weakness. Clinically this would be in keeping with a transient ischaemic attack. The features wouldn't be convincing of migraine or seizures.

- 2.190 On 9th February 2012, the patient met with Dr Watt, who explained that their records could not be changed.

- 2.191 On 17th September 2012, the patient wrote to the Head & Skeletal Service Group in the Royal Victoria Hospital "*to contest the diagnosis of TIA*".

- 2.192 On 21st September 2012, the patient wrote to her GP confirming that she was contesting the report from the Royal Victoria Hospital dated 2nd October 2007. In her letter, the patient stated:

This is a case of principle and some sort of respect for the patient. To attend a routine procedure, be told that all tests are clear and nothing was found and then informed by an insurance company many years later that in actual fact you suffered a TIA is unacceptable and should never have happened. But more importantly it is a case of truth where a diagnosis has been made contrary to what the tests were carried out for, to *completely rule out* any issues including a TIA and of course the tests did that quite successfully.

- 2.193 On 20th February 2013, the patient then invoked the complaints procedure and set out chronologically the substance of her complaint, which reflected the gist of what had been given to her GP.

- 2.194 The patient's letter of complaint in 2013 concluded:

As expressed in my final letter to my GP, this is a case of principle and some sort of respect for the patient. To attend a routine procedure be told that all tests are clear and nothing was found and then informed over 4 years later that in actual fact you suffered a TIA is unacceptable and should never have happened. But more importantly it is a case of truth where a diagnosis has been made with nothing solid to back it up.

- 2.195 On 9th April 2013, a draft response was drawn up by Ms Lundy, the Assistant Services Manager. Ms Lundy had attempted to contact Dr Watt twice during March. The draft followed very much the template of apology for distress, a recitation of involvement with the service and a further concluding apology. The response was reviewed by Dr John Craig, newly appointed Clinical Director, who recommended the insertion of information relating to patients having a normal MRI scan following a TIA.

- 2.196 In this instance, however, while Dr Watt was not prepared to change his diagnosis, he had suggested a second opinion from another colleague in neurology. The formal letter of response was dated 30th April 2013 and was signed by Mrs Owens, then Interim Director of Unscheduled Care.
- 2.197 INI 347 wished to avail of such a second opinion. In consultation with Dr Watt, Ms Clare Lundy arranged for Dr Ailsa Fulton, Consultant Neurologist and, at that time, a colleague of Dr Watt, to see INI 347. Ms Lundy asked Dr Watt to *“avoid making reference to your clinical decision regarding [INI 347] experiencing a TIA”* and Dr Watt asked his secretary to remove references to the diagnosis accordingly.
- 2.198 A report of 4th June 2013 was drawn up by Dr Fulton and forwarded to Dr Watt after she had the opportunity to review the notes and examine INI 347. Dr Fulton took a different view based on the history given to her and stated:

On balance the bilateral arm symptoms, the bilateral eye pain and the preceding history of neck pain would be unlikely to be suggestive of a vascular /TIA event. Also the patient’s lack of vascular risk factors and the lack of family history would be against a diagnosis of TIA. Following the clinic appointment I have reviewed [INI 347’s] investigation results, her original GP referral letter and her original TIA clinic letter. There would appear to be discrepancies in the described clinical symptoms in the GP letter, the TIA clinic letter and now in the history I elicited today at clinic. I would be happy to discuss the case in further detail at any time. I have explained to [INI 347] today in clinic that my opinion is purely based on the information provided by her to me at clinic today.

- 2.199 The letter was sent to the patient and on 18th June, in an email to Ms Lundy, the patient sought clarification that the initial diagnosis was incorrect due to discrepancies in the described clinical symptoms, in the GP letter, the TIA clinic letter and the history received at the recent consultation with Dr Fulton. Dr Fulton responded by letter of 24th June 2013 as follows:

Further to your email correspondence with Mrs Claire Lundy in the Neurosciences office I am writing to clarify my opinion and diagnosis of your symptoms. The history and examination from your clinic attendance with me on 4th June 2013 are highly suggestive of cervical muscle spasm with associated nerve root irritation as a cause for your symptoms. I do not feel the history provided or examination was suggestive of a TIA given the bilateral symptoms and the lack of vascular risk factors. I hope this clarifies the information provided in my previous clinic letter. If you require any further details please do not hesitate to contact me.

- 2.200 On 19th February 2014, the patient again wrote to Ms Lundy seeking reimbursement of £455.40, being the additional premiums, which had to be paid as a result of the incorrect diagnosis. In her letter, the patient stated:

Further to the investigation by the Belfast Health & Social Care Trust which subsequently confirmed I did not suffer a TIA due to the bilateral symptoms, lack of vascular risk factors, lack of family history and the amount of discrepancies in the case history notes taken at the Royal Victoria Hospital I have now received confirmation from Scottish Provident that due to the new information and true account of my health has resulted in an honest premium of £24.52. I have since calculated the difference between what I have been paying over the years verses [sic] the true rate and now request reimbursement of the same.

Period (years)	Money Paid (£)	Difference (£)	x 12 months
April 2013 – April 2014	£36.95	£12.43	£149.16
April 2012 – April 2013	£35.33	£10.81	£129.72
April 2011 – April 2012	£33.49	£8.97	£107.64
April 2010 – April 2011	£31.26	£5.74	£68.88
			<b>£455.40</b>

- 2.201 The patient followed this up on 23rd April 2014 with a reminder letter noting that she had not received any reply. In particular, the patient wished to have it confirmed that *“the incorrect diagnosis of TIA had been removed from my personal records”*.

- 2.202 The complaint’s file was then recalled on 8th May 2014 and in a handwritten file note dated 22nd July 2014, Maura Quinn, Complaints Manager wrote:

Patient has since been reviewed by another neurologist, Dr Fulton. Clare [Lundy] will write to patient and copy letter to Complaints for file.

- 2.203 A suggested response was drawn up by Ms Lundy on 20th October 2014 and formalised on 28th October 2014 in a letter from Mrs Owens. The salient paragraphs of the response are set out below:

I understand that Mrs Lundy arranged an appointment with Dr Ailsa Fulton, Consultant Neurologist who then felt that on the balance of probability, you had not suffered a TIA.

Unfortunately I am unable to offer you any financial reimbursement in respect of premiums which you had paid to your private health care provider based on the information which had been initially provided by Dr Watt. As previously mentioned, this was Dr Watt’s clinical opinion and it had remained unchanged.

In your letter dated 23rd April 2014 you have asked for confirmation that “the incorrect diagnosis of TIA” has been removed from your personal records. Unfortunately I am unable to remove any medical records from your file. However, I would like to reassure you that Dr Fulton’s letter is also contained within your medical record which records her diagnosis following the explanation of symptoms you experienced on 6th September 2007. I understand from Mrs Lundy that you have a copy of this correspondence. If you would like a further copy, Mrs Lundy would be happy to arrange this for you.

2.204 On 4th November 2014, a Complaints Administrator indicated to Mr Atkinson and Ms Lundy that this patient’s complaints could now be closed off and that all of the investigation notes, statements from staff, etc should be forwarded for inclusion in the complaints file “*should this file be requested by the Trust Legal Department or the Commissioner for Complaints*”.

2.205 Despite the concern about the case being included in the complaints’ documentation, the complaint was not in the Medical Director’s pink file<sup>11</sup> nor does any summary appear to have been sent to the Health & Social Care Board. The Inquiry presumes that this case was one of those referred to at the DDCRM of 3rd June 2013. The file note stated:

Mrs Owens indicated that she had recently signed two complaints in relation to Dr Watt.

Although the patients’ names are not mentioned, these two complaints appear to refer to INI 334 and INI 347. This complaint was forwarded to Dr Ken Fullerton, the Associate Medical Director, by Mr Atkinson on 26th July 2013. Dr Fullerton had been asked by the Medical Director, Dr Stevens, to conduct a Finding of the Facts exercise, given the number of times that Dr Watt had been discussed at the DDCRM. Problems included the INI 45 complaint to the GMC, difficulties with completing appraisal and the complaints referred to by Mrs Owens on 3rd June 2013.

2.206 The Inquiry Panel noted that the matter was included in the updated Datix record of 2018. The complaint was correctly classified under clinical diagnosis and designated as a low risk or priority.

2.207 In oral evidence to the Inquiry Panel on 3rd September 2019, Dr Stevens, the Medical Director, gave evidence:

I have a more benign view of this case, for several reasons. The first is that she attended a joint TIA clinic ... there was a consensus between the two on the result ... My reading of all of it is that ... the lady’s symptoms changed and ... this falls, to some extent, within the acceptable difference between doctors.

<sup>11</sup> This was a file kept in relation to specific doctors who had been the subject of complaint.

2.208 Dr Fullerton, the Associate Medical Director, who had clinical experience of diagnosing TIAs, stated on 5th November 2019 to the Inquiry Panel:

Now, if I were a responsible clinician working in a TIA clinic and a patient turned up, and there was a reasonable chance that they may have a TIA, I have to then say, "What would a reasonable doctor do? If I do not treat this as a TIA, then the risk of the patient having a stroke is actually highest ... What happened at the clinic seems to me to be reasonable ...

... My criticism of Dr Watt in this case is that his attitude to the patient may not have been the same as mine, but, in terms of his treatment, again, it seemed to me it was within the realms of what might be considered reasonable.

2.209 The Inquiry Panel reviewed the same evidence from the vantage point of seeking to ensure that there was an effective process and the extent to which this complaint should have been highlighted or considered as part of a broader pattern. The Inquiry Panel noted the following:

- (1) When Dr Watt is recorded as having made clear to the patient in 2012, following a consultation, that his opinion remained unchanged, there is no written evidence, which either required or sought Dr Watt's views, in light of Dr Fulton's report. A phone call with Dr Watt was not sufficient. Dr Fulton had raised doubts about the diagnosis and this should have raised questions for those investigating.
- (2) It is correct to say that Dr Fulton emphasised that she was basing her view on the patient history as given to her in June 2013. There is some suggestion that this differed from the patient history as recorded back in 2007. There is also, however, concern about inaccuracies in the various contemporaneous notes and symptoms described in 2007, both in the GP report and the letter to the consultant. The investigation should have tried to reconcile the alleged varying accounts. What is clear is that the patient has been extremely proactive since discovering some years afterwards that she had been, in her view, incorrectly diagnosed.
- (3) While Ms Clare Lundy is to be commended for the manner in which she sought to address the contradiction, the template within which she was operating had limited scope. There is little expectation that the Trust would have come to its own view on a case based on the evidence collated. In circumstances where there is a stark and significant index case or where, as in this case, there was other evidence of a pattern of treatment and clinical approach then an independent view could be obtained from outside the Belfast Trust.

- (4) At that juncture, there was a focus by the Medical Director and by Dr Fullerton in assessing the revalidation status of Dr Watt. The Inquiry Panel has consistently stressed that it was essential that the Medical Director had the most accurate and up to date view of all relevant complaints. This applies even more acutely when the Medical Director is was being asked to provide details to the GMC as Regulator. This case is one of many instances where information was not collated properly.

### INI 334:

- 2.210 On 15th February 2013, a patient complained that he had been misdiagnosed with epilepsy and prescribed medication when, in fact, he was suffering from chronic fatigue syndrome. In his letter to the Chief Executive, the patient stated:

I was diagnosed with epilepsy and was treated under the care of Mr Watt, Neurologist, at the Royal Victoria Hospital in Belfast. I was prescribed Tegretol by Mr Watt to treat my epilepsy.

It transpired that I did not have epilepsy and should never have been subscribed Tegretol. I have suffered from chronic fatigue syndrome and depression from taking same and my mental health has declined since.

- 2.211 The correspondence was acknowledged promptly on 18th February 2013. The letter from Ms Maura Quinn, Complaints Manager apologised that INI 334's experience of *"the service has been less than satisfactory"* and provided an assurance that *"the issues you have raised will be investigated under the Trust's complaints procedure"*.
- 2.212 A suggested response was drawn up by Ms Clare Lundy, Assistant Service Manager, and she indicated that this draft response had been reviewed by both Mr Gerry Atkinson and Dr John Craig<sup>12</sup>. There is no evidence that Dr Craig suggested any amendments and emailed Ms Lundy on 22nd April, 2013 shortly after receiving the draft with the comment *"This is fine"*.
- 2.213 The draft went through several iterations and eventually on 31st May 2013 a letter from Mrs Owens, as Interim Director of Unscheduled Care, was forwarded to INI 334. The letter to INI 334 has been set out in full below because it is a good example of the manner in which complaints were addressed:

Thank you for your letter dated 7th February 2013. I would firstly like to

<sup>12</sup> On 22nd April 2013 Ms Lundy emailed Dr Craig as follows:

*Can you please review the suggested response who suggests that Dr Watt mis-diagnosed him in 2022. You will note from the response that this gentleman DNS'd several OPD appointments. Dr Craig responded the same day as follows: "Thanks Clare. This is fine, however clearly if a patient fails to engage properly with the service they bear more than a degree of personal responsibility".*

apologise for the time delay in responding to the concerns which you have raised. A senior manager with the Neurology Service at the Trust has investigated your concerns and we are now in a position to provide you with a response.

I understand that you were referred to the Neurology Department at the Royal Victoria Hospital on 29th January 2002 and that you attended your first appointment with Dr Watt, Consultant Neurologist, on 19th June 2002. At this appointment Dr Watt recorded the symptoms which you had expressed. It was his opinion at this time that the episodes you described were partial seizures and he prescribed Epilim 500mg daily. An MRI scan of the brain was suggested along with a review appointment which was arranged for 25th September 2002. Our records indicate that you did not attend the appointment on this date and arrangements were made for you to attend on 23rd April 2003. Regrettably, this appointment was cancelled as Dr Watt was on annual leave.

At a subsequent appointment on 23rd July 2003 Dr Watt reviewed your symptoms and suggested that the Epilim medication that you were taking should be changed to Tegretol 300mg. As you had not had an MRI scan, Dr Watt stated that he would request the MRI scan again. Dr Watt indicated that he would review you again in four months time. An appointment had been rescheduled for 11th August 2004 but was cancelled by our appointments office as Dr Watt was on annual leave. I apologise if this and the previous cancellation had caused you any undue anxiety, or if this was inconvenient for you.

Our investigation has shown that unfortunately the Imaging Department did not receive a request for you to have an MRI scan of the brain, and it is unclear from your medical records if the request was forwarded from Dr Watt's office to the Imaging Department.

I understand that further review appointments were then organised for you for 10th November 2004, 29th June 2005, 10th May 2006 and 24th January 2007, although our records indicate that you did not attend any of these appointments. As a result of your non-attendance at the clinic, Dr Watt was unable to review your clinical condition and assess the symptoms which you were experiencing in order to review his diagnosis and treatment plan. You were therefore discharged from Dr Watt's care and a letter in this regard was sent to your General Practitioner.

I am sorry if you feel that you have sustained personal injury, loss and damage as a result of an incorrect diagnosis. As previously mentioned, Dr Watt was not able to reassess your condition, symptoms and medication as you did not attend appointments which had been organised for you.

I understand that you recently attended Antrim Area Hospital under the care of Dr Esmonde, Consultant Neurologist. I am sorry to note from your

correspondence that you have suffered from chronic fatigue syndrome and depression. I sincerely hope that your condition has started to improve following your discharge from Antrim Area Hospital in November 2011.

In your correspondence you have requested a copy of all relevant notes and records pertaining to your care in the Belfast Trust. I understand that you have since been forwarded the relevant information to assist you in this request.

Once again, I would like to thank you for your letter and for drawing our attention to the care which you have received. If I can be of any further assistance, please do not hesitate to contact Ms Maura Quinn, Complaints Manager

- 2.214 The letter follows the traditional template of apologising for the person's distress followed by a comprehensive history of attendances and a further apology to the patient who is now suffering from chronic fatigue syndrome and depression. The response did not analyse or answer the question that had been asked. The patient believed he was wrongly diagnosed. A neurologist in a different Trust, on the face of it, appeared to agree with the patient that he was incorrectly diagnosed. The complaint would seem to have been investigated by an Assistant Service Manager (Ms Lundy), who had liaised at least in some part with Dr Watt. The fact that the letter of response was reviewed by the Service Manager, Mr Atkinson, and the Clinical Director, Dr Craig, as well as the Director of Unscheduled Care, Mrs Owens, provided no further enlightenment.
- 2.215 In his evidence to the Inquiry Panel, Dr Craig explained that he would often have been asked to "*sense check*" correspondence. He would have done this in the absence of the medical notes and records and would not have reviewed this as an independent evaluation of the substance of the complaint. The Inquiry Panel accepts that this was his view, though notes that other managers believed that they were getting a more considered view which could be relied upon. The Inquiry Panel takes the view that even a high-level review by Dr Craig would be able to spot an obvious pattern of clinical approach.
- 2.216 While it is the case that this patient's complaint was one of the cases referred to by Mrs Owens at the DDCRM meeting on 3rd June 2013 and appears to have been before the Associate Medical Director, Dr Fullerton, in his Finding of the Facts exercise in July 2013 prior to Dr Watt's revalidation, the problems of the initial investigation remained.
- 2.217 The Inquiry Panel took the view that the investigation of this complaint, both when it was made and by Dr Fullerton, was inadequate in the following respects:

- (1) Those investigating the complaint spoke only to Dr Watt. No effort was made to discuss the case with Dr Esmonde nor was the Clinical Director asked or advised to consider the clinical notes and records, not did the clinical director of his own initiative seek the notes or access the electronic care record.
- (2) The letter of response dated 31st May 2013 did not answer the simple question. The issue was whether it was reasonable for Dr Watt to have made the diagnosis of epilepsy and to have prescribed Epilim and then Tegretol.
- (3) The patient should have been asked why he did not attend review appointments and his medical notes and records reviewed to consider the ongoing prescription of Epilim and then Tegretol.
- (4) There was a difference of understanding about the extent to which Dr Craig was asked to provide an opinion, which was being relied upon by those in the Service Department and the Director who signed the letter. The confusion led to what in many instances was a superficial review of the draft response, which had limited benefit in the absence of the Clinical Director accessing the patient's medical notes and records. In this regard, the reference to the response being reviewed by the Clinical Director provided the misleading impression that the Clinical Director was satisfied with the diagnosis, which is the subject matter of complaint. All such a review can provide is a high-level overview, which may spot glaring errors.
- (5) Dr Fullerton's review was also problematic, although the Inquiry Panel accepts that he worked hard to collate information, which was incomplete when he commenced the process. He has not kept any notes of his assessment of the case and does not appear to have reviewed the patient's medical notes and records.

2.218 What is striking about this case is that, despite the complaint response being looked at by a range of individuals, and being reviewed by the Associate Medical Director, no one seems to have considered the basic question posed by the patient. The response given is entirely in keeping with the approach that was taken in most cases and the system in place can provide no reassurance in terms of patient safety or the identification of potential aberrant practice.

#### INI 348:

2.219 INI 348, whose husband was a senior official in a health organisation, initially wrote to Dr Tony Stevens, the Medical Director, following the patient being diagnosed with

a stroke in 2009 and issues with claiming under her critical illness cover which began in 2010. The patient attempted to contact Dr Watt without success. On 12th June 2013 she wrote to Dr Stevens explaining that she had attended the RVH Emergency Department in January 2009 with left arm weakness and eyesight disturbance. An emergency CT scan showed no abnormality, but the doctor on duty remained concerned about the patient having suffered a stroke and referred her to the TIA clinic where she was reviewed by Dr Watt. Further tests, including an MRI were arranged but Dr Watt stated that, in his opinion, she had *“definitely suffered a stroke”*.

- 2.220 A claim was subsequently lodged in respect of a critical illness policy. There was initially a significant delay. Dr Watt wrote to AXA Insurance stating that the patient had *“suffered in fact as no evidence??? of haemorrhage on imaging”*. In February 2010, AXA disputed evidence of stroke but agreed to review the situation if the consultant would clarify. Dr Watt, despite numerous telephone calls, did not clarify his views.
- 2.221 The patient was reviewed by Dr Watt in February 2012 as she had a separate episode of unusual facial and oral sensation which resolved within 24 hours. Dr Watt did not believe this was a stroke, but it was alleged by the patient that he was *“100% certain”* she had previously suffered a stroke and changed her medication. He also promised to write a further letter to AXA. This was subsequently not provided despite reminders being sent.
- 2.222 At a further review in September 2012, the patient complained again that Dr Watt had not provided a report as previously promised. The letter of complaint stated:

Despite further repeated phone calls from ourselves as well as the Ombudsman to Dr Watt’s secretary over the next 5 months, he still did not provide such a written statement and as a result the claim on my critical illness plan which the ombudsman agreed appeared to be very valid was delayed by a further significant period. Indeed it was only when the ombudsman played an audio recording of one of his brief conversations with Dr Watt that the insurance company eventually agreed a partial settlement of our claim which I accepted as I felt I could no longer continue with the stress and frustration of trying to pursue the issue with Dr Watt.

- 2.223 On a review of the complaint on 14th June 2013, Dr Stevens emailed Dr Fullerton, the Associate Medical Director and Dr Craig, the Clinical Director:

Ken/John

There is a pattern here that causes me some concern. While I would acknowledge Michael’s clinical skills and commitment, there does seem to be an issue about administration and communication that has previously caused him difficulty

This letter really needs to be managed as a complaint (I have also copied to [the complaints Dept]).

In parallel I would be grateful if you would consider any professional issues, taking account of previous concerns.

Regards

Tony

2.224 Responding on 17th June 2013, Dr Watt stated to Ms Clare Lundy:

I can only apologise for my failure to provide the reports to [INI 348's] insurers. I am aware that I have had problems providing reports over the years. I see a huge number of patients and as a result at times struggle to keep on top of the workload. I only get as far as doing reports when I am on top of other work, and this sometimes doesn't happen for months. Reports on patients who I have diagnosed as having a stroke despite normal imaging are a particular problem and often lead to repeated inquiries. These reports are not part of my job in the Royal and are not meant to be done in hours, and as it is not part of my employment my secretaries should not help me to prepare them.

2.225 Various iterations of the response were drawn up by the then Assistant Service Manager, Ms Clare Lundy and the reply was considered by, amongst others, Dr Stevens, Dr Craig, Dr Fullerton, who was at that time carrying out a Finding of the Facts review pursuant to the informal stage of the Maintaining High Professional Standard ("MHPS") process, and the Interim Director of Unscheduled Care, Mrs Bernie Owens.

2.226 Ms Lundy prepared a detailed draft outlining the history of appointments as gleaned from the medical notes and records. This draft recorded that Dr Watt's letter to INI 348's GP in 2009 stated a *"probable diagnosis of a minor stroke"*, a letter in February 2012 indicating that the diagnosis *"once more lies between migraine and a further stroke with migraine appearing the more likely"*, and correspondence dated 9th October 2012 which, in Ms Lundy's assessment, did *"not make reference to you suffering a stroke and states that your MRI scan did not identify anything of any significance"*.

2.227 On reviewing the complaint, Dr Fullerton indicated that he *"would be inclined not to put in so much clinical detail, as this is not material to the case"*. Ms Lundy, to her credit stated on 9th July 2013 that she was content with her draft as *"there is information there that suggests that maybe the symptoms were in relation to migraines"*. The clinical detail was subsequently omitted on the recommendation of Dr Fullerton. Dr Stevens, responding to Dr Fullerton's query as to whether the completion of such reports was a part of a consultant's contract, stated:

... I would make the point that this complaint reflects an aspect of practice that is still covered by revalidation and reflects earlier concerns regarding MW. I would expect that Dr Watt send a letter of apology.

- 2.228 The final draft of the letter was sent out on 19th June 2013, signed by Mrs Owens, and did not address the issue of the diagnosis raised by AXA in February 2010. Dealing with the contractual obligation point the letter stated:

Dr Watt has offered his sincere apologies for his failure to provide the necessary reports to you and AXA insurers regarding your critical illness cover claim and if you have incurred any subsequent financial loss as a direct result of this. While the provision of reports for insurance companies is not part of Dr Watt's contractual obligations with the Trust, I would nevertheless have expected Dr Watt to meet the commitments he gave to you verbally, by providing a suitable written report in a timely way.

I have asked that Dr Watt write to you separately with his apology. We will follow this matter up with Dr Watt as part of reflective practice.

- 2.229 The complaint, and associated correspondence, was collated and placed in the complaints file following a direct request from the Complaints Administrator. An apology to the patient was compiled on 22nd July 2013 and sent to Ms Lundy for onward transmission. The matter was also evaluated by Dr Fullerton as part of his review of Dr Watt's practice prior to revalidation.

- 2.230 This complaint happened to be received at a time when Dr Watt was being reviewed by the Associate Medical Director, Dr Ken Fullerton. The fact that the patient had contacted the Medical Director, Dr Stevens, appears to have given greater urgency to the importance of responding promptly and apologising directly.

- 2.231 A further feature of this complaint is that the original letter of complaint, when properly analysed, also raises a question of diagnosis. This was put to Dr Fullerton, who agreed with the Inquiry Panel on 5th November 2019 that there was a clinical component. Dr Fullerton, however, stated:

... but, again, the question is, "Is Dr Watt behaving reasonably?" Firstly, an MRI scan, particularly if it's not done in the early stages, does not necessarily exclude a stroke. Secondly – and I'm not sure – it's a particular MRI modality that needs to be applied ... a negative MRI a while after the symptoms does not exclude a stroke. It's still a clinical call.

- 2.232 When the complaint was analysed and the query raised by AXA considered, it was apparent that there was a clinical dimension, which should have been appropriately reviewed when Dr Fullerton was carrying out his Finding of the Facts exercise. As

with other complaints, it was not, in the view of the Inquiry Panel, appropriate for the person carrying out the review to rely solely on their own medical knowledge or to limit their investigation to those matters explicitly raised by the complainant. At a minimum, the medical notes and records should have been obtained, and the matter discussed with someone, who was independent of the reviewer.

2.233 A matter of concern was that although Dr Stevens highlighted a pattern, which caused him concern, there was no written evidence, which would allow a proper triangulation of all those instances where complaints focused on a failure to provide a report. Dr Stevens was of the view that those were obligations that all consultants would have had as a part of their role as a medical consultant. The issue tended to be viewed within the Neurosciences Service Department, however, as something, which was outwith the consultant's contract with the Trust. In reality, however, Dr Watt had already received a 5-year warning from the GMC regarding his failure to furnish reports and this failure became regular and persistent. At no point did there appear to have been appropriate management of what had become a chronic problem. There are clear clues in the papers, which suggest that Dr Watt's workload had become overburdened. In his email to Clare Lundy of 17th June 2013, Dr Watt stated:

I see a huge number of patients and as a result at times struggle to keep on top of the workload.

2.234 This admission does not seem to have alerted those in management to check whether Dr Watt was working to an appropriate clinic template or whether his job planning was up to date. For the avoidance of doubt, the Inquiry Panel accepts that it was the case that Dr Watt was greatly assisting the Trust by seeing a huge volume of patients. It is also recognised that a degree of pragmatism is required, and a purist approach can be unhelpful. Nevertheless, the role of the manager is to monitor the situation and be aware of the possible dimension of overworking. Frequent complaints specific to Dr Watt should have been a warning sign that needed to be investigated.

2.235 The views of Dr Watt expressed to Ms Lundy on 17th June 2013, principally that *"reports on patients who I have diagnosed as having a stroke despite normal imaging are a particular problem and often lead to repeated enquiries"*, could perhaps have led to the identification of broader issues. It is unreasonable to expect an Assistant Service Manager, relatively new to the post, to identify clinical issues of concern. A properly functioning complaints and management system could, however, have identified broader issues of concern arising out this and other contemporaneous complaints.

**INI 449:**

- 2.236 INI 449 also wrote to the Trust in June 2013 complaining that, following an outpatients' appointment with Dr Watt in April 2013, an urgent MRI request was drawn up, but not sent to the Radiology Department by Dr Watt. Eventually, INI 449 was admitted to Ward 4E and the MRI scan was completed. A clear apology was provided by the Trust on behalf of Dr Watt in a letter from Mrs Owens, then Director of Unscheduled and Acute Services, on 29th November 2013, which stated:

Dr Watt had completed the urgent MRI request form, but unfortunately he did not send this to the Radiology Department. Dr Watt states that he had a conversation with the Neurosciences Admission and Discharge Coordinator, Ms Vanessa Boyd, but unfortunately he did not follow through with this by providing Ms Boyd with the appropriate documentation, or with your mother's details. Dr Watt would like to offer his sincere apologies for the delay which ensued as a result of miscommunication and poor administration when dealing with the MRI request form, and the need for possible admission to hospital for further investigation and follow-up. Dr Watt would also like to apologise if this has caused your mother to suffer any further symptoms and for any undue anxiety and stress.

- 2.237 Given the candour of the response, the question arises as to what was being done to address the problem of miscommunication and poor administration by Dr Watt.

**INI 349:**

- 2.238 This complaint was forwarded to the Trust via the Patient Client Council and once again related to medical reports for two insurance companies regarding critical insurance cover. One of the reports had been outstanding for 14 months and had been the subject of continual complaint directly with Dr Watt on a monthly basis. The complaint was received in September 2013, just as Dr Fullerton had recommended Dr Watt for revalidation. It is noted that when the email was received from the Patient Client Council, it was logged by Ms Maura Quinn in Complaints as an 'inquiry,' not a 'complaint'. Given the context, this is surprising. The actual letter from the Patient Client Council stated:

The insurance companies are Scottish Provident and Bright Grey. In the case of the former the initial request was 14 mths [sic] ago. I understand that reminders are being sent to Dr Watt on a monthly basis; [INI 349] has also been in touch with his secretary on a number of occasions. One report for both will suffice.

The delay is causing [INI 349] some difficulty.

Is there anything that can be done to speed things up?

2.239 The complaint was initially forwarded to Dr Craig, the Clinical Director, and Mr Atkinson, the Service Manager.

2.240 In October 2013, Ms Lundy emailed Mr Atkinson to say that she had heard nothing back from Dr Watt, but that she thought Dr Fullerton was dealing with this.

2.241 On 11th October 2013, the patient personally filled in an online complaint notification, which stated as follows:

I have been awaiting my insurance forms to be completed for over year. I have asked Dr Watt on several occasions for the completion of the required forms. Further to this my wife wrote a letter to Dr Watt in April 2013. I ring Dr Watt's secretary every month for an update with no progress. The insurance company also write to Dr Watt monthly. The MS nurses have also intervened on my behalf and spoke to Dr Watt but with no success. The insurance company have also contacted me about the lack of progress and have said that they will close the claim if no further progress is made which means I would have to start the claim procedure all over again with the loss of month.

Please can you assist by speaking to Dr Watt and ask that he completes the forms the insurance company requires as soon as possible.

2.242 On 15th October 2013, Mr Atkinson contacted Dr Fullerton and Dr Craig offering to pursue the matter with Dr Watt "*mindful of previous complaints in a similar nature*". Dr Fullerton replied:

I thought this one had been resolved. When I met Michael he indicated that a previously outstanding report had been completed, and I took it to mean this one.

2.243 On the same date, Dr Fullerton emailed Dr Watt:

When we met, I was assured that there were no more reports outstanding.

Please respond to this one immediately, and advise me that you have done so. I can assure you that it is much quicker to respond to these requests at the time than a year after the event.

2.244 On 17th October 2013, Dr Watt responded:

Ken

As I told you at our meeting I have been paid for a report on [INI 349] – he must have another policy – I will complete it as soon as I can.

2.245 On 22nd October 2013, Mr Atkinson informed the Complaints Department that Dr Watt had advised Dr Fullerton that he had been paid for a report on INI 349. The email stated:

Dr Watt thinks [INI 349] must have another policy and he has assured Dr Fullerton that he will complete this as soon as he can.

2.246 By 5th November 2013, a complaints administrator contacted the Neurosciences Department, copying Dr Fullerton in, and stating as follows:

[INI 349] called yesterday seeking an update on his response. He advised 1 insurance company had received the consultant's reply but there was no date stated from when his MS was 6 months consistent, therefore he is losing out on 17 months, he asked if this could be resent with the date included. He also advised that Scottish Provident has not received any completed documentation.

2.247 The second report appears to have been forwarded by Dr Watt shortly before Christmas 2013.

2.248 Just as with the previous complaint, this patient's concern does not appear to have alerted those in management that there was a serious and chronic issue with Dr Watt's administration taking place in plain sight. These are not minor matters. The absence of a report to insurers can, in many cases, result in policies being paid out late or not at all. The Inquiry Panel again noted the following pattern:

- (1) The lack of any proper triangulation of the available data.
- (2) No hint that management believed that further action needed to be taken against Dr Watt for what had become a problem. This case is relevant because it is lodged just as Dr Watt has been revalidated in September 2013.
- (3) The reluctance by the Complaints Department to initially log it as a complaint implied a reticence to analyse the information that was being lodged with the Complaints Department. To refer to this situation as an '*inquiry*' failed to grasp the seriousness of what was being alleged.
- (4) Despite the urgency, Dr Watt, once again, took several months to deal with the substance of the complaint and provide the second report. His delay was met with continual requests and reminders that carried no threat of sanction or action. Consequently, the reminders had a negligible impact.

#### INI 350:

2.249 On 17th September 2013, the Complaints Department received a complaint from a patient, who had attended Dr Watt's clinic on 8th May 2013 and discussed the possibility of changing from his current medication to one of the more effective oral therapies. The patient indicated that he met the criteria and alleged that Dr Watt had

advised him that the new oral therapy would be a more effective treatment. In his letter the patient stated:

... Dr Watt assured me I met the criteria and advised that this would be a more effective treatment for me.

I asked the process and approx. time scales for this and all was well explained

1. Blood test
2. ECG
3. Request top up funding
4. Drugs available
5. Hospital bed request as a short stay is required

This could take from “a few weeks to a few months”

I had the bloods taken on 8th May at the MS Clinic and had an ECG that day too.

I had contacted the clinic on May 22nd and again on June 26th to try and get a progress update.

On both occasions I was told to keep going with the Copaxone until such times that the Gylenia was available.

On September 3rd I contacted the Clinic again to find out about progress.

On this occasion I was told that Dr Watt “had trouble getting a cardiologist to read the ECG” taken on 8th May.

I find this incredulous that it took 12 weeks for someone to approve a normal ECG. Considering as I had already been through Cardiology twice in the City for an ECG and a 24 hr Monitor on 28th May and 6th August respectively.

My complaint is that as of September 10th the top up funding has not even been applied for and the process of a “few weeks to a few months” has not even started, never mind arranging a short stay in Hospital ...

- 2.250 The response letter following investigation by Glen Cartmill a Senior MS Nurse, was completed on 19th December 2013 and signed by Mrs Owens. It was noted that funding approval had been obtained for the patient to commence the relevant treatment. In the interim, it transpired that the patient wished to travel to Spain and, after liaison with Dr Watt, it was decided to postpone commencement of the treatment and continue on the current medication. This complaint appears to have been dealt with comprehensively and is relevant only because it was received at or about the time Dr Fullerton was confirming revalidation. It appears that Dr Watt had considered and reflected on this complaint with Dr Fullerton. In the view of

the Inquiry Panel, the complaint illustrates the value of obtaining assistance from a specialist nurse, who appears to have been proactive in managing the response from the Multiple Sclerosis service.

#### INI 450:

- 2.251 On 27th January 2014, the husband of INI 450 complained that Dr Watt had carried out injections on his wife's back (which had not worked) and had left his wife in significant pain. At that time, INI 450 was informed that she was being placed on a waiting list for an MRI scan, but she was told that there was a long waiting list, despite the fact that she was "in extreme pain".
- 2.252 The issue of blood patching is dealt with in a separate chapter, but the Inquiry Panel noted that this was a patient complaining of extreme pain after several blood patch procedures carried out in 2014.
- 2.253 Ms Lundy identified a further complaint from INI 450 dated 9th April 2015 prior to her appearance before the Inquiry Panel on 25th May 2021. The complaint was a familiar one. The complainant indicated that his wife was under the care of Dr Watt and that, following surgery in March 2014, a claim had been submitted by the complainant's wife for disability cover. In November 2014, the insurance company wrote to Dr Watt asking him for a report on the complainant's wife. No response was forthcoming and eventually a complaint was lodged. In a typically effective and proactive way, Ms Lundy sought to resolve matters. She described the action she took in a written statement, which was submitted to the Inquiry Panel before she gave oral evidence. The relevant paragraphs are set out below:

34. [INI 450] and her husband had written to Dr Watt and requested a report on several occasions. I had dealt with a previous complaint by this patient in 2014 which related to delays in an MRI and treatment.

35. The patient complained by letter dated 8 April 2015. I escalated the matter to Gerry Atkinson, then Neurosciences Service Manager. Gerry's office was next to mine and I spoke to him about it. I told Gerry I was going to draft the report myself and ask Dr Watt to review it. I used the patient notes to complete the questions in the report request.

36. I recall I went to see Dr Watt on the ward with the report I had prepared. I recall Dr Watt went to sign the report without reading it, however, I suggested he should read it first. I had brought with me the letters within the patient's notes which I had used to compile the report. Dr Watt read the draft report and suggested one change. I made the change and brought it back for him to sign.

37. In preparing this statement I was discussing this instance with Mr Johnston and he was not familiar with it. It appears that the material relating to this complaint has not previously been provided to the Inquiry.

38. I checked with the Complaints Department as to why this complaint was not previously identified as relating to Dr Watt. I have been informed that unfortunately the complaint from this patient was not linked to Dr Watt on Datix. The Complaints Department has explained to me that the process for linking is not as robust as it is now, and I understand that the Belfast Trust is going to explain the position generally in response to a statutory notice from the Inquiry.

2.254 Notwithstanding Ms Lundy's efforts, the report was not received by the complainant until 3rd February 2016. No final response was issued as this complaint was deemed to have been locally resolved by Ms Lundy. Ms Lundy provided further information on the meaning and effect of local resolution in the same witness statement as follows:

Local resolution of a complaint is where direct engagement with the complaining patient results in an outcome to their satisfaction, and where, as a result, they do not require a formal written response. If it is appropriate to resolve a complaint in this way, then I will communicate that internally to the Complaints Department and update them on any agreed actions or plans put in place. I cannot say how the Complaints Department record or analyse complaints resolved in this way.

2.255 While Ms Lundy's efforts and motives are laudable, the Inquiry is concerned that the local resolution of complaints such as INI 450 created clear issues with regards to the recording of complaints and outcomes and impeded the identification of any potential trends. It is, however, of note that this complaint only came to the attention of the Inquiry Panel thanks to the efforts of Ms Lundy.

#### **INI 434:**

2.256 On 10th July 2014, a long and detailed complaint was submitted by INI 434 regarding the treatment and care received while a neurology inpatient and, the lack of care provided by a team, which included Dr Watt. Issues regarding the nature of communications with INI 434 and the fact that she alleged she was not physically examined were also raised.

2.257 The complaint was forwarded to Dr Watt on 15th July 2014 by Ms Clare Lundy asking Dr Watt to comment on each concern/question that the complainant had raised. This was to be completed by 22nd July 2014. Ms Lundy also felt that, given

the complications and the length of the complaint, the matter might be best resolved in a meeting with the complainant. The following day, Ms Maura Quinn from the Complaints Department agreed that a meeting would be the best way forward. It is noted that Dr Peter Short, a Consultant in Emergency Medicine, commented on the emergency department attendances in December 2013, May 2014 and June 2014 by the complainant. This response from Dr Short was completed within days of being received.

- 2.258 On 30th July 2014, the Complaints Manager offered to meet with the complainant. The complainant agreed to the proposal, and it was suggested that Dr Craig and Dr Watt would attend the meeting on behalf of the neurology team and Ms Lundy would also attend as Assistant Service Manager in the Neurosciences department. It is noted that, in a file note of 6th August 2014, the complainant had asked for a second opinion. Getting a date, which would suit all parties for a meeting proved difficult. After further delay, a meeting was arranged for 28th October 2014. A detailed agenda was drawn up for that meeting, which raised a series of 15 questions regarding the treatment received by the complainant and her request for a second opinion. The meeting proceeded and notes were drawn up by the Medical Director's Office following the meeting. Before these were forwarded to the complainant, Ms Quinn from the Complaints Department spoke at length with the complainant on 4th December 2014.
- 2.259 The notes of the meeting highlighted concerns, which focused on communication of results and confusion about the views of Dr Watt. The notes reflect the fact that most of the complainant's concerns had been answered and the complainant was distressed that she had had to go to such lengths to get answers, suggesting that things would have been much different if Dr Watt had taken the time to discuss her case with her in more detail. Dr John Craig, Clinical Director, was present at the meeting but, on being asked to address issues raised in further correspondence by the complainant, summarised his role as follows in emails of 6th November 2014 and 9th December 2014:

As I pointed out at the start of the meeting I was not present at the meeting to give any form of clinical opinion, rather I was there in a managerial role and also to demonstrate how seriously we take complaints. I will not be giving any form of summary response in regards to the clinical care that was received.

I was at the meeting as an observer. I do not think it would be appropriate for me to be giving an opinion based on differing opinions. I will reply to any letters from [INI 434], but will be making the above position clear.

- 2.260 A draft response to the initial letter of complaint was drawn up in December 2014, but despite a great deal of email correspondence, the formal response was not completed until 14th May 2015. The minutes of the meeting were also not forwarded for many months, and this was the subject of further complaint in April 2015. This was, in part, due to a failure by Dr Watt to forward necessary information despite pressure from Dr Craig, Mr Atkinson, Ms Lundy and Ms Quinn. On 13th March 2015, Dr Craig advised Dr Watt that: *“this is likely to get escalated to the Medical Director if not sorted in line with Trust Guidelines”*. Dr Watt eventually provided the requested information on 18th March 2015.
- 2.261 On 1st April 2015, notes of a telephone call from the complainant to the Complaints Department were shared. In response, Dr Craig queried as follows: *“can I ask that complaints provide comment on level of care provided to [INI 434]. It seems like an unusual request and outwith the complaints procedure”*. The Inquiry has seen no response to Dr Craig’s email.
- 2.262 On 8th May 2015, the complainant wrote to Dr Cathy Jack, the Medical Director. The complainant was concerned that she had still not received a formal answer from the Complaints Department nor the minutes of the meeting in October 2014. Following a detailed response of 14th May, and enclosure of the minutes of the meeting, the complainant responded to the author of the Trust correspondence, Mrs Owens, on 18th May 2015. The reply from the complainant took issue with what she believed were inaccuracies in the summary note of the meeting in October 2014 and she also queried many of the answers to the 15 questions that had been posed in the initial complaint. A draft response to this letter was commenced in July 2015. This draft required input from Dr Watt and the number of issues raised caused further significant internal emails to be generated. A second iteration of the draft response was drawn up in December 2015 and a further draft in March 2016. It is clear from the email correspondence that attempts were being made to deal with discrete aspects of the queries raised. In this case, Ms Anne Flynn, the Complaints Manager, spoke with the complainant on 19th May 2016. In an email to Mr Atkinson, Ms Flynn stated:

I spoke with [INI 434] today and she advised me that she wanted to close her complaint. She felt that the process had dragged on for far too long and she was tired of receiving holding letters. I did explain that I felt a response was imminent, but she was adamant that she wanted to draw a line in the sand.

- 2.263 On the following day, the Belfast Trust wrote to the complainant noting that she had withdrawn her complaint and apologising for the delay to the subsequent queries that had been raised.
- 2.264 What is conspicuous in the handling of this complaint is the concentrated efforts that were made by those leading the complaints process to try and get detailed answers to a significant number of questions. In some ways, the long delay between the correspondence from the complainant and a formal response is understandable, given the resource issues required from many parts of the health system within the Belfast Trust. It is further clear that the efforts made on behalf of complaints' staff were genuine and the complexity of the case almost overwhelming.
- 2.265 This was one of several complaints, which had been lodged by articulate and determined complainants. The number of questions raised made resolution of the complaint extremely difficult. It is the case that consultants are often required to expend significant time and effort in responding to a wide variety of complaints and the Inquiry Panel recognises that the investment required is often disproportionate to the outcome that can be achieved. Given the length of time it takes to see a neurology consultant, and the myriad of questions that can be included in a complaint, there is a case for an initial screening process, which would seek to discern whether there is a serious clinical issue before committing to a comprehensive process.
- 2.266 In written evidence provided to the Inquiry on 23rd May 2022, the Belfast Trust stated that, at present, they are bound by the regional complaints process. Paragraph 3.31 requires that:
- Where the complaint involves clinical/professional issues, the draft response must be shared with the relevant clinicians/professionals to ensure the factual accuracy and to ensure clinicians/professionals agree with and support the draft response.
- 2.267 The Department's regional guidance quoted above clearly instructs and requires Trusts to ensure that any response must be approved by the person who is the subject of the complaint. This may explain the pre-eminence that was given to obtaining the views of Dr Watt in respect of all of the complaints but it makes no sense that the approval must be obtained from the clinician who is the subject of the complaint. While natural justice would ensure that this clinician would be fully informed of the complaint and given an opportunity to respond, that response should not be determinative.

## INI 130:

2.268 The complainant wrote to the Medical Director of the Belfast Trust, Dr Tony Stevens on 26th May 2014. The complaint was raised following a lack of response from Dr Watt and the gist of the complaint focused on the attitude of Dr Watt, delays in treatment and his alleged failure to give the complainant a diagnosis and advice regarding the use of Benzodiazepine. A further letter of complaint was written to the subsequent Medical Director, Dr Cathy Jack, on 10th September 2014, which related to the outstanding assessment of an alleged abnormal brain SPECT scan of 6th November 2013. The patient was concerned that her medical history of 27 years long term Benzodiazepine use had not been linked to the abnormal result in the brain scan. The patient stated:

No neurologist to date – has ever made any contact with my Benzodiazepine expert on my behalf at any time, or evidently, even looked into the extreme relevance of this Benzodiazepine subject. Clearly all relevant evidence and information has quite simply just been dismissed and ignored.

2.269 The complaints in total stretched to 11 pages of closely typed script, which raised a wide variety of concerns and allegations.

2.270 As with the previous complaint, Ms Lundy suggested that a meeting with the patient might be a better way forward. In this instance, however, the patient felt sufficiently unwell so as not to be able to attend a meeting. It is noted that the Medical Director, Dr Jack, encouraged resolution in October 2014 when she emailed Mrs Owens, Dr Fullerton (the then Associate Medical Director) and Dr Craig, the Clinical Director. On 7th October 2014, Ms Lundy, the Assistant Service Manager in Neurosciences, telephoned the complainant and, over three phone calls lasting nearly 2 hours on that day, sought to understand the complainant's main concerns.

2.271 Dr Craig met with Dr Watt in order to put in place a plan to respond to the complainant's concerns. Ms Lundy completed a timeline of appointments, investigations and admissions to hospital. Dr Watt was tasked to write a covering letter to the timeline. It is noted that on 8th October 2014, Dr Craig stated:

My biggest difficulty in trying to help deal with this woman's concerns is that I do not think that a neurologist should be giving an opinion on the chronic effects of benzodiazepine use and the effects of their withdrawal. In doing so they expose themselves and the Trust to unnecessary risks. Neither of these issues would be considered 'neurological' and I suspect that most practising neurologists would agree with this opinion. This is not to say that there are not facets of this woman's symptomatology that require consideration from a neurological perspective. I feel that Dr Watt should focus on these.

- 2.272 A draft response was first drawn up on 30th October 2014. This was revised in November 2014 and forwarded to the complainant on 25th November 2014. At the core of the complainant's concern was that her symptoms were related to the use of Benzodiazepines. It was noted that Dr Watt had spoken to Dr Lynch regarding the abnormalities in the SPECT scan. A further PET scan was carried out on 27th October 2014, which was entirely normal. The Trust also offered in this correspondence a second opinion with one of the leading neurology centres in England and offered to safely transfer the patient to the identified hospital with one other person.
- 2.273 The complainant responded on 20th January 2015. This letter consisted of 22 closely typed pages. Following a phone call on 27th March 2015, Ms Lundy suggested a meeting, which would include Dr Watt and Ms Lundy as well as members of the complainant's family. Ms Lundy asked the complainant if she would reconsider referral to England for a second opinion. This was declined because of the complainant's condition. A further letter was written by the complainant on 30th April 2015 to the Chief Executive of the Belfast Trust. The opening paragraph presents a useful summary of the essential complaint and concern:

This very serious matter of functional, metabolic and biochemical damage and deterioration, is still outstanding. To date my neurologist has failed to get any help or properly address my benzodiazepine condition, knowing that I suffer daily and increasing neurological functional brain damage. All due to, the addictive nature and physiological dependence, symptoms and effects, of long-term benzodiazepines; as verified in my abnormal SPECT scan and previously repeatedly recorded with my neurologists by my GP and particularly since 2008, by 2 world recognised benzodiazepine experts. Both experts repeatedly offered to speak and even meet with my neurologists and 1 also offered to come to RVH. My neurologists declined all offers of help.

To reiterate; it is most alarming, that for over 6 years, particularly since my completely paralysing seizure with extreme autonomic dysfunction etc, that a systematic cycle of serious and obvious neurological damage from the exact injury site – has been completely dismissed. Especially when since 2008, having the post benzodiazepine diagnosis and concerned input, of 2 world recognised benzodiazepine experts and then since 6th November 2013, also having a recognised functionally abnormal brain SPECT scan, identifying the damaging effects of long-term benzodiazepines.

- 2.274 There then followed a long sequence of internal emails, where efforts were made to try and set up a meeting with the complainant. A letter from the Complaints Manager on 3rd June 2016 apologised for the delay, but the problem of obtaining availability for Dr Watt to attend such a meeting proved to be challenging. At a meeting with Dr

Craig and Mr Young on 30th August 2016, it was noted that there was an outstanding request for Dr Watt to attend a meeting to discuss the ongoing complaint from the complainant. Although there had been a number of dates suggested by Dr Watt in March/April 2016, which had not proved to be possible for the complainant, numerous other requests by the Service Manager and the Complaints Department had not been addressed

- 2.275 Following the meeting on 30th August 2016, it was noted that Dr Watt was due to see the complainant at the Ulster Independent Clinic (“UIC”) the following Wednesday and it was hoped that this would bring some degree of closure.
- 2.276 On 26th September 2016, Dr Watt informed the Service Manager, Mr Atkinson, who was following up on the outstanding issues involving Dr Watt that the complainant had undergone a blood patch procedure.
- 2.277 Despite the procedure, requests to arrange a meeting continued to no avail.
- 2.278 On 10th December 2016, the complainant wrote to Dr Watt following the blood patch procedure. The correspondence from the complainant indicated that the blood patch procedure had not resulted in any improvement and the correspondence focused on the ongoing problems the complainant believed had been caused by Benzodiazepine dependence. This correspondence then resulted in further intensive emails between Ms Lundy and Dr Watt. By way of example, on 20th December 2016, Ms Lundy wrote to the complainant stating:

I strongly believe that the best way of trying to resolve your ongoing concerns would be to have a meeting with you and Dr Watt. This would be facilitated by a member of the Complaints Department. Notes and action points would be produced. I understand that this has been difficult for you in the past when we have arranged meetings that unfortunately you were unable to attend ...

- 2.279 Unfortunately, despite efforts to convene the meeting, this did not occur. Further detailed correspondence was then forwarded by the complainant to the Chief Executive of the Belfast Trust, Martin Dillon on 22nd July 2017. This had been preceded by a detailed letter to Dr Watt of 24th June 2017.
- 2.280 On 28th July 2017, Ms Lundy summarised the ongoing management difficulties:

This is a longstanding complaint which goes back a few years. It has been very difficult to manage. I have started to gather information in relation to the difficulties experienced by many consultants and registrars when managing this lady’s symptoms and admissions. Several meetings and consultations were arranged but cancelled by [INI 130]. There is a very long list of admission and

OPD DNAs and cancellations. [INI 130] has declined the offer of a referral to London for a 'second' opinion.

2.281 Various drafts were considered, in terms of the response to the complainant's letter to the Chief Executive. Eventually, the letter was approved by Mrs Owens, Director of Acute & Unscheduled Care, on 12th October 2017. In the concluding paragraphs of the correspondence, Mrs Owens stated:

... At this point, the Trust believes that all reasonable measures have been taken to offer you the care and support that you require. I appreciate that you have been unable to avail of some of the meetings or consultations which had been arranged for you due to your ongoing poor ill health. As previously stated, the Trust will continue to provide you with ongoing care and treatment as per your clinical requirements however; the Trust would now consider that local resolution into your complaint is now complete ...

2.282 In response to the correspondence, the complainant telephoned the Complaints Department indicating that she had wanted her SPECT scan reviewed as soon as possible. It was decided to arrange for an external review of the SPECT scan. In answer, the complainant, in her correspondence of 2nd April 2018, asked a number of questions, which are set out below:

1. I should be grateful if you please provide me with a copy of the proposed terms of reference for the review.
2. Can you confirm who will carry out the review and where they are from?
3. Will you confirm what kind of review this will be – a paper review alone or will the person undertaking the review be questioning staff. If so, will I also have the chance to speak to the person carrying out the review?
4. Why have I not been contacted about the adverse effects caused by Dr Watt's epidural blood patch September 2016, or about the talk with Dr Peukert in March 2017?
5. Who is the senior manager for Neurology services?

2.283 Following a further letter of reminder, Ms Lundy emailed Mrs Owens to say that the terms of reference had been drafted; that the images would be sent to the independent reviewer on that day (3rd May 2018) and that turnaround time was approximately 7-10 days.

2.284 Before a meeting could be arranged with the complainant to discuss the independent review, an email was received from the Litigation Management Office on 12th June 2018 indicating that allegations of clinical negligence were to be raised against

the Belfast Trust. Ordinarily, this would have closed the complaint because legal proceedings were pending. A letter, however, dealing with the review carried out by Dr Kevin Bradley was forwarded by Mrs Owens on 29th June 2018. The complainant also wished to know why she had not been included in the neurology recall and, by letter of 1st August 2018, Mrs Owens explained that as she had been discharged from the care of Dr Watt, she had not been included.

- 2.285 INI 130 gave evidence to the Inquiry Panel on 1st February 2019. It became increasingly apparent that this was a complex case in which genuine and substantive efforts had been made by the Trust to investigate the clinical issues. The Inquiry recognises that there are some complaints, which are so complex that they become almost impossible to manage within the complaints system. The present system is designed for resolution within 20 days. Where there are clinical issues of substance, however, days can stretch into months and sometimes years. Discerning at an early stage that a complaint should be handled differently or, in some cases, cannot be addressed fully because of resource issues, should also be a priority.

#### INI 435:

- 2.286 INI 435 attended an appointment with Dr Watt on 12th September 2013, who diagnosed her as suffering from Moyamoya Disease. It was believed that the patient might benefit from re-vascularisation surgery, and it was arranged for the patient to see a specialist in Addenbrooke's Hospital in England. There was a delay in funding because paperwork was not properly processed by Dr Watt. Approval was eventually given in January 2014.
- 2.287 On 17th September 2014, the patient wrote to Dr Watt. It was clear that part of the complaint related to her treatment in England. In respect of the delay caused by failure to properly process the forms for an extra contractual referral, Mrs Owens wrote on 22nd October 2014 to the complainant and apologised for the administrative mistake highlighting that *"unfortunately, the paperwork regarding the funding was not processed at the time and these omissions were not realised until January 2014"*. The referral to Addenbrooke's was followed by a consultation with Dr Watt on 2nd October 2014 and this provoked a further complaint dated 10th October 2014. In an email INI 435 stated:

... It was a very strange meeting. I had brought a list of questions to be answered regarding my condition and possible treatment. Dr Watt was unable to answer any questions on Moyamoya disease and at one stage, told me to look it up on the internet. I asked if he would be able to put me in touch with other Moyamoya

sufferers that had been through his office. There was a Japanese violinist, but he didn't know how to contact her. He suggested I log into a Japanese support group. I found his flippant attitude extremely disappointing. I left his office wishing I hadn't bothered attending. He was unhelpful and uninformative. I had to ask if I would be monitored. He will see me in a year, keep taking the aspirin and try not to get diabetes, high blood pressure or high cholesterol. Lose weight and keep fit ...

- 2.288 Dr Watt was asked on 4th November 2014 as to his commentary on the complaint. Dr Watt made a number of amendments to the proposed letter and the template that had been provided to Dr Watt, which then formed the basis of the formal response from the Trust on 20th November 2014. The letter stated:

... In your email, you have mentioned that Dr Watt was unable to answer any of your questions on Moyamoya disease and have described him as "unhelpful and uninformative". Dr Watt has commented that he had tried to answer your questions to the best of his ability, and that he felt he had given you time to raise any issues which you wanted to discuss with him. However, I extend sincere apologies that you were disappointed with the consultation and did not feel that your questions were adequately answered. Dr Watt has suggested a referral for a second opinion to another neurologist with a particular sub-specialty interest in vascular disease, such as Dr McCarron, Consultant Neurologist at Altnagelvin Area Hospital. I appreciate that this may be a longer journey than you would wish to travel, however if you feel this is a good idea, we can most certainly make arrangements for this ...

- 2.289 It is noted that when the complainant met with Dr McCarron, Consultant Neurologist employed by the Western Health & Social Care Trust, she called the Trust to advise that he had addressed her outstanding concerns.
- 2.290 Aspects of this complaint were clearly handled well. In particular, the Inquiry Panel noted that it was Dr Watt who suggested a second opinion and, as one would expect, on many occasions when a second opinion is obtained, a patient can be reassured.

#### INI 284:

- 2.291 On 29th December 2014, a friend of the patient wrote to the Belfast Trust. The letter was initially addressed to the patient's MP, Dr Alasdair McDonnell, and reached the Complaints Department on 29th January 2015. The letter of complaint was generic in nature and referred to concerns that the patient had not had successful treatment following a serious back injury at work and subsequent internal problems. The response to the complaint proved to be of much greater interest. The normal template

response was adopted; namely an initial apology, followed by a detailed review of the medical treatment received and a further apology. The Inquiry Panel noted the detail that was eventually formally included in a letter to the complainant, who had written to the Trust on behalf of the patient. The letter set out in some detail the treatment received and this is included below because of its broader relevance:

Our records indicate that [INI 284] was referred to Dr Michael Watt, Consultant Neurologist by Mr Gibson, Specialist Orthopaedic Registrar and was seen by Dr Watt on the 7th November 2012, where he performed an epidural blood patch on her. He then saw her again on the 14th November 2012, where he noted that the epidural blood patch was unfortunately unsuccessful in treating [INI 284's] on-going headaches and dizziness. Dr Watt then repeated the epidural blood patch treatment on the 11th December 2012 and noted there was still no improvement when he next saw her on the 18th December 2012.

... I understand that [INI 284] was then seen by Dr Seamus Kearney, Consultant Neurologist at Belfast City Hospital on the 13th May 2013. She had been referred to Dr Kearney by Mr Cooke, Consultant Orthopaedic Spinal Surgeon. At this appointment, Dr Kearney noted there were no objective abnormal neurological findings, therefore he arranged for [INI 284] to undergo MRI (magnetic resonance imaging) scanning of the head, which took place on the 20th June 2013. [INI 284] was then reviewed by Dr Kearney again on the 29th July 2013. Dr Kearney notes that MRI scanning showed no evidence of intracranial hypotension and arranged for [INI 284] to undergo a further MRI scan of the spine, which took place on the 21st August 2013. This showed no evidence of cerebrospinal fluid leak however did show degenerative changes and evidence of her previous spinal surgery.

Dr Kearney thought it was unlikely that [INI 284] was suffering from idiopathic intracranial hypotension, however referred [INI 284] to undergo a lumbar puncture. This took place on the 17th October 2013. [INI 284] was subsequently reviewed again by Dr Kearney on the 21st October 2013. He noted there was no evidence of intracranial hypotension or chronic infection to explain [INI 284's] ongoing symptoms. Dr Kearney noted he felt [INI 284] was possibly suffering from chronic migraine, as well as analgesic overuse headache. He also felt she had some symptoms suggestive of functional neurological symptoms and provided her with information with these. Dr Kearney planned to review [INI 284] again in 3 months' time. Dr Kearney subsequently referred [INI 284] to Dr Raeburn Forbes, Consultant Neurologist at Craigavon Area Hospital for a second opinion.

[INI 284] was subsequently reviewed at Dr Watt's outpatient clinic on the 4th March 2014. She was seen by Dr Watt and Dr Campbell, Specialist Registrar. Dr Campbell notes [INI 284's] neurological examination was entirely normal. However, he referred her to undergo a CT (computerised tomography)

venogram to exclude venous sinus thrombosis, though he felt it was unlikely this was the cause of her symptoms. This CT venogram was performed on the 3rd April 2014. [INI 284] then underwent a CT head scan on the 23rd April as well as a further MRI head scan and an MRV (magnetic resonance venography) cerebral veins scan on the 9th May 2014. She was then reviewed by Dr Watt again on the 24th June 2014, who noted that the CT venogram and the MRV showed evidence of chronic partly recanalised thrombus and thus suggested starting a course of Apixiban ...

- 2.292 This complaint raised a difference between the diagnoses of both Dr Watt and Dr Kearney. Efforts were made by the Inquiry to see whether Dr Kearney had been specifically approached, but the Trust, through its solicitor, responded that the management intern, Pearse Gibson, had checked his email and none were found to be communicating with a clinician. Mr Atkinson believed that the information would have been sourced from records held on the Northern Ireland Electronic Care Record.
- 2.293 The lack of evidence within the results from multiple tests performed by Dr Kearney is notable and has been documented clearly in the response. INI 284 is not just a case of alleged misdiagnosis, but the lack of objective evidence to support Dr Watt's diagnosis is laid out for all to see and does not appear to have been picked up on.
- 2.294 This complaint was also raised with Ms Lundy when she gave evidence to the Inquiry Panel on the second occasion on 25th May 2021. There does not seem to have been a means by which the person investigating the complaint, who has, correctly recorded the difference in diagnoses between Dr Watt and Dr Kearney, has highlighted the discrepancy to the Clinical Director or other clinicians. In this instance, it would have been both necessary and appropriate for the person investigating to seek the comments of Dr Kearney, both in relation to the number of blood patches that had apparently not worked, when carried out by Dr Watt, and to the record of Dr Kearney, where, in his view, he did not think the patient was suffering from spontaneous intracranial hypotension. Further, the complaint was not contained in the Medical Director's Office file, or on the updated Datix record in 2018.
- 2.295 The problem emerges that highly relevant evidence regarding blood-patching was uncovered and passed over without being remarked upon or evaluated. This is commented on in further detail in the Blood Patching chapter. This complaint was also being considered at an important time when, shortly thereafter, other issues came to light in respect of Dr Watt's practice and these matters are commented upon in more detail in the 2016 Missed Opportunity chapter.

## INI 436:

2.296 In this instance, a Welfare Co-ordinator acting on behalf of the patient contacted the Complaints Department on 2nd February 2015. The letter of complaint had an initial paragraph, which, given the response in the previous complaint, should have raised concern. The letter stated:

... [INI 436] was referred to Neurology at the Royal Victoria Hospital where he was diagnosed as having orthostatic tremor due to spontaneous intracranial hypotension. His Consultant at the Royal Victoria Hospital, Dr Michael Watt, tried blood patches on 4 occasions (1 private and 4 through the NHS) to try and rectify the matter but to no avail ...

2.297 The Welfare Advice Co-ordinator went on to state in the letter:

... [INI 436's] complaint is 2 fold.

- (1) He feels that he should have been scheduled for an MRI and photo imaging at the outset of his treatment to allow his consultant to see exactly where the leak was, so that treatment could be concentrated in that area ...
- (2) He wishes to complain about the cancellation of his appointment on the 26th January 2015 as he urgently needs the MRI and treatment.

2.298 While the other aspect of the complaint was about the cancellation of the patient's appointment on 26th January 2015, the significant clinical question, which is similar to the previous complaint, is that a patient, who does not appear to have had an MRI scan, has undergone 4 or 5 blood patches without success. The focus of the investigation was on trying to deal with the question of the MRI scan being apparently cancelled. It transpired that the appointment for the MRI may well have only been a review appointment.

2.299 A further letter from Dr Watt to the patient's GP dated 2nd February 2015 is also of interest. Commenting on the blood patches, Dr Watt stated to a GP:

Each of the 4 lumbar epidural blood patches worked for only a few hours. He is having an MRI of brain and spine at the end of February and if this doesn't show anything particularly remarkable, we will then go ahead with a dynamic CT myelogram along with an image guided epidural blood patch if we can identify a leak and I will see him again once this has been done.

2.300 A formal response signed by Mrs Owens was issued on 11th March 2015. This response focused entirely on issues pertaining to the MRI scan and did not address, or refer to, epidural blood patch procedures.

- 2.301 This complaint had numerous clinical queries, which have not been picked up on by the Neurosciences Service Department. The fact that blood patches appear to have been carried out on numerous occasions with a question mark as to whether there was objective evidence to justify the diagnosis, could have raised a clinical red flag. The management intern, who was collating much of the information, was both proactive and assiduous in his approach. In the absence, however, of independent or other neurological input from a consultant, it is unlikely that the clinical issues that are now apparent, were going to be spotted. The focus, understandably, was on the immediate concern of a patient, whether that be a cancelled appointment or ongoing personal distress. This complaint is an example of a complaints system, which is not set up to discover potentially significant clinical issues.
- 2.302 The complaint was also lodged just as the incidence of blood patch procedures was increasing dramatically and was the subject of complaint from nursing staff because of the facilities and space required on the neurology ward. This is commented upon further in the Blood Patching chapter.

#### INI 437:

- 2.303 INI 437's complaint was received by the Trust on 30th March 2015. This complaint related to the difficulties in obtaining a response from Dr Watt when the complainant's condition deteriorated. The complainant had been attending Dr Watt since October 2014 and was informed that he should ring Dr Watt if his condition deteriorated. He subsequently felt worse, rang Dr Watt on 12th March 2015, wrote to him on 19th March and rang his secretary on 26th March to be informed that Dr Watt was not responsible for the TIA clinic.
- 2.304 This complaint was forwarded to Neurosciences on 5th May 2015 and Ms Lundy promptly forwarded it to Dr Watt and indicated that "*[INI 437] has requested the possibility of another consultant to review his case. What are your thoughts about this?*" Dr Craig emailed Dr Watt the following day and asked him to "*put something brief down and get it out ASAP to prevent this escalating*".
- 2.305 On 6th May 2015, Ms Lundy asked Dr Craig which consultant neurologist this matter should be referred to. Dr Craig was clear that "*if TIA, patient should be referred to stroke service and not neurology*". It appears from email correspondence that Ms Lundy successfully arranged a subsequent appointment with which INI 437 was "very happy".

- 2.306 The concern of the Inquiry Panel was that this complaint was not attributed anywhere to Dr Watt and was disclosed only after Dr Craig gave oral evidence about the complaint, which led, in turn, to a request by the Inquiry to the Trust. The answer to the complaint may well be correct, but there was an apparent breakdown in communication between patient and doctor and little attempt seems to have been made to rectify same.
- 2.307 This is one example of a complaint, which was ‘locally resolved’ with no formal response being issued. The complaint would have been logged and closed which raises a question about the efficacy of a governance system that has struggled to collate an accurate record of relevant complaints, including during the lifespan of this Inquiry.

**INI 438:**

- 2.308 INI 438 saw Dr Watt and was apparently informed that he would receive a further appointment within three months. In anticipation of this, the patient booked a private MRI scan so that this would be available for the next review. Subsequently, the complainant stated that he never received an appointment and was told by Dr Watt that he was booked up until the end of October 2015. A complaint was subsequently lodged with the Trust on 15th September 2015.
- 2.309 When the complaint was referred to the Neurosciences Service Department, the Service Manager tried to bring the appointment forward, but was informed by Dr Watt’s Secretary that all of Dr Watt’s clinics were overbooked. In her oral evidence to the Inquiry Panel, Ms Lundy indicated there was a clinic template for the number of patients to be seen and that whereas consultants may overbook to a certain extent, persistent overbooking should lead to a flag being raised.
- 2.310 While this complaint was resolved by the provision of an earlier appointment, the information that Dr Watt’s clinics were all significantly overbooked should have caused questions to be asked. This matter was again ‘locally resolved’ and no formal response issued, nor does there appear to have been any attempt to address the issues with regards to the numbers at Dr Watt’s clinics. This complaint did feature in the updated 2018 Datix record.

**INI 441:**

- 2.311 On 11th March 2015, INI 441 wrote to the Trust regarding an alleged failure to provide medical care. INI 441’s complaint consisted of three elements. Two

elements, which are outside the Inquiry's Terms of Reference, involved confusion about medical records and the obtaining of an MRI scan and the other part of the complaint concerned an incident on 21st December 2014 when the patient went into anaphylactic shock. The Inquiry was concerned with the neurological aspects of the complaint which stated as follows:

Roughly 14 years ago I had a stroke and was referred to Doctor Watt who also diagnosed me with epilepsy. The side effects of the treatment for the epilepsy made me very unstable and I came off all tablet [sic] in fear of what I would do to myself. I always told Dr Watt that I did not agree with his diagnoses and as a result he refused to ever see or treat me again. I now have letter from another doctor from the Royal stating that in his medical opinion I do not and have not ever had epilepsy.

- 2.312 An initial response which was sent to Mrs Owens, in an email of 21st May 2015, omitted any reference to the neurology component of the complaint, instead being based solely on a response from Immunology. This matter was flagged by Mrs Owens and returned to Neurosciences for their comments. The matter was then considered by a management intern, Pearce Gibson. In an email of 27th May 2015, he asked Mr Atkinson, Service Manager, and Ms Lundy, Assistant Service Manager:

Can I confirm that the only issue based in this complaint for neurology is the epilepsy diagnosis? I had asked Dr Watt to provide comment on this on the 25/03/2015 but his sec weren't able to get the notes from ICU until 14th April. I called up a few weeks later to get them as I thought we had to respond to the issues regarding the wrong address etc but wasn't able to find anything in the notes.

- 2.313 Later the same day, Ms Lundy commented:

Bernie is right about the letter. It does not address the concerns raised by this lady. The neuro aspect of this complaint is highlighted and requires a response. Pearse and myself will do this. When you break this complaint down, basically, the patient requires the following:

- MRI scan
- Neurology appt.
- Immunology appt.
- Apology regarding admin confusion with addresses (not sure how this happened) and also apology regarding wait for MRI scan.
- A basic plan of care for this patient.

## ACTIONS:

- I phoned this lady this evening and advised of the immunology appt. and will organise the MRI and neurology appt (with Dr Kearney).
- I have given the lady my contact details and advised that I will phone her, at the latest next Tuesday (if not before this).

I am hopeful, that when all is sorted, this complaint will be resolved without the need for a long letter.

- 2.314 By 4th June, Ms Lundy was able to email the Complaints Department indicating that she had spoken to the patient and that the patient did not require a response because *“I have addressed all her concerns and the appropriate actions have been taken”*. These included the various steps identified by Ms Lundy in her earlier email of 27th May, with INI 441 being given an appointment for an MRI and, subsequently, an appointment with a consultant neurologist.
- 2.315 There was extensive evidence, both from her oral testimony to the Inquiry and the documents that were disclosed, which highlighted the fact that Ms Lundy took a proactive and pragmatic approach to complaints. She would often contact a patient who had lodged a complaint as soon as she received details from the Complaints Department. She looked for ways to resolve matters quickly and was often successful. Such an approach is to be commended, but when the focus is on obtaining hospital appointments and breaking through administrative impediments, sometimes clinical questions can get missed.
- 2.316 Unfortunately, that is what happened in this case. Dr Watt should have been spoken to. If the notes weren't available, as suggested by Pearce Gibson, they should have been obtained. The clinical questions in relation to the epilepsy diagnosis needed to be addressed and Dr Kearney, who had indicated to the patient that the complainant never had epilepsy, should have been spoken to. The Inquiry takes no view as to what would have happened as a result of the complaint about diagnosis, but the matter required to be investigated and, if necessary, by an independent consultant, if there was a continuing dispute between the neurologists and there was a clear pattern emerging.
- 2.317 Once again, this complaint evidences the fact that the focus within Complaints and the relevant Service Department was to resolve and address concerns raised. If a complainant does not further complain or indicate that a question has not been answered to his/her satisfaction, then there is no opportunity for learning to occur. Further, the method utilised inevitably fails to analyse the possibility of a pattern

of aberrant practice because there is little or no focus on the clinical questions that were being raised, save for a desire to get another consultant to see the patient or obtain tests that are outstanding.

2.318 The difficulties in trying to address clinical questions was the subject of detailed questioning by the Inquiry Panel. This is commented upon in the Conclusion section, but despite sincere efforts by people within the Neurosciences Service Department, the Inquiry Panel was not at all convinced that the clinical aspect of complaints was properly addressed in a manner, which would give real insight into the practice of a consultant. Ms Lundy gave evidence, for the second time, on 25th May 2021 and the following interaction took place with the Inquiry Chairman:

**Mr Lockhart QC:** Surely the decision about whether this was a misdiagnosis needs to be properly looked at, talk to Dr Watt, get the notes, potentially talk to another doctor and to say, 'was this reasonable?' It may well be that's right, and we all know that from looking at this ad nauseam for the last few years is there can be differing diagnoses, but that has to be a decision a neurologist would surely have to take?

**Ms Lundy:** Absolutely, and the patient was referred to see, I think it was Seamus Kearney saw the patient then.

**Mr Lockhart QC:** But the question hasn't been answered. Her question is inter alia or amongst other things, 'I was misdiagnosed with epilepsy'. Surely that has to be dealt with, that has to be considered?

**Ms Lundy:** Absolutely. Looking back now if this was a case that came in now, a complaint that came in now, then I would be doing the clinical record review, and I would be making sure the patient would see the consultant, and then I would be writing and explaining to the patient, or I would be inviting the patient up to meet to go through, but at this stage again this is whenever pseudomonas was around and I would say that I had fully intended to go back on this.

**Mr Lockhart QC:** The significance of it, to some extent, is when in 2016 they were considering -- and we are going to come into this as well -- what restrictions to impose, the only restriction was placed on blood patching. But if they had said to you, 'have there ever been any questions about diagnosis regarding epilepsy', you might have been able to say, 'I do remember a complaint and we will get that one looked as well'. It's not as if there isn't a possible consequence if you don't actually join the dots at the time, that's what I am saying, Clare.

**Ms Lundy:** Whenever the complaint comes to the Complaints Department they are supposed to log it in that way and it is supposed to be connected to a particular consultant with a particular issue. Obviously the system in this

case let us down in that it didn't actually link the consultant with the actual complaint itself.

**Mr Lockhart QC:** The system let you down at Complaints Department level because it wasn't logged. But then when it got to Neurology Service Department, the question wasn't answered. The question identified by Pearse is never answered. He is saying this is a question of an epilepsy diagnosis, and Bernie Owens is saying there's Neurology concerns here, and the answer is, 'let's get various appointments'. You have to answer the question surely was there -- there may well not have been for the very reason you are saying, but, 'let's talk to Dr Watt, let's get the records, let's look at somebody else's and ask them the question was it reasonable for Dr Watt to diagnose this patient with epilepsy in the absence of', and it may well have been fine.

**Ms Lundy:** In the same way you would expect if there was a patient going to see a consultant for another opinion, knowing that they had already seen somebody else that you would expect them to come back to you as well if there was an issue with a diagnosis.

#### INI 451:

- 2.319 On 12th March 2015, the husband of INI 451 wrote to the Trust Complaints Department regarding the waiting time at Dr Watt's clinic. In a draft response prepared by the Complaints Manager, the following is stated:

Our records confirm that your wife had an appointment with Dr Watt at his clinic on the 3rd March 2015 at 2.30pm. However in your e-mail you noted this was delayed by a further two hours. Unfortunately, due to the high volume of patients that attend Dr Watt's clinic, there can often be delays and I am sorry that your wife's appointment time had such a significant lapse. I can completely understand both of your frustrations with this lengthy wait and I am sorry that you and your wife have been inconvenienced by this delay.

- 2.320 Of interest to the Inquiry Panel was the perennial problem of overbooking at Dr Watt's clinic, which appears to have re-emerged. On this occasion, there is no question of reviewing the template. The draft letter of response is apologetic, but simply hopes that the next experience will be better. There is no evidence that the situation was being adequately managed or addressed.

#### INI 452:

- 2.321 On 1st October 2015, INI 452 telephoned the Complaints Department because he had had to wait for over 2 hours to see Dr Watt. The letter of response from Mrs

Owens of 9th March 2016 stated:

Regrettably, the Outpatient Clinic you attended is particularly busy due to the high volume of requests for appointments. Dr Watt regularly overbooks his clinics in order to provide patients with a more timely appointment and reduce the length of time they remain on the waiting list. Unfortunately, this can lead to delays at the clinic and patients often have to wait beyond their scheduled appointment time and on behalf of the Belfast Trust I apologise for this.

- 2.322 The fact that there was a further complaint about waiting times is unsurprising<sup>13</sup>. What was of interest to the Inquiry Panel in this letter is that the regular overbooking of clinics by Dr Watt was justified by the Trust on the basis that it reduced the waiting list. In one sense, that is understandable. Waiting lists in neurology have been problematic. Managers seeking to ensure that patients are seen, will anxiously attempt to do all that can be done to reduce the waiting list for patients. Unfortunately, however, there is a template for a reason and as Dr Watt's clinics were well outside the template guidance, then that is also an issue which needed to be considered and reflected upon. There is some evidence that this may have occurred at some point in 2007, but by 2015 there appears to be no question of reviewing the template. The difficulty is that this is not an issue that can be overlooked. If doctors' see too many patients in a fixed period of time, then axiomatically there is a greater likelihood of error.

#### INI 371:

- 2.323 On 10th February 2016, a further complaint was received regarding the failure by Dr Watt to complete insurance forms on behalf of INI 371. A request was sent on 1st October 2015 and followed up every 2 weeks. On 9th February 2016, the Complaints Department emailed INI 371 and stated:

I must also advise you that as completion of these forms are not part of their NHS contracts we are unable to log as a formal complaint.

- 2.324 The husband of INI 371 responded:

If completion of these forms is not part of the consultant's contracts, then can you tell me how we are supposed to get the information as all of the tests etc were done in the RVH under the NHS?

<sup>13</sup> The problem of overbooking was a problem throughout Dr Watt's career. It was noted by the Inquiry that on 9th February 1999, reference 18.99G related to a patient, who was complaining about the failure by Dr Watt to provide a medical report and 00.O123 dated 5th April 2000 was a complaint about the waiting time at one of Dr Watt's clinics. Under the section entitled 'outcome' the legacy Datix system has recorded "Dr Watt always has overbooked clinics. If he had a no overbooking policy, it could delay serious diagnoses".

- 2.325 The forms were eventually provided in March 2016, but the point made in this case by the patient's husband was both obvious and compelling. The consultants who gave evidence to the Inquiry Panel all recognised that this was an obligation which should be fulfilled. The GMC certainly regarded it as part of a doctor's obligation. The GMC had already given Dr Watt a 5-year warning, which had expired in 2012, for not completing a report. At the very least, the Trust should have forwarded such complaints to the GMC if they were powerless to do anything more than try to persuade and cajole Dr Watt.
- 2.326 The Inquiry Panel noted that at this time, Dr Watt had been referred to the DDCRM and issues regarding Dr Watt's failure to respond within a reasonable time frame to requests from the Coroner and complete appraisals were escalated to the Medical Director's Office. As this case was resolved locally, with no formal response being issued, it could not be discussed at DDCRM or escalated to the Medical Director's Office as part of a pattern of delays in administration.

**INI 439:**

- 2.327 On 14th March 2016, an anonymous letter of concern from a fellow inpatient in Ward 4E was lodged regarding the treatment of a male patient on the same ward. The anonymous letter of complaint alleged that the answer given by Dr Watt to a query by the patient was *"insensitive, cruel, unethical, spiteful and totally unprofessional"*. It was alleged that Dr Watt had stated in answer to a question as to what happened if his present treatment did not work was *"we'll stick a tube in your stomach and throw you out"*.
- 2.328 When the letter was sent to the Neurosciences Service Department, the Complaints Department indicated that *"we can't investigate this as we have no details of the complainant however this is being passed to you for your information"*. Mr Atkinson wrote to Mr Young to enquire whether the Service Department should be doing anything, given that the letter was anonymous. The response of Mr Young to the complaint was set out in an email of 16th March 2016:
- As there's no name to this complaint it will be impossible to respond so investigating and drafting a response would be a complete waste of time. This should never even have come to us.
- 2.329 The Clinical Director, Dr Craig, asked for advice on what he should do about the complaint as he had taken a view that the content was serious. Dr Fullerton, then Associate Medical Director, referred the matter to Mr Peter Watson in the Medical

Director's Office indicating that it was for the Medical Director's file as it was not a complaint within the ambit of the Department of Health Guidance. Dr Fullerton also, however, suggested, while passing on the anonymous complaint, that Dr Watt should be added to the DDCRM to get a view on what needed to be done, given that Dr Fullerton was due to retire. Mr Watson sought legal advice from the Trust's legal adviser, on the specific issue and the then Medical Director, Dr Jack, emailed Mr Watson when she was informed of the complaint and stated:

Are there other recent complaints about Dr Watt? Should we treat this as a whistle blowing? I have copied to Claire [sic] to consider.

2.330 On 7th April 2016, following liaison with the Trust's legal adviser, Mr Watson emailed Dr Jack and agreed the way forward as follows:

- (1) If [the patient] is an actual patient, we should seek clinical advice (presumably in this context from the [Clinical Director]) in order to inform decision-making as to whether and how he is advised that he has been named in a complaint that has been received.
- (2) Dr Watt is entitled to see the complaint and should be advised that we will conduct preliminary enquiries (including of him and others) to see if there is substance to the concerns which may warrant informal or formal action within MHPS.
- (3) There should be a clear pathway for the management of concerns from anonymous sources – maybe there already is? We do not think it appropriate merely to discard just because we don't know the source; there is even more reason of course to investigate in a context where the alleged victim is apparently identified.

2.331 Mr Watson followed up this initial advice with Ms Gillian Atkinson, the Senior Manager for Data Protection within the Trust, who advised on information governance and who confirmed that the Trust had a duty to investigate anonymous concerns because it was in the public interest to do so.

2.332 As a result of this advice, Dr Craig, the Clinical Director, spoke with the patient. All of the clinical notes were reviewed, and Dr Craig concluded that there did not appear to be any concerns regarding any aspect of the patient's care. Dr Craig followed this up with a conversation with the patient's wife, who believed that they had an excellent relationship with Dr Watt. The approach taken by Dr Craig and the report that he compiled was comprehensive and adequately detailed.

2.333 This case was interesting to the Inquiry for a number of reasons. It demonstrated the difference in attitude between the Neurosciences Service Department and the

Complaints Department, where the anonymity itself was sufficient cause for the matter not to be investigated, and the Medical Director's Office, which took the matter seriously and, it is fair to say, directed that it be investigated thoroughly. The manner in which the Medical Director's Office approached the question of anonymity was appropriate, proportionate and comprehensive. In contrast, the attitude of Mr Atkinson and Mr Young suggested that the purpose of the complaints process, in the view of those who investigated complaints, was to respond to a complainant as opposed to considering whether there was, in fact, a potential problem, which needed to be investigated on the basis that it may raise concerns about a doctor's practice<sup>14</sup>.

#### INI 440:

- 2.334 On 9th May 2016, INI 440, who suffered from Moyamoya Disease, and believed that she had had a stroke, complained that Dr Watt had informed her that there was nothing they could do for her and that she was taking up a bed. Dr Watt was asked to comment on the specific complaint and when he failed to do so in a timely manner, the issue was raised in a meeting with Mr Young and Dr Craig on 9th August 2016. An initial response was given by Dr Watt on 31st August, but he had wished to review the notes. The notes were eventually obtained and reviewed by Dr Watt in October 2016. In an email of 22nd October 2016, Dr Watt stated to Mr Atkinson that he had reviewed the patient's chart and that this confirmed what he initially believed, which is that he had recommended that the patient stay in hospital, but that she insisted on going home. This was directly opposite to the gist of the complaint, which is that Dr Watt had sent the patient home.
- 2.335 The response was eventually provided on 11th January 2017 and the normal template of apology followed by a detailed description of clinical treatment concluding with a further apology. The discrepancy between the patient's complaint and Dr Watt's response was properly included in the letter as follows:

... I am extremely sorry that you also have concerns regarding your care and treatment with the Neurology team. I am sorry that you feel that Dr Watt did not find it necessary for you to remain on the ward. Dr Watt has commented that he recommended that you stay in hospital, but that you wanted to go home because your boyfriend was returning to the United States of America within the next few days. Dr Watt's view was that, apart from improving your blood sugar and blood pressure control, as you were already fully anti-coagulated

<sup>14</sup> In fairness to Mr Atkinson, the matter was only provided to him for information purposes. He did escalate the matter appropriately asking senior management whether there was anything to be done by the Neurosciences Service. This is what ultimately led the matter to be brought to the Medical Director's Office.

with the correct dose of medication, there were no other treatments available while you waited for your surgery in Addenbrooke's at Cambridge. As your condition had improved, he was therefore content for you to go home with advice to return to hospital if you had any further symptoms ...

- 2.336 It is noted that this complaint was not initially provided to the Inquiry and raises again a question as to the effectiveness of the management of the complaints system. The matter only came to the Inquiry's attention because the Service Manager disclosed a note of the meeting between Dr Craig, Mr Young and Dr Watt on 30th August 2016 prior to his evidence to the Inquiry on 22nd January 2019.
- 2.337 The Inquiry Panel also notes that there does not appear to have been any investigation as to why there was a discrepancy between the response of Dr Watt and the complaint made. It appears that Dr Watt's response was treated as decisive, and no further investigation was required.

**INI 284:**

- 2.338 This is the second complaint by or on behalf of this patient. The gist of the complaint, which was received on 23rd May 2016, was that the patient had been waiting since February 2016 for Dr Watt to complete an Extra Contractual Referral (ECR) form. This case was also discussed at Dr Watt's meeting with Mr Young and Dr Craig on 30th August 2016. Dr Watt had undertaken, following that meeting, to review his dictated referral letter, when his secretary returned from leave.
- 2.339 This was a further case, which was not initially identified by the Trust and forwarded to the Inquiry. The Inquiry became aware of the complaint following the disclosure by Mr Atkinson of the notes of the meeting of 30th August 2016 between Dr Watt, Dr Craig and Mr Young prior to his evidence to the Inquiry on 22nd January 2019.
- 2.340 A formal response to the complaint was eventually made on 2nd November 2016 and signed by Mrs Owens, the Director of Unscheduled & Acute Care. The response did include a full apology from Dr Watt for the delay and it was disclosed that Dr Watt had completed the ECR form on 8th September 2016. The matter had been referred to Queen Square in London on 19th September.
- 2.341 When the complainant went to London, it transpired that none of her scans had been sent and that the appointment was, in the view of the complainant, "*a waste of time*". The four outstanding reports were then sent to Queen Square in time for the revised appointment on 30th November 2016.

2.342 As far as the Complaints Department was concerned, the fact that the referral was made and the subsequent radiological reports, which were delayed, were then furnished, that was the end of the complaint. This was not the view of the complainant, who telephoned the Trust on 18th May 2018. The Complaints Department commented to the Service Department by email of 20th May 2018:

As briefly discussed on Friday, I took a call from the above lady (15:49pm) she stated that she previously spoke to you about the complaint made regarding Dr Watt and that she considers this still open. I had a look on Datix and cannot find an open case. She would like you to call her.

2.343 On 22nd May 2018, Mr Atkinson, the Service Manager, was informed that the patient wanted a written response explaining why there was a downfall in communication at the time.

2.344 A formal response to the complainant's various telephone calls was issued on 11th December 2018. It is correct to say that Dr Watt had already apologised for the delay, and this had been included in the original response. The outstanding query from the Inquiry Panel, however, was why Dr Watt did not appear to have been challenged about his continual administrative tardiness. If he was being overwhelmed at work, then this would have been an opportunity to address that problem. The difficulty is that such questions did not seem to occur to those who were investigating the complaint.

#### **2007-2016 Consultant Neurologist Complaints:**

2.345 On 15th April 2019, in response to a written request from the Inquiry, the Belfast Trust provided details of the number of complaints made against each Consultant Neurologist since 2007. The said details are set out in the following tables in respect of the consultant neurologists employed in the Trust at the time of disclosure along with those who were no longer employed by the Trust. The Inquiry has not reviewed the handling of complaints in respect of the other Consultant Neurologists. The Inquiry is mindful that the details were prepared at the request of the Inquiry and understands that such a table did not exist prior to the Inquiry's request.

2.346 From other evidence obtained by the Inquiry it became clear that the number of complaints recorded against Dr Watt in the table below was lower than it ought to have been although the Inquiry accepts that this was not an attempt to mislead (the correct figure in respect of Dr Watt's complaints as ascertained by the Inquiry has been added in brackets by the Inquiry). It may also be that there are other complaints

that haven't been accurately recorded against the other consultant neurologists (some of whom also worked in other Trusts) however the general picture of having no more than one or two complaints per year was consistent with their oral evidence. According to the tables, Dr Watt was regularly receiving multiple complaints per year whereas by contrast only one other Consultant Neurologist had more than one complaint in any year since 2007.

Current Consultant Staff	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Michael Watt	12 (14)	1 (2)	0 (1)	4 (1)	0 (3)	0 (2)	3 (6)	3 (6)	1 (6)	3 (6)
Stephen Hunt	0	0	0	0	0	1	1	1	1	1
Gavin McDonnell	0	0	0	0	1	0	0	0	1	2
John Craig	0	0	0	0	1	0	1	0	0	0
Paul McMonagle	0	0	0	0	1	0	0	0	1	0
Ellen Campbell	0	0	0	0	0	0	0	0	0	0
Seamus Kearney	0	0	0	0	0	0	0	0	0	1
Karen Doherty	0	0	0	0	0	0	0	0	0	0
Thomas Peukert	0	0	0	0	0	0	0	0	0	0
John McKinley	0	0	0	0	0	0	0	0	0	0
Aidan Droogan	0	0	0	0	0	0	0	0	0	0
Stella Hughes	0	0	0	0	0	0	0	0	0	0

Former Consultant Staff	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Ailsa Fulton	0	0	0	0	0	0	0	0	1	0
Victor Patterson	0	1	0	0	0	0	0	0	0	0
Jim Morrow	0	0	0	0	0	0	0	0	0	0
Stanley Hawkins	0	0	0	0	0	0	0	0	0	0
Tom Esmonde	0	0	0	0	0	0	0	0	0	0
Mark Gibson	0	0	0	0	0	0	0	0	0	0

### Conclusions and Findings:

- 2.347 While the Belfast Trust has in more recent years augmented the Departmental Guidance and sought to address the problem of identifying the potential significance of a clinical complaint, the Inquiry Panel is not satisfied that there was, prior to 2016, sufficient understanding within neurosciences of what was trying to be achieved. Dr Craig’s description of the exercise as, in his words, “*a sense check*” may have been a misdescription of what was expected, but the Inquiry Panel saw no evidence that the review by Clinical Directors was discussed, explained or that adequate training on the Guidance had been given. Ultimately, medical notes and records were not reviewed when a complaint response was forwarded to the Clinical Director and the checks made were superficial and could not be described as a proper review.
- 2.348 The evidence regarding the number of complaints in respect of each Consultant Neurologist set out at paragraph 347 makes clear that Dr Watt was an outlier. Notwithstanding that the information was prepared to assist the Inquiry and was not as accurate as it could have been, it illustrates the general picture that anyone dealing with complaints in neurology should have observed. Whilst Dr Watt being an outlier in respect of complaints would not in itself indicate aberrant practice it ought to have led to greater curiosity and further investigation to understand if there was a pattern of clinical complaints and reason for concern.
- 2.349 Dr Craig in his evidence and having viewed the relevant documentation concluded:
- Whenever I look back on that, there is no doubt that there were more than clues in those complaints. The very themes that are often raised were similar to the themes actually that Dr Colin Fitzpatrick [Discussed in detail in the Chapter on November 2016 - May 2018] was raising, and which we have seen time and again since.
- 2.350 The Inquiry Panel agrees with Dr Craig and believes that it is difficult to resist the conclusion that, had the information contained within the complaints system been properly and independently analysed by someone with the relevant expertise, a problem could have been identified at a much earlier stage.
- 2.351 The revised guidance in 2019 and the original ‘*Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning*’, which were promulgated by the Department of Health in Northern Ireland, are both substantial documents of over 100 pages, which have detailed principles and a comprehensive framework. There was, however, a disconnect between the aim of promoting ‘safety and quality’ and the manner in which complaints were actually investigated and dealt with. To some

extent, the Department's focus on resolution and response times deflected those in Complaints Departments from properly considering patient safety issues. While guidance refers to minimising risk and identifying trends, there is a lack of detail on how this should be done. In a similar vein, while there was clear guidance on monitoring and recording, the systems in the Belfast Trust did not adequately and compendiously ensure that the key persons from a clinical perspective had a proper view in relation to all the relevant information about a doctor. This included when the Medical Director was investigating a concern about a doctor and the complaints relating to a particular doctor could contain extremely valuable information. This was demonstrated in the history of disclosure and by the fact that some complaints were not known about by the Medical Director's Office or, if they were aware of the existence of the complaint, the clinical issues had not been properly highlighted to the Office and noted for future reference. A system must support a Medical Director, who has a responsibility as the Responsible Officer, to be sighted, when necessary, on problems that have been identified elsewhere.

- 2.352 Paragraph 4.2 of the guidance in 2019 requires "*effective processes in place for identifying and minimising risk, identifying trends, improving quality and safety and ensuring lessons are learnt and shared*". The reality is that the processes in place were almost wholly ineffective prior to November 2016 in identifying trends or ensuring lessons were learned.
- 2.353 Triangulation of data is perhaps an esoteric term, but it is a critical tool in any evaluation of a complaints process. Essentially it allows an investigator to collate all the relevant information to ensure that a decision-maker is fully sighted on the relevant material. There are many examples of where this did not occur such as:
- (i) Mr Peter Walby's summary of issues to the GMC in 2005, which missed any number of the now destroyed complaints and contemporaneous complaints regarding report writing.
  - (ii) Mrs Pauline Webb's summary report to the Medical Director in December 2006 omitted numerous relevant complaints.
  - (iii) In 2012 the Datix print off revealed only 5 complaints, which was used to inform the Trust's response to a GMC query regarding INI 45.
  - (iv) The failure to recognise potentially significant complaints referred to in DDCRM in June 2013.
  - (v) When Dr Ken Fullerton commenced his Finding of the Facts exercise, he was only given 6 complaints by the Neurosciences office.

- (vi) The DDCRM in 2016 was not informed of salient complaints.
  - (vii) In 2018 when the Trust eventually asked for and looked for all complaints, a number of significant complaints were discovered for the first time.
  - (viii) The absence of significant complaints from the pink file in the Medical Director's Office.
  - (ix) The difficulties experienced in ascertaining the true number of relevant complaints as evidenced by the disclosure of 100 potentially relevant complaints over 3 years after the Inquiry commenced.
- 2.354 The present target of dealing with complaints is weighted towards 'resolution' of the problem within proscribed time limits, as set out in Regulation 14 of the Health & Social Care Complaints Procedure Directions (NI) 2009. The 20 working days for response is something which is measurable, and this has become a focus of review, despite the fact, that it was almost never achieved in relation to clinical complaints. The timeframe for clinical complaints is wholly unrealistic and needs to be changed. It is not surprising that the present emphasis within the Trust is on meeting the target time for a response as opposed to ensuring the quality of the answer given or any learning, which might be derived from the complaints. If staff are measured on response times, and that is the priority set by the Department of Health, then that is what they will concentrate on.
- 2.355 The storage and retention of complaint data must be an urgent priority for the Belfast Trust. In this regard, while the independent review into the destruction of relevant material in September 2018 was a welcome sign of a serious approach being taken by the Trust, the recommendations advanced by the review do not go far enough. The Inquiry Panel agrees with Dr Michael McBride that clinical complaint material should be retained throughout the career of a doctor to ensure patient safety. In this regard, the Inquiry sought a legal opinion from David Scoffield QC (now Mr Justice Scoffield) and Alistair Fletcher BL on the retention of complaints material in light of GDPR and other legal requirements. The opinion concluded:
- It seems to us that, in principle, this information can be lawfully retained by a responsible officer as it concerns a matter that is intimately related to their role under the Regulations. There is a specific obligation to investigate concerns raised by patients or staff; and to record the details of what steps are taken. Our starting point is that any information raising legitimate concerns about patient safety is entitled to be retained for so long as it may be relevant to the protection of patient safety. In general terms, this is likely to be for so long as the relevant clinician remains in practice and treating patients.

- 2.356 The Inquiry Panel strongly agrees. If patient safety is to be paramount and trends are to be identified, then relevant clinical complaints' material should be retained throughout a doctor's career.
- 2.357 The Inquiry Panel noted the evidence of Mr Frank Young<sup>15</sup> on 22nd April 2021, former Co-Director of the Neurosciences Division in relation to the overall issue of complaints. In his prepared statement, given in response to a number of questions posed in advance by the Inquiry Panel, and received by the Inquiry on 16th April 2021, Mr Young reflected:

The Department of Health and the Health and Social Care Board expect that all complaints verbal or written are responded to within 20 days of receipt. The focus of dealing with complaints was placed on time limits and answering complaints, not on assessing or analysing the content of complaints. Within my division on a daily basis an average of four Assembly or Parliamentary questions were forwarded by Corporate Communications and had to be responded to by close of play that day or within 48 hours ...

Historically each Directorate had its own dedicated complaints personnel but due to retirements, reorganisation and staff shortages, complaints had become centralised, and in doing so organisational memory and knowledge were irretrievably lost. In effect what this meant was that there was no one to see a problematic pattern emerge and pull senior management aside.

... getting responses turned around as soon as possible were seen as an overriding objective and analysis of the reasons a complaint had been made in the first place became secondary. There simply were not the resources to do both well and in hindsight this system was imperfect as it really failed to be timely or analytically useful.

- 2.358 Mr Young in his evidence to the Inquiry Panel on 22nd April 2021, augmented a number of his earlier prepared responses:

... the Service Manager got the patient's notes, looked at what was going on, and we put together a response. I would have reviewed that. Then it was topped and tailed by the Complaints Department. Then it had gone to the Director. If the Director looked at that and said, 'not happy about this,' or, 'I want more information,' that came back, it was clarified. Then once that was done, it went back to the Director, and then the response went out. We had a response time of 20 days, and for most complaints it's a nonsense ...

We didn't have a robust system around the management of complaints. It was more about turnaround.

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<sup>15</sup> Co-Director of Unscheduled & Acute Care.

I can remember speaking with Bernie Owens as the Director and saying, 'this isn't working.' The Complaints Department just ain't fit for purpose and we needed to have our own dedicated complaints manager within Unscheduled Care, because of the number and the complexity. I was told, 'no, it was being organised centrally.' It had been centralised and that was that, because if you appointed a complaints manager that probably would have been at an 8A or an 8B level and somebody was going to have to fund the budget.

- 2.359 While Mr Young was correct in his observation that the Complaints Department was not set up to investigate complaints, but to run a process, the Inquiry Panel does not share his view that a dedicated Complaints Manager within neurosciences would have made any difference. The fundamental problem was that the focus at all times remained on resolving the complaint rather than evaluating the clinical aspect of a complaint or recognising if there was a potential patient safety issue.
- 2.360 It is regrettable that the issues surrounding complaints were not appreciated or grasped by senior management despite the findings of the Lamey report in 2013<sup>16</sup>. The Inquiry Panel appreciates that there were budgetary constraints, but there is little evidence of evaluation or reflection on the system generally. The result was the delivery of a complaint service that contributed little to the critical process of identifying patterns of aberrant practice or improving patient safety generally.
- 2.361 The style of the response was often to describe the process by which the patient had been managed, sometimes to repeat the result of investigations, and to apologise profusely for the fact that the patient was in some way aggrieved. Whether or not the complaint was valid was usually not assessed or commented on and, therefore, no learning could conceivably be derived, or underlying trends identified.
- 2.362 What became a rigid response template was in contradistinction to the stated aim of the Trust as set out in the DOH guidance to inter alia: (i) address the concerns of the complainant; and (ii) to learn from complaints.
- 2.363 Unfortunately, the actual focus on ensuring an efficient and timely response undermined the more important aims of ensuring that:
- (a) All clinical complaints are adequately considered by the Clinical Director or someone of equivalent expertise and seniority. Such person examining should have access to the medical notes and records and provide a conclusion as to whether the clinical concern in the complaint is substantiated or not, as the case may be.

<sup>16</sup> The Lamey Report was a non-statutory report chaired by Brian Fee QC, which considered the actions of the Trust in relation to the investigation of a dentist within the Belfast Trust.

- (b) If the Clinical Director or equivalent is for any reason unable to come to a view on the substance of the complaint, then the matter should be referred to an independent expert outside the Trust for an independent view.
  - (c) An investigation is carried out, or at least informed, by someone competent to address the complaint from a clinical standpoint.
  - (d) Complaints would be collated in such a manner as to enable effective interrogation by the Medical Director's Office to gain an accurate picture of the history of complaint as well as for review in the appraisal process.
  - (e) Patterns of certain types of behaviour or concern would be a specific focus of those investigating and evidence of similar complaints would be a trigger to more in-depth investigation.
  - (f) The outcome of all complaints should be retained and available for future reference and inquiry.
- 2.364 In those cases where efforts were made to address a clinical concern, it was felt sufficient to ask for the views of the clinician who was the subject matter of the complaint, rather than also seeking an informed view from another clinician in the same specialty. While the Clinical Director may have sometimes checked the response, he did not access or review the medical notes or records. Unsurprisingly, his comments were limited. It is obviously critical to obtain the views of the treating physician but if the answer given does not accept that there is any problem, little if anything will be learned without some form of independent review.
- 2.365 A further issue is that complaints tended to be generic and included a wide variety of concerns from car parking to catering. Discerning when a diffuse complaint had a clinical component or identifying a pattern of concern often required specialist expertise. Neurology complaints were sent to the Neurosciences Service Manager, who, in most circumstances, would not have been in a position to assess such a complaint in the absence of specialist advice. Too often the procedure followed was limited to obtaining a response from the physician, who was the subject matter of the complaint and developing a formal reply on that basis. This clearly led to many significant issues being missed.
- 2.366 The principal manner where a complaint was considered by a medical practitioner was through annual appraisal. This process, however, was primarily one of self-reflection by the appraisee, occurring months and often years after the treatment in question, and was not focused on identifying aberrant patterns of practice. This

is commented upon further in the Appraisal & Revalidation chapter. The evidence suggested that, in relation to Dr Watt's appraisals, when they did occur, complaints were not recorded consistently or, sometimes, at all. Unless the appraisee was alert to ensuring that all complaints were considered at appraisal, then, as the situation with Dr Watt's appraisal demonstrated, complaints which had not been properly or independently investigated in the first place ended up in a Datix system, which did not reveal the full extent of the complaint. This may have been because the complaint was categorised in a different way or not attributed to the relevant clinician(s).

2.367 What is clear, however, is that when required, the Medical Director's Office needs to have a clear overview of all complaints to ensure (i) that they have been reflected upon by doctors; (ii) that patterns of potentially aberrant behaviour are identified and (iii) that learning can occur. At present the Medical Director's Office will ask the Complaints Department to search the Datix system and provide a list of relevant complaints especially prior to revalidation. If that record is incorrect then the system is diminished in its effectiveness.

2.368 The Inquiry noted carefully that when the Independent Neurology Inquiry was announced in May 2018, the Belfast Telegraph published an article,<sup>17</sup> which highlighted the views of the Trust regarding complaints:

On Wednesday, Dr Jack told the BBC: "We've reviewed our complaints over the last seven years and there is no red flag in relation to the complaints and in particular none around his diagnosis and treatments."

But last night the Belfast Trust said that no complaints made by patients regarding Dr Watt were seen as "red flag" issues.

"Most doctors receive complaints from time to time, some of which may be about diagnosis and treatment pathways," it said in a statement.

"We take every complaint very seriously and they are thoroughly and fully investigated through a robust complaints procedure." Dr Cathy Jack was completely accurate in her explanation." Any complaints received regarding Dr Watt (of which there were few) were fully investigated and did not raise any areas of concern."

2.369 The Inquiry carefully considered whether, in retrospect, there were any "red flag" issues, to what extent those complaints that were received were "thoroughly and fully investigated through a robust complaints procedure" and whether those complaints did not raise "areas of concern".

<sup>17</sup> Belfast Telegraph 4th May 2018. Article entitled: *Belfast Trust patient recall: Northern Ireland mum reported concerns four years ago after frightening diagnosis put life on hold.*

2.370 Dr Jack provided a detailed statement to the Inquiry in September 2021, which sought to clarify several issues that had been raised earlier by the Inquiry about the statement to the BBC and the subsequent reporting in the Belfast Telegraph. The statement is reproduced at length as the issue requires detailed scrutiny:

**During your attendance of 12th December 2019, a BBC News article dated 21st May 2018 (wherein it was indicated that the Trust had reviewed complaints for the preceding seven years and you are quoted as stating that there was “no red flag” in relation to the complaints. In evidence, you stated as follows:**

**Dr Jack:** Within about half an hour, it was OK, and there was a conversation about, “What am I going to say about complaints?” and, basically, there’s no red flag – now I think there was a wee histogram or something or a table from complaints sent up, where a lot of them were communication or waits or delays. They’re only categorized into one element, so you look at that: you know, “There isn’t anything here, Cathy”. You go on and you say it. And now, you know, that statement’s going to haunt me, isn’t it? I would not have said it ... If you’d had two weeks, if you’d had the complaints file ...

**Please consider the email chain into which you are copied on 24th April 2018, and wherein complaints data from DATIX is shared directly of complaints concerning Dr Watt was, therefore, held within the Medical Director’s Office from at least 24th April 2018.**

**Please provide any further comments you may have in respect of this issue in light of your previous evidence to the Inquiry.**

**Dr Jack Written Response.**

This question relates to the interview I gave to the BBC, a small aspect of which was carried in the BBC news article of 21 May 2018 to which I was referred by the Inquiry. The BBC Newsline interview itself was at lunchtime on 2 May 2018. This was the day after the Belfast Trust announced the initial recall of approximately 2,500 patients. It was also the day I was to meet with hyponatremia families. It was to be the first meeting with the families since the hyponatraemia report was published. The meeting had to be cancelled on the morning of 2 May 2018, due to a bereavement occurring in one of the families. However, in the week prior to 2 May 2018, I had spent a substantial amount of time preparing for the meeting. This Inquiry will be aware that the main body of the Hyponatremia Inquiry report alone was more than 400 pages.

On the day of the recall itself the preparation included lengthy discussions with the Trust bereavement coordinator on the appropriate approach to take with these deeply distressed and heartbroken families.

The evening before, 1 May 2018, I was also involved with senior staff in the Belfast Trust dealing with an urgent communication from the Department of Health (DoH) about an upcoming Institute for Health Improvement Conference in Amsterdam. A DoH letter received at 17.00 required a response before 22.00. A substantive detailed reply left the Chief Executive's office at 19.45. At 10pm on 1st May 2018 Peter Watson left with me a 26-page timeline in relation to Dr Watt. The timeline did not have reference to any complaints. Even by the standards of the Belfast Trust, the 1 and 2 May 2018 were extremely busy and lengthy working days, and my focus was not on preparing for a media interview regarding Dr Watt that I did not know I had to give. I openly admitted to the Inquiry on 12 December 2019 (see internal page 9 of the transcript of 12 December 2019) that my reflection on the subject interview was that it would "haunt me". I had not expected to be doing the interview.

What I was trying to explain to the Inquiry during the session on the 12 December 2019 (I did not know the Inquiry was going to raise this issue with me; I had prepared to deal with matters from a much earlier period of time) was that I had not had the opportunity to prepare for it in the way that I would have liked. On the day of the interview, I was involved in discussions with the then Chief Executive, Martin Dillon, when the Trust's head of Corporate Communications came in and said one of us would have to do a television interview about the neurology recall. We discussed it, and, as it related to a doctor, we agreed it was appropriate that I, as Medical Director, should do it. We had a very short time to prepare what I was going to say. We discussed, amongst other things, the subject of previous complaints. I previously acknowledged before the Inquiry, that the Inquiry has a much fuller picture than we had at the time. The position, based on the information we had, was that there were "no red flags". My recollection is that the phrase "no red flags" was in fact one first suggested by Martin Dillon in our discussion, though it is my responsibility for having adopted it and used it during the interview. As I reflect on it now, it was not a useful phrase to use because the general public would not necessarily have understood what I meant by it as a Medical Director in the context of complaints relating to doctors.

The Inquiry has drawn my attention to an email that Rachel Maxwell sent to Peter Watson on 24 April 2018 at 11.30. It is clear from the email that the previous day Peter Watson had sought the known complaint history of Dr Watt. Ms Maxwell provided a 10-page summary table of the complaints known to her.

The Inquiry has asked me to accept that this communication from Ms Maxwell indicates that knowledge of complaints relating to Dr Watt was held within the Medical Director's office from at least 24 April 2018. I have no difficulty accepting this proposition, and do not believe I or others have ever suggested otherwise. It was always the case that I knew there had been complaints about Dr Watt. In fact, I believe I explained to the Inquiry that there was information

on some complaints relating to Dr Watt contained within the relevant pink file in the office of the Medical Director.

The point about the available information, as it was understood at the time, was (leaving aside the November/December 2016 concerns that prompted the restrictions) that none of it amounted to the type of concern that would have caused the Belfast Trust to consider that the medical practice of Dr Watt was putting the safety of patients at risk. That was the point I was trying to convey during my interview with the BBC. One of the key aspects of learning for myself, arising from this process, is about the information I based my answers on during the BBC interview. I answered on a mistaken belief that our complaints handling in the Belfast Trust was robust enough to identify a performance concern about a doctor.

- 2.371 The Inquiry Panel welcomes the clarity of Dr Jack’s written response and agrees with her that complaint handling in the Belfast Trust was not robust enough to identify a performance concern. It is also fully accepted by the Inquiry Panel that Dr Jack was not in any way seeking to mislead and was at that time preoccupied with other matters of real gravity. Nevertheless, there are other aspects of the events at this time which raise further concerns not just about the complaints process, but the manner in which information is collated:
- (i) While a long list of complaints had been forwarded to the Medical Director’s Office. The list was far from complete.
  - (ii) There was little or no focus on anything, but the events post December 2016 and the pervading sense that action had been taken following Dr Fitzpatrick’s concern and the subsequent Royal College of Physicians review.
  - (iii) The dichotomy implicitly introduced by Dr Jack in her explanation to the Inquiry between *“a concern which was putting the safety of patients at risk”* and other complaints/concerns is unhelpful. The Inquiry believes that when matters emerged, a detailed evaluation of other concerns/complaints should have been carried out by the Medical Director’s Office. Those in the Neurosciences Division should have been queried about and should have volunteered that there were previous concerns and This should have disclosed that, as recently as August 2016, Mrs Owens the Director of Acute Services had directed a conversation with Dr Watt about a range of matters of concern.
  - (iv) To rely on the robustness of the complaints system was misplaced. The complaints system was not fit for purpose, if one of the stated aims was to ensure that learning occurred.

2.372 The Inquiry Panel further noted that Brian Fee QC, who provided a report to the then Minister for Health in relation to the dental practice of Professor Lamey<sup>18</sup>, made a specific recommendation that all clinical complaints should be independently investigated.<sup>19</sup> It is not clear to the Inquiry Panel that this recommendation was implemented by the Department or led to any substantive change to the extant guidance.

2.373 It is instructive to recite the following extracts from the Lamey report on the question of dealing with complaints and concerns:

4. A protocol is required in relation to the assignment of each complaint/concern to the SAI, MHPS or other process. This protocol would include documenting the considerations and deliberations which informed the rationale and the reasons for choosing which process to follow, together with details of the parties to the decision. It would be prudent to avail of the opinion of the Board, in particular, when making the decision, as sometimes happens at present. The decision, when taken, should not be considered as definitive. It should be subject to regular review (frequency to be determined) as investigations, such as look-back exercises, are progressed and be subject to escalation or de-escalation, as appropriate.

5. A template is required to record interactions, consultations, advices, deliberations, decisions, rationale and progress in relation to SAI and MHPS investigations.

6. The raising of an SAI/MHPS should result in the generation of a living document/dossier of all related material which would facilitate the ongoing investigation, reports and response to queries.

7. Risk assessments need to be conducted at intervals during the investigation process and as information emerges. Patient safety should always be the criterion for escalation irrespective of other considerations.

8. Commissioned reports, expert opinion, advices from regulatory bodies and NCAS should be used to inform and, if appropriate, alter the course of the investigations/look-backs. The institution, in its own right, has an obligation to uphold and foster patient safety and quality assurance on behalf of its patient cohort and to exercise a level of urgency in so doing.

9. It is necessary to ensure that those charged with conducting investigations, look-back exercises, etc are willing and able to devote the time necessary to bring

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<sup>18</sup> The Report was published by the then Minister for Health in 2013.

<sup>19</sup> See Page 68 at [40]. "When a Trust receives a complaint concerning the clinical performance of a consultant level staff, an opinion from an appropriately qualified consultant independent of that Trust should be obtained on the merits of the complaint unless there are exceptional reasons for not so doing"

the exercise to a conclusion within a reasonable time frame. Regular review and evaluation should ensure that if expectations in this regard are proving difficult to meet, the matter is documented and brought to the attention of all bodies for resolution.

10. Human Resource concerns in respect of any employee need to be recorded and collated. This would include complaints; issues raised by the employee; differences in perception; expectations; compliance and non-compliance all of which should be documented and followed to conclusion through the use of a stepped protocol, which if it exists needs to be implemented and adhered to in all cases.

2.374 What is concerning to this Inquiry is that the current system relies on the proactivity of a small number of individuals, while others in the system are insufficiently aware of their governance responsibilities. This chapter has highlighted and commented above on the reasons that the current arrangements do not work effectively.

2.375 The Inquiry does recognise that under the leadership of Dr Jack, both as Medical Director and subsequently as Chief Executive, the issue of complaints has been highlighted as one of the main themes of emergent learning. Work has commenced<sup>20</sup> in relation to a structured case note review for complaints and the issues raised regarding complaints have been prioritised. It remains to be seen to what extent this addresses, what the Inquiry Panel believes was a fundamental problem.

2.376 In summary:

- (i) Information was kept by the Complaints Department, the Medical Director's Office and, in Dr Watt's case, the Neurosciences Directorate. Maintaining information within such silos ensured that no one person, and, in particular, the Medical Director, was able to take an overall view and numerous opportunities were missed with regard to Dr Watt's practice in being able to both identify concerning patterns of clinical diagnosis and adequate and independent investigation of relevant complaints.
- (ii) There was no systematic way of collating clinical complaints and of looking at the information available. This difficulty was identified in the report of the Dental Hospital Inquiry chaired by Brian Fee QC. At Paragraph 8.1.2 the report stated:

It does not appear that these various concerns were contemporaneously collated into a single record or file. It may be that Trust management had

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<sup>20</sup> Full details of the actions taken are set out in the footnote to para 22

anecdotal knowledge of all the concerns, however, the records obtained do not suggest a proper or adequate system for recording or collating concerns in respect of the quality of care or clinical performance delivered by Dr X.

- (iii) The Inquiry found that this concern had not been adequately addressed and that it was still difficult to construct an accurate and contemporaneous overview of a doctor's practice in a single record or file, notwithstanding the Datix system.
- (iv) The method of responding to complaints was inadequate and resulted in a system of response, which was artificial, patronising and ultimately inept from the point of view of investigation. It was only in recent years that the first steps were taken to obtain an independent view from a relevant specialist outside the Belfast Trust. While this is to be welcomed, there remained confusion about the role of the Complaints Department, the Service Department investigating and the resolution of complaints. Even the term '*resolution*' can lead to confusion. The absence of a system, which upholds, dismisses, or requires a complaint to be further investigated, ensured that clinical complaints were not adequately addressed. Apologising profusely for a patient's distress, in most cases at the beginning and end of every letter, tends towards the disingenuous and ultimately causes many people to either give up or develop a cynicism towards the Trust. For those few complainants, who had the patience to persist, they were offered nothing greater than more profuse apologies or greater clinical detail.
- (v) If the Complaints Department is performance-managed solely on response times, then that will become their primary focus as that is what they are measured against. If the Service Departments are reticent to go beyond the clinician, who has been the subject of complaint, and are unable to challenge a doctor, then the result will be a complaint that is responded to inadequately and without ever addressing the question that has been asked. Reciting long chronological histories of a patient's involvement with the Trust is only of value if this sets out the context in which the complaint is addressed or analysed.
- (vi) The evidence in relation to many complaints set out above would suggest that Service Managers and administrators are reluctant to challenge a doctor.
- (vii) There was, until recently, little evidence of the person investigating accessing a view form another suitably qualified clinician other than the clinician to whom the complaint related. The responses of the Trust were written in a

generic format, which apologised profusely for the distress of the complainant, recorded in minute detail the interactions of the patient with the Trust, but almost invariably failed to address the substance of the complaint.

(viii) A further failing of the system was that when complaints were being assessed or considered in light of ongoing concerns the person reviewing, if they were medical, would often deem that they were competent to assess the medical aspects of a complaint, even if the issue raised was outside their own specialism. While the Inquiry Panel recognises that it will not be every complaint that justifies obtaining an independent opinion, using relevant specialists outside the Belfast Trust, neither can it be appropriate to simply check with a doctor who is the subject of the complaint as to their view of what has occurred.

- 2.377 The Inquiry Panel is aware that, in some cases, the Neurosciences Directorate was faced with complaints, which were both complex and diffuse. On occasion, extraordinary efforts were made to both deal with the issues arising and resolve the complaint. The system lacked a filter or overview which would have given some relief to those, such as the Assistant Service Manager and Service Manager in Neurosciences, who often invested countless hours in seeking to come up with a detailed response that was sometimes immediately answered in the most exhaustive detail by the complainant. Obtaining detailed replies to a wide range of questions from numerous medical professionals, including consultants, often took months and sometimes years of delay. In the view of the Inquiry Panel, early analysis of the substance of the complaint, and an assessment of its clinical seriousness, could lead to a proper sifting of complaints, which would ultimately reduce the time taken with less serious complaints or complaints that are easily answered. The focus on providing extensive response in every case is not an efficient use of resources.
- 2.378 There needs to be a mechanism within the system, and as a part of the overarching Department of Health guidance, that allows for the Trust to give the best response they can (after appropriate investigation) and not be embroiled in years of fruitless correspondence. As ever, the driving force should be patient safety. There would be an obvious benefit in having another consultant review a complaint to discern: whether there is a clinical issue that needs to be investigated. The process may also help to discern whether a complaint is unjustified or even vexatious, at which point the Trust can adopt a more laconic response.
- 2.379 The complaints system was unfit for purpose and needs a radical overhaul to ensure that complaints are properly collated, stored and analysed in a way that will assist the Medical Director/Responsible Officer to have the most comprehensive picture

possible of a doctor's practice and have the opportunity to identify patterns of behaviour, which give rise to additional concern.

- 2.380 When Northern Ireland's largest patient recall was announced in May 2018, the Trust was placed under intense media scrutiny. One of the obvious questions that emerged was whether the issues surrounding Dr Watt's practice had been apparent to the Trust prior to November 2016 when Dr Fitzpatrick raised concerns directly with the Medical Director's Office. It is at this point that the various departments involved in such matters needed to co-ordinate carefully to ensure that accurate information was both collated and highlighted. Unfortunately, the public reassurances given by both the Medical Director and Chair of Division were unintentionally misleading. The fact is that there was information in various places, which should have alerted Trust managers to a pattern of potentially aberrant practice. Complaints that had apparently been investigated should have been reviewed and the Trust should have intensively focused on ensuring that the information available was properly triangulated.
- 2.381 To state, as Trust spokespersons did to the Belfast Telegraph in May 2018 that complaints were: (i) taken seriously; (ii) thoroughly and fully investigated; and (iii) considered through a robust complaint procedure, was manifestly wrong. In the view of the Inquiry Panel the complaints system was broken and contributed little to the essential process of identifying problems. Complaints were not adequately investigated and information was not properly collated or classified. The Medical Director's Office had only a partial view of the entire complaints picture and the investigations carried out within Neurosciences not only failed to identify clinical issues, but adopted an investigatory method that almost guaranteed an outcome that found nothing of substance or concern.
- 2.382 In a written submission sent to the Trust on 4th April 2022, full details of the initiatives taken by the Trust since the advent of this Inquiry in May 2018 are outlined.<sup>21</sup> The Inquiry Panel welcomes the priority this matter has been given and, although not in a position to evaluate the actions that have been initiated, recognises that undertakings given to the Inquiry at an early stage have been taken seriously and implemented.

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<sup>21</sup> See paragraphs [21] to [23] *supra*.

## CHAPTER 3 – LONE PRACTITIONER WORKING AND PRACTICE VISIBILITY

### Introduction:

- 3.1 Paragraph B of the Terms of Reference requires the Inquiry to review the Trust's participation in processes to maintain standards of professional practice. The focus on examining lone working arose out of the evidence presented at an early stage of the Inquiry to the effect that Dr Watt's practice was relatively isolated from that of his colleagues.
- 3.2 The Inquiry heard that, initially, for the purposes of conducting ward rounds, there were 3 consultant teams within Neurology: 'A', 'B' and 'C'. Team A was comprised of 2 consultants and Teams B and C were each comprised of 5 consultants. Following the retirement of Dr Stanley Hawkins in 2012, the Belfast Trust Neurology Department had 2 teams comprising 5 consultants each (Teams B and C) and one 'team' with 1 consultant (Team A). From 2012 to 2017, Dr Watt was the sole remaining consultant practising in Team A. This imbalance was never addressed.
- 3.3 It is accepted that organising consultant teams for inpatient care is much more practicable than arranging a team for outpatient care. Inpatient care involves a relatively small number of patients who will be in hospital for a period of time. In contrast, outpatient care can involve a large number of patients, who may only be reviewed for a brief period of time by a consultant at a clinic. Dr Watt had several outpatient clinics where he would review many patients. While he was often assisted by a registrar and liaised closely with consultants from other sub-specialties in those clinics, the opportunity for the kind of team working seen in the inpatient context would have been more limited.
- 3.4 The views of all neurologists in respect of peer review and team working were sought. In addition, the Inquiry Panel sought explanations from management as to its view of extant practices. The concepts of peer review and multi-disciplinary team working were accepted by almost all the medical witnesses to the Inquiry<sup>1</sup> as being a positive and important working practice. As outlined below, many consultants also felt that team working offered the most effective safeguard against aberrant practice.

<sup>1</sup> The Inquiry does note that Dr Paul McMonagle, a Consultant Neurologist in Team C of the Belfast Trust Neurology Department, acknowledged that multi-disciplinary teams undoubtedly had a place for inpatient care and many outpatient disciplines, but was concerned that in some situations peer review teams could slow down progress, particularly where there was pressure on waiting lists. In his view, there were more multi-disciplinary structures at the Royal Victoria Hospital than in many other hospitals where he had worked.

- 3.5 The terminology is at times confusing and ‘multi-disciplinary team working’ and ‘peer review’ between colleagues are sometimes conflated and used interchangeably. There is, however, a distinct difference. In multi-disciplinary teams a patient is assessed collectively by a range of professionals across various disciplines, such as nursing, social work, medical, etc. Participants seek to integrate their contribution with the overall goal of improving the patient’s care. By contrast, consultant peer review, as operationalised within the Neurology Department in the Belfast Trust, is *intra*-disciplinary and tends to involve consultant colleagues in the same specialty liaising with each other and, on occasion, working together on the treatment of a patient. Although the focus is on collaboration, there will be, to some extent, an element of assessment or evaluation occurring.
- 3.6 Peer review, in this sense, covers more than just *intra*-disciplinary teams and there are a number of existing mechanisms through which a consultant may have the opportunity to either work alongside, or discuss cases, with peers. It is the case that the Neurosciences Grand Round, Morbidity and Mortality meetings for neurology and specific audits were part of an overall peer review system within the Belfast Trust. For instance, neurology consultants and registrars within the Trust will engage with specific Morbidity and Mortality (“M&M”) meetings for Neurology<sup>2</sup>, where adverse outcomes are discussed between colleagues with a view to distilling learning and improving patient safety. Similarly, a weekly Neurosciences Grand Round meeting takes place, which is attended by a variety of colleagues from across the Neurosciences Division, e.g., neuroradiology, neurology, neurosurgery, and neuropathology. The Grand Round provides an opportunity for difficult or interesting cases to be presented and discussed and for learning to be shared. Typically, practitioners deliver presentations on a rotating basis. Dr Watt was reported to have attended many, if not most of these meetings. The Inquiry is aware that Dr Watt gave three presentations in the Grand Round meeting on cases of suggested spontaneous intracranial hypotension<sup>3</sup>.
- 3.7 In addition, various audits of procedures or other discrete aspects of neurology practice will, from time to time, be carried out. Clinical audit may, if specifically targeted, identify discrepancies in practice. Whilst the limitations of such audits are recognised, it is considered that they may, potentially, provide an opportunity for valuable insight into aspects of an individual’s practice which may not otherwise be readily visible.

2 In his oral evidence on 2nd May 2019 Dr Jamie Campbell, now a Consultant Neurologist in the Southern Health and Social Care Trust explained that M&M meetings in Neurology did not occur when he was a registrar in the Belfast Trust which was from August 2011 up until January 2017.

3 This is discussed in more detail in the chapter on Epidural Blood Patching.

- 3.8 The more specific focus of the Inquiry, however, relates to opportunities for consultant peer review, particularly in *intra*-disciplinary teams, within the Neurology Department. The Inquiry was keen to explore how lone working came to be a feature of Dr Watt's practice and the view that was taken of this arrangement by those in Trust management.
- 3.9 In light of the above, the Inquiry Panel wished to consider: (i) the extent to which team working was considered beneficial by the medical professionals involved; (ii) how it developed that there was a 5:5:1 working arrangement in the 3 Neurology inpatient teams; (iii) to what extent this was commented or reflected upon by management, and (iv) the actions, if any, that were taken to redress the imbalance between the teams.

#### Advantages of Team Working:

- 3.10 The Inquiry canvassed with all Consultant Neurologists and registrars their view of team working and the extent to which they believed that such a method was a protection against the development of aberrant practice. There was a strong consensus that team working was not just advantageous, but essential and extracts from the evidence are set out below.
- 3.11 In oral evidence on 15th January 2019, Dr Ailsa Fulton spoke positively of her experience of working with her Consultant Neurologist colleagues, Dr Orla Gray and Dr John McConville, in the Neurology Department of the South Eastern Trust at the Ulster Hospital. Dr Fulton highlighted how *intra*-disciplinary teams can afford some opportunity for peer review:

With Orla Gray and John McConville. We grew up together as registrars ... we all know each other fairly well, and certainly, communication I think, between the three of us is very strong. We don't always agree completely. We go round together on a Friday as an MDT. On a Friday, we have ward consult sessions, and on a Friday, the three of us are all on the Ulster site, except Orla once a month is in Lagan Valley, but the rest of the time we're there. We go round together, and we really use that as an opportunity, so if one of us is seeing somebody who is a bit sick or we're not really sure what's happening or we've seen them and we think they need to be given something strong like maybe consider cyclophosphamide, rituximab, some of the very invasive therapies, we would use the Friday as an opportunity to say to the others, "What do you think of this case? Do you think this is a reasonable approach?" And it's really useful. And even in outpatients, you know, probably less than once a month, one of us might ask another to have a look at somebody and the patients will kind of cross paths.

- 3.12 In oral evidence on 28th March 2019, Dr Seamus Kearney, a Consultant Neurologist in Team B of the Belfast Trust Neurology Department, highlighted both the difference between multi-disciplinary and *intra*-disciplinary teams and the advantages of several consultants sitting down to talk about each other's patients:

My view is that there's a difference between multidisciplinary teams and multi-consultant teams. So, neurology is probably quite uncommon to have the current set-up for teams B and C, whereby you've got several consultants sitting down, talking about each other's patients and, you know, then going to see the patient collectively ... I think there are definite benefits in it ... I don't see any disadvantages to it.

- 3.13 In oral evidence on the 20th December 2018, Dr John Craig, Clinical Director for Neurosciences and part of Team B in the Neurology Department at the Belfast Trust, gave particularly clear evidence about the benefit of team meetings:

... whenever we have our team meeting, everything's presented. It's warts and all. So, you know, my cases will be presented in front of other neurologists, and these are often elective cases. So these are not necessarily people who've come through the doors of [the Emergency Department] and I just happened to inherit them because I was on call last night. These are people, for example, I'm bringing in who I think they've got a particular type of epilepsy. They might be a surgical candidate. Sometimes when it's being read out, what I'm doing — not what I'm doing, what I've brought them in for, it's, "Did I really think that?" But there's the opportunity for other people to question you and all the rest of it.

So, in a specialty like ours, where we spend most of our time in our rooms on our own, maybe with a nurse but often not with a nurse. When I do my [District General Hospital] clinic in Newry, I'm the only neurologist in Daisy Hill. I'm the only neurologist ever in Daisy Hill. So, there's nobody to look over my shoulder or question me. But, again, taking into account that we spend most of our time on our own, I think we really have to be clever in how we use the opportunities when we're together, and, clearly, team-based working and hearing what people are doing, there's a huge educational component to it. I'm far better at movement disorders now than I was two or three years ago, because I've got the other colleagues.

- 3.14 The Inquiry Panel recognises that neurology in Northern Ireland is a regional specialty, which entails a greater preponderance of outpatient attendance outside the Belfast Trust. As Dr John Craig explained, a number of Belfast Trust neurologists provide neurology clinics at District General Hospitals, where they are the only neurologists. The opportunities, therefore, for team working are more limited than within other sub-specialties. Further, the benefits of working as a team are also

clearly illustrated when neurologists deal with inpatient admissions in the Royal Victoria Hospital.

- 3.15 The advantages of team working were strongly endorsed by practising neurologists. The experience gained from seeing a large volume of patients is critical and, whilst the ability to always work in a team may be at times limited, the importance of receiving the advice and input of colleagues is heightened in the context of a specialty that deals with high numbers of cases, where diagnosis can often be complex or protracted.

#### History of Working Arrangements:

- 3.16 Given the benefits peer review and team working present, the Inquiry sought to understand the genesis of the working arrangements within the Belfast Trust and the impact upon the practice of neurology within the Trust during the relevant period. The history of how *intra*-disciplinary teams were constituted and maintained was discussed in oral evidence by a number of neurologists. Pressure initially seems to have originated from nursing staff to improve the efficiency of ward rounds. This was explained by Dr Aidan Droogan in his oral evidence on 10th April 2019. Dr Droogan is a Consultant Neurologist in Team C in the Belfast Trust Neurology Department:

When I was originally appointed, there were no consultants working in teams, apart from Tom Esmonde ... We were asked by the nursing staff would we make teams, so it was actually driven by the nurses. There wasn't sufficient nurses to do all the many, many ward rounds that would be going on in the unit throughout the week. They just didn't have the time, so they said, 'Would you mind bunching together and doing combined rounds?' and we said, 'Of course', so we sort of divided into groups.

- 3.17 Dr Stephen Hunt, Consultant Neurologist in Team B in the Belfast Trust Neurology Department, confirmed the genesis of the initiative in his oral evidence on 2nd May 2019:

It was sort of calculated on the back of an envelope and there was going to be 18 or 20 ward rounds now for nurses to attend; they couldn't do their job otherwise. So, it was more, sort of, to corral people into the same place at the same time to help facilitate other aspects around the ward.

- 3.18 An 'away day' was organised in 2002 and a facilitator duly appointed, to assist with organising consultants into teams. However, despite these efforts, Dr Hunt confirmed that initially agreement proved to be elusive:

My understanding is that in 2002, there was a meeting held ... and it took all day to try and get agreement for people to be in which particular team. And even at the end of that day, there wasn't agreement and the facilitator left because they just got fed up. Now, the purpose of arranging into teams wasn't to do with oversight of safety or quality, albeit you could say that would be a good idea. It was just physically because they were new appointees and there were going to be more ward rounds. So, the typical ward round comprises not just medical staff but nursing staff and, increasingly, other members of the multi-disciplinary team.

- 3.19 Eventually a loose team structure did emerge. Initially, team A comprised Dr Mark Gibson, Dr Stanley Hawkins and Dr Watt, but, with the untimely death of Dr Gibson in 2010 and the retirement of Dr Hawkins in 2012, Dr Watt remained the only member of Team A. In his oral evidence on 20th December 2018, Dr Craig explained the evolution of the teams:

So I think it went to three — at one point, it was three, six, three. And then obviously, unfortunately, there was some retiral and, you know, loss of a colleague. What happened after that was the teams then started to form more around people would retire and somebody would be replaced; the person that was replaced, say, was an epilepsy specialist, so then they joined the team that had the epilepsy doctor. So if you look at my team now, which is team B, there's three epilepsy specialists and three movement disorder specialists. Team C is a bit more disparate. There's two MS, one headache, one cognitive disorders. And then there was team A, which was Dr Watt.

- 3.20 Evidence was also received from registrars under Dr Watt who later became consultants and who had the opportunity to work alongside each of the teams. Dr Fulton (quoted above at paragraph 11) was in this category until she left the Belfast Trust to work for the South Eastern Trust. Her oral evidence on 15th January 2019 also helpfully explained the following:

When I arrived back [from working in Dublin], there were three consultant teams: team A was Stanley Hawkins, Mark Gibson and Michael Watt, and they had a ward round on a Monday morning, a combined ward round; team B, John Craig, Jim Morrow and Tom Esmonde, who had a ward round on a Monday afternoon and a Thursday afternoon; and Team C were Gavin McDonnell, Mark McCarron used to visit down from Altnagelvin and join that team, Aidan Droogan and Victor Patterson, and they had their ward round on a Tuesday afternoon. So, all very different personalities and a lot of consultants, where I'd been used to kind of working with one consultant at a time. And, I suppose really, from the start, the differences that I saw between Dublin and Belfast were the team system, and quite different personalities, and consultants who

had very different subspecialty interests in those teams. So, team A, to me, was always the least cohesive team, because of the personalities ...

... And, you know, kind of looking at time frames, I suppose in preparing for coming here, and thinking, "Well, why did it fall apart?", whenever Mark Gibson got sick, the first nine months were covered. John McConville did a bit of locum and then Dr [Inaudible] was a Polish locum who covered for a while, and then I took over as a locum for six months. But when I took over as a locum, instead of going into that Monday team, I had been asked to cover a Monday morning clinic in the City Hospital. So I was put into team B as a consultant. So, suddenly, it became four consultants and team A dropped to two consultants. Which was Stanley and Michael. And then it fell apart even further. Although those jobs were then filled permanently, Stephen Hunt and I kind of, I suppose, filled those roles, but nobody was ever put back into team A, so it was left as Michael and Stanley. But the other teams were unmanageable. They became unmanageable because there were so many consultants all wanting their say and having other commitments that they had to get to. No, but even it became — there was a detriment to the other teams, in that it was so unbalanced. So Michael was left as a lone practitioner. The other teams rapidly expanded, and trying to manage that number of consultants around a bedside, seeing patients —. I think it caused a difficulty ...

I think that the blame is being laid at his [Dr Watt's] feet without seeing how we, as a team, let him become a sole practitioner.

3.21 Dr Hunt also gave a useful insight into the actual workings of Team A in his oral evidence on 2nd May 2019:

At that time, Team A was Dr Watt, Dr Gibson and Dr Hawkins. So, the first ward round of the week was Monday morning, and the format was we all sat in a room and the various cases were discussed and then we went around and we physically saw the patients. Now, the conduct of that was slightly different from the conduct of other teams, laterally, OK, but that wasn't for any, sort of, particularly nefarious reasons.

... while they may have discussed the cases in the room together, they weren't necessarily in the practice of walking round the ward at the same time together.

So, depending on the availability of an SHO ... it could be the case that Dr Gibson would be away with me and Dr Watt might be walking round by himself. Now, more often than not, there would be another junior doctor with him, but he could be by himself. Once the ward round was finished, there was a session where Dr Gibson and Dr Watt and Dr Hawkins would teach, and that session used to be 10 to 11. It's now 11 to 12. But 10 to 11, you know, in trying to get anything done and red-up before 10, you know, first thing on a Monday

morning, was always a bit tight ... I can't remember at that stage – I don't think there was a formal second weekly ward round with the three of them together, but, as I say, Dr Hawkins would've been on the ward every day. He would've come and seen his patients. Dr Gibson would have come and seen his patients. He would've, again, insisted that, if you were physically present, you would go with him. He would indicate his displeasure if you weren't there. And he was a man of exacting standards, but he expected those of the people around him too ... Dr Watt was present in the talking bit. You know, in a meeting room like this – a lot smaller than this – but we discussed the cases and then we move on and you go and see the people.

3.22 Dr Hunt also explained to the Inquiry Panel how he had initially been assigned to Team A and had subsequently transferred to a different team:

**Professor Mascie-Taylor:** Could you just clear up why —? What was the situation over at team A and team B and C, and how it happened?

**Dr Hunt:** My initial appointment was as the locum.

**Professor Mascie-Taylor:** Of course, yes.

**Dr Hunt:** I cannot remember a conversation, but Dr Gibson was on team A, so, if I was notionally his successor or locum, then –

**Professor Mascie-Taylor:** You'd be on team A.

**Dr Hunt:** I'd be on team A. That was consistent with the timetabling of other sessions, outpatient sessions. So, I saw great value in continuing to work with colleagues that I had already been productive with. And one of the things that we were trying to aim for was to actually in Northern Ireland have a working, proper epilepsy service. Because, while the large majority of epilepsy management is medication-related, some of it's surgical-related, and that doesn't happen in Northern Ireland, and it still doesn't happen. We have been in discussions with colleagues in Dublin. And, you know, that actual, the progression of that – and this is of no criticism at all for the panel. But the progression of that has been stymied by the fact that all this is going on, and, you know, your time, your energy, everything else is totally consumed by it.

**Professor Mascie-Taylor:** Sure. Absolutely. Hugely. Huge distraction.

**Dr Hunt:** Yes. So, you know, it's like Brexit. There's no other – Nothing else happens except this. So, anyway, to go back to that point in time: I was then moving into a substantive post, thinking, you know, I'm going to be here for the rest of my days, potentially. Where do I want to be? And, you know, where I wanted to be was working along with these guys. They're busy people. You know, you wouldn't necessarily see them at other times in the week. And it

meant that that would be time where you could facilitate — you could say, “John, here, come with me, I want to talk about this now” — you know, which you wouldn’t have got otherwise. Plus, you know, if you ask about modelling yourself on —. You know, a lot of what I do is, sort of, the way that Jim Morrow does it, or did it. You know, so he’s somebody I respect enormously. And, you know, you sort of gravitate towards those persons.

- 3.23 The overriding impression from the evidence, in addition to the usefulness of *intra-disciplinary* teams and the protections they afforded was of the voluntary nature of the teams. They were organised at the request of the nursing staff and not management, and were arranged by consultants for consultants with little or no involvement by management. The Belfast Trust, in its written evidence of 16th December 2021, highlighted that management responsibility for the organisation, operation and oversight of teams of doctors is that of the relevant Clinical Lead and then the relevant Clinical Director.
- 3.24 The Inquiry Panel can only reflect that it saw little evidence that such clarity about first tier management responsibility for team working was effectively communicated by senior management within the Belfast Trust to the relevant Clinical Lead / Clinical Director within Neurology.

#### **Nursing Staff:**

- 3.25 Some of the most insightful evidence on the working practices of Dr Watt were given by those nurses who worked alongside him and who were also in a position to contrast and compare the practices of other neurology consultants.
- 3.26 In his oral evidence on 19th March 2019, Christopher McKee, Ward Manager in Neurology and a qualified nurse, noticed a difference with Dr Watt:

So, the Registrars went into different consultancy teams, but, obviously, Michael wasn’t part of one of those teams – Dr Watt. So, they would’ve been assigned to Dr Watt or you would’ve been assigned to the movement disorders, which was Seamus and John and all that.

He did his own [ward round]. So, Michael came in and Michael worked outside that. He didn’t – he wasn’t part of the sit-round-the-table ward rounds that the other two teams had. He worked alone.

I spoke to Vanessa about it and I spoke to Clare about it, and I was told that they tried – they’d looked at this and they tried but, because of Michael’s clinic commitments and how his clinics fell, he was not able to be part of that, which I

found a bit – a bit [short pause] dubious. Because, I think, if we – if there had've been a – a real emphasis put on, I think that could've been workable.

- 3.27 Evidence was also received from nursing staff in Ward 4E, who would have been familiar with the practices of the consultants in BHSCCT who worked in Neurology. On 26th March 2019, Sister Sharon McConkey gave evidence of the situation that pertained after the retirement of Dr Hawkins in 2012:

Dr Watt continued on his own. I think that team became quite depleted really, and there were new consultants coming through, but nobody seemed to be appointed to the team to work with him ...

We kept thinking it was a bit strange ... I think there was a general -. He was-. He probably liked to work alone. I think that's his personality. I think that's the way it was. But I think that the other teams seemed to be expanding and he was still on his own and-. Well, it was commented on. Why is nobody else on to this team? You know, and -. But, you never would've got a straight answer from anybody. There was this perception: we all want to be on the A team, the best team in the house, you know. And, there was just personalities that got on very well together.

- 3.28 Sister McConkey highlighted the different dynamic between the various teams:

The Monday afternoon and the Tuesday afternoon teams definitely worked in different ways. Tuesday would've been a quieter team; Monday was a more vocal team. I think he was quite happy to work on his own, but I'm not saying that was the right way. I'd be happy to work on my own, but I have to work as part of a team.

He was working on his own, and I do believe that was -. It wasn't good for him, as much as anything, because he had no accountability, because he worked on his own there, then he went to his outpatient clinics, and, you know, and he was putting so many people through. And I know there were other people that worked there closely with him. But, you know, I never doubted his ability as a consultant.

- 3.29 Sister Vanessa Boyd gave similar evidence during her attendance at the Inquiry on 21st March 2019:

I would've said that there was an in-vogue team – the one to be in- and there were the ones, perhaps, that were a little bit subopt – not suboptimal in terms of not doing a good job but just that they weren't the 'A Team'. Do you know what I mean?

He always did his ward rounds with the registrar. He never – he unfailingly did those, but I don't think that he had the same access to peer review as other people did because he was on his own.

- 3.30 Nurses worked with Dr Watt at various clinics. They described how Dr Watt would make diagnoses and they would provide the aftercare. Several nurses who had experience in other locations or departments commented on how the culture within neurology did not enable them to challenge the consultants. They explained this by reference to the consultants being the primary decision-makers in a pyramidal hierarchy. The nurses also observed that Dr Watt did not have the same support from registrars as other consultants had. Some of the nurses commented on Dr Watt ordering fewer tests than his consultant colleagues. The nurses observed that Dr Watt did not work in a multi-consultant team like his colleagues and, as a result, did not have his decisions scrutinised and challenged like the other consultants. In addition to the oral evidence at paragraph 26 above, Nurse Manager Christopher McKee also told the Inquiry Panel how he had queried Dr Watt being in a team but was told by his own manager at the time, Ms Clare Lundy, that this could not be facilitated because of Dr Watt's clinical commitments. Nurse Manager McKee also raised these queries with Dr Craig, Clinical Director, but was told it was difficult because of the various clinics. Nurse Manager McKee agreed when it was put to him by Professor Mascie-Taylor that the response he got to his queries could be summarised as *"well, we've tried and we've failed."*

#### **Dr Watt in Team A:**

- 3.31 The Inquiry Panel thoroughly investigated the background to the extant arrangements and the reasons why, save for the exceptions detailed above, there seemed to be an overall lack of curiosity that Dr Watt was practising on his own in Team A. The Inquiry Panel was especially focused on the reaction of Dr Watt's consultant colleagues to Dr Watt's situation.
- 3.32 On 28th March 2019, Dr Seamus Kearney referred to the issue of covering Dr Watt when he was on holiday:

The only time that it would've come up would've been in terms of cover at the times of leave ...

I think, it wasn't of concern. It seemed --. Looking back now ... my recollection of it was, you know, that it was within that normal spectrum.

- 3.33 In his oral evidence on 1st February 2019, Dr Gavin McDonnell, Consultant Neurologist in Team C in the Belfast Trust and Clinical Lead for Neurology, highlighted how busy other neurologists were:

If I thought about it, I mustn't've thought about it for very long. The difficulty is

that we're all individually very busy, but extremely busy over the last number of years – a huge number of patients, working on so many different sites ... that my focus wouldn't have necessarily been on that. But when you look at it from the outside, yes, it does look odd. It doesn't look helpful. It can't be helpful for him. He's not getting other individuals to bounce ideas off. But it wasn't something that he was flagging up.

- 3.34 On 20th December 2018, Dr John Craig, the Clinical Director for Neurosciences and part of Team B in the Neurology Department at the Belfast Trust, candidly reflected that an opportunity to address the situation had been missed:

I mean, even at a purely operational level, it is an issue. So, for example, I've a ward round after this. If I'm late, I don't have to ring my colleagues. They're there. They will see my patients. I will discuss what the outcomes -. If there's anything left over, I will go and sort that out. So, even operationally, the way things developed were far from ideal. There was a good relationship, I suppose, if Dr Watt was going off on holiday and he'd a – we never really have any more than about six or eight inpatients ... but if you had two epilepsy patients, he would come and ask me, 'Can you look after my epilepsy patients?' And that's fine. There was a degree of teamworking there. But it should be more seamless than that. It should just happen."

"We probably asked it sometimes around, you know, if he was off on holiday, who's actually looking after his patients, as opposed to - ... You know, he never came to me and said, 'I should be -. I'm in a team, and I'm -', or 'I'm isolated. I should be with you, and I feel very -. And you guys don't have to-.'

"So, again, you know, is that an opportunity missed? I think that was an opportunity missed."

- 3.35 In his oral evidence on 8th May 2019, Dr Michael Kinney, a locum consultant at the time of his attendance before the Inquiry Panel, and previously a registrar in the Belfast Trust, noted in relation to Dr Watt:

... even back in 2011 ... Dr Watt was working in isolation because the other consultants would meet at pre-specified times ... he was always on time for his ward rounds as such, but they never coincided with Dr Hawkins's ward rounds, even whenever they overlapped in their time together.

if you offered me a job in a hospital where I was the only person on the team, I wouldn't want to take the job.

- 3.36 On 14th May 2019, Dr Fiona Kennedy, a Registrar, who had been in London working as a Neurologist between 2009 and 2014, noted when she returned to Belfast that the "striking difference" with Dr Watt was that "he worked a lot on his own".

- 3.37 Dr Aisling Carr, now a Consultant Neurologist in Queen Square in London, recognised the importance of the larger teams for new consultants in her oral evidence on 11th November 2019:

If you're a new consultant you want robust, challenging peers to help you, you know, maintain your education, and it was already obvious that you got better peer support in those larger groups.

Michael was a very instinctive neurologist. He was very well read. He was very, very knowledgeable ... that instinctiveness to his character allowed him, and all acknowledged this, to process clinical situations at a slightly different rate to others.

- 3.38 The benefits of team working, and *intra*-disciplinary practice were strongly endorsed by neurologists. This general positivity, however, needs to be juxtaposed alongside what could only be described as a lack of curiosity by neurology colleagues. Team working was not a mandatory requirement and there was clearly space for those like Dr Watt, who preferred working on their own.

#### Clinical Audit:

- 3.39 In assessing the opportunities for an employer or a manager to recognise problem signs in a doctor's practice, the Inquiry Panel recognises that merely working in an *intra*-disciplinary team in an inpatient ward setting is not, of itself, sufficient. The problem is, however, how one can see or assess what is going on in another consultant's practice. The system observed in neurology within the Belfast Trust provided limited opportunities for one consultant to know what was going on in another consultant's practice. This is, in part, inevitable, owing to the pressures that the NHS has been under. The practice <sup>4</sup>appears, however, to have been hardwired into the mindset of individual consultants. The question is, how one affords periodic opportunity for the decisions of one consultant to be reviewed by their peers? This theme is expanded in the Recommendations section below, but one possible way is through the process of clinical audit and the case note review introduced by former Medical Director and now Chief Executive, Dr Cathy Jack.
- 3.40 Clinical audit is essentially an assessment tool with the prime purpose of measuring outcomes and identifying trends. It is not designed, nor intended as a means of strengthening patient safety, but in some instances, data collected in the course of such audits have the potential to identify patterns and reveal practice trends. In that

<sup>4</sup> It may well be that there are other examples of departments in various Trusts across Northern Ireland, and beyond, where there are similarly limited opportunities for practice visibility.

regard, clinical audit can potentially lead to an opportunity for learning or assist in other processes. The Inquiry sought to review those audits which had taken place in neurology during the relevant period.

3.41 The Inquiry Panel sought all of the relevant documentation within the Trust on clinical audits carried out within the Neurology department between 2007-2019. A brief summary of the relevant audits is set out below:

(i) **Neurosciences Medical Records Audit 2014 (uncredited)**

The audit notes that clinical records should include details such as clinical findings, information given to patients, planned investigations, drugs and so forth. However, the audit criteria and results show that none of these were considered; rather, based on General Medical Council (“GMC”) guidelines, each record for time, signature, printed name, printed designation, GMC number and lead consultant was audited. Given what subsequently transpired regarding Dr Watt’s record keeping from the Gray/McConville reports, the Royal College of Physician’s (“RCP”) report, and the oral evidence taken by the Inquiry, it seems likely that an audit could have picked up serious issues with Dr Watt’s clinical record keeping. However, in this case, the results are only broken down into neurosurgery and neurology, so it is unlikely this would have been flagged in this instance.

(ii) **Neurologist adherence to guidelines when prescribing Plasma exchange**

This was an audit specifically aimed at assessing compliance by a neurologist with guidelines. Two particular points were of note to the Inquiry Panel:

- (a) There are two different sets of guidelines;
- (b) There is no breakdown of numbers by consultant. With an overall compliance rate of 88.7% (i.e. at least one guideline), it would be interesting to have known if those 12.3% of non-compliant cases were distributed pro rata amongst consultants or if there was an outlier.

(iii) **Audit of Prescribing Practice of Natalizumab (uncredited)**

The audit notes that all patients met NICE<sup>5</sup> criteria to commence treatment. It only states that NIECR<sup>6</sup> was used for data collection. The audit is of patients commencing Natalizumab ‘from April 2017’. It is not clear what time period the audit covers.

<sup>5</sup> National Institute for Health and Care Excellence. NICE guidance comprises ‘evidence-based recommendations developed by independent committees, including professionals and lay members, and consulted on by stakeholders’. <<https://www.nice.org.uk/guidance>>

<sup>6</sup> Northern Ireland Electronic Care Record.

- (iv) **Lumbar Puncture waiting List Quality Improvement Project (Aug – Oct 2018)**
- (v) **Audit of Natalizumab Prescribing in Northern Ireland (2011) (Hughes & McDonnell)**

Again, this audit showed relatively good adherence to NICE/ABN<sup>7</sup> guidelines – 85% overall. However, again, it does not appear to go behind the initial diagnosis and there is no consultant breakdown to assess whether any individual is responsible for a disproportionate number of the non-compliant cases. It is only when a consultant breakdown is prepared that information could come to light, which would be likely to assist in identifying possible aberrant practice.

- (vi) **DMT Prescribing audit for Disease Modifying Treatment started Jan – Dec 2013**
- (vii) **Re-audit of natalizumab prescribing in NI (Stella Hughes, 2015)**

This audit was presented at a meeting of the Multiple Sclerosis Special Interest Group (“MS SIG”) on 10th February 2015. It shows that, in 2015, the prescribing criteria were met and reasons for starting was documented – no cause for concern was identified.

- (viii) **Managed Entry of Disease Modifying Therapies (Dec 2012, uncredited)**

This audit showed that 13% of cases involving disease modifying therapies did not meet NICE criteria; of the 87% that did, the requirement for a ‘disabling’ relapse was not clear in 67% of cases. Further, 4% did not meet at least one of the ABN criteria.

3.42 Consideration and comment on the governance around Dr Watt’s use of Human Immuno-Globulin (“HIG”) is contained in the Prescribing chapter. In respect of analysing clinical audit within neurology, the audits rarely compared individual clinicians. The opportunity, therefore, to discover aberrancy or whether a consultant was a clear outlier in terms of prescription, or the obtaining of tests, was quite limited. On the rare occasions when an audit was individualised, such as the use of HIG, there appears to have been no pressure to question or further interrogate the data on the part of those neurologists who were in attendance when that audit was presented by Dr Carr in 2007. It was the case that Dr Watt was, by some measure, the outlier in respect of the use of HIG. In her evidence to the Inquiry Panel on 11th November 2019, Dr Carr stated:

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<sup>7</sup> Association of British Neurologists.

**Dr Carr:** ... If you look at the human immunoglobulin usage per consultant and you look across the spectrum of all of the consultants, there was significantly larger volume of use by Dr Watt, and I presented that at an audit to the neurosciences group in 2006- 07.

You also look at how the usage per consultant – and it's divided up according to the Department of Health guidelines into red indications, which are first-line; blue, which is second-line; and grey, which is, "You're allowed to use it, but there really isn't the evidence" – and, if you look at the proportion of blues and reds to greys, it would appear that Dr Watt's proportions were - .

**Professor Mascie-Taylor:** Ratio was different, yes.

**Dr Carr:** Now, when we discussed that – and I say "we"; I was a very junior registrar – when that was discussed at the neurosciences meeting in 2007-ish, there were a broad range of consultants there, and that data was in front of everyone.

Now, at that time, there was the very recent discovery of antibodies which explained the autoimmune encephalitis. Essentially, these were a group of conditions where a patient would, really very suddenly – over days to weeks – become confused and in a coma and having epilepsy which was very refractory. Up until 2007-08, we didn't know the cause of this, and, essentially, those patients would've died. So, now – then, at that time, it was being discovered that these were actually autoimmune-based and, therefore, treatable, potentially treatable ...

Now, all neurologists everywhere were becoming very aware of these things, and, in that setting at that time, the discussion was, "Yes, we need to be behaving as per the commissioning guidelines. However, as clinicians, we cannot be allowed to be overpoliced in this setting, because medical understanding of these rare conditions is evolving and, if we have a patient in front of us, our clinical assessment should have enough power or weighting to allow access to these potentially life-saving treatments." So, the basis of the discussion at that time wasn't dismissive of policing or guidelines, but it was – everybody needed to, wished to acknowledge that our understanding of these rare conditions is changing and limitation on clinical practice from afar can be detrimental to the individual. So, in the context of purely the number of patients that Dr Watt saw through his high-turnover public or NHS practice, alongside his high- turnover private practice, the actual numbers of his HIG use was not deemed to be a very worrying outlier, if you know what I mean. That was if you look backwards, and interpret those numbers. Now, over time, commissioning of IVIg<sup>8</sup> has become tighter and tighter and tighter.

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8 Intravenous immunoglobulin.

**Professor Mascie-Taylor:** Indeed.

**Dr Carr:** Now, my naïve suggestion, as a very junior registrar at that time was, “Well, if we are using this product or this therapy to help in the diagnostic process – so, if we do a load of tests and we just don’t have the answer or they don’t tell us for definite – if we use it to see if the patient responds –”.

**Professor Mascie-Taylor:** Yes, therapeutic trial.

**Dr Carr:** Yes. “Should we be trying to make measurements of that?” That was my suggestion at the end of the audit. Now, that wasn’t taken up.

- 3.43 The Inquiry Panel fully accepts that one has got to put the matter into context. The lengthy extract from the evidence of Dr Carr reveals that at the time of the audit, there was, on the face of it, a potential explanation for the fact that Dr Watt was an outlier in respect of the prescription of HIG. What is disappointing, however, is that the results of the audit did not form an effective reference point whenever the issue of HIG prescribing and the process subsequently agreed upon was raised on subsequent occasions and, particularly, in early 2016. The impression given is that, if there is a perceived explanation for what could be viewed as a discrepancy, then that is the end of the matter. The Inquiry Panel further notes that Dr Carr’s suggestion regarding a therapeutic trial was not taken up or agreed upon by the body of consultants. Once again, an opportunity to further interrogate the data was missed. The subsequent difficulties are best described in the chapters on Prescribing and the Missed Opportunities in 2016.
- 3.44 The ineffectiveness of clinical audit as a means of identifying problems is also illustrated by the problems that Dr Watt had with record-keeping. The external reviews which were carried out, such as the report from the RCP, which was formally delivered in April 2018, and the draft Verita report, referenced the problem of Dr Watt’s record-keeping. In this regard, these reports linked the deficiency with the broader issue of accurately assessing the quality of care provided. At no point did any of the audits link a deficiency in record-keeping with a care quality or patient safety issue. The Inquiry Panel accepts that clinical audit is not the same as a detailed report from the RCP but may form the basis for further investigation and inquiry.
- 3.45 The perceived difficulties in relation to clinical audit within neurology were alluded to in the evidence of Dr Gavin McDonnell on 1st February 2019:

**Dr McDonnell:** I think it should do. I think a lot of the things that we audit — and you’ve probably heard the criticism before — you tend to audit things that you can measure.

**Professor Mascie-Taylor:** Absolutely. It's easier to do.

**Dr McDonnell:** So, it might be that there's a requirement that, you know, if you're on a particular drug, that you're getting your thyroid function test checked every three months. So, you think, "Well, we'll audit that because that's important and we can measure that very easily". But auditing the diagnosis of —

**Professor Mascie-Taylor:** It's more difficult.

**Dr McDonnell:** — is more difficult, and that might be more difficult if you perhaps don't have the expertise about to do that effectively. So, for instance, I suppose, maybe the epidural blood patches might be an example of that, because I don't think anybody else in Belfast would've considered themselves to be an expert on spontaneous intracranial hypotension.

- 3.46 While audit within neurology may present its own challenges, the Inquiry Panel was struck by what might be termed as a lack of curiosity within the consultant body. The almost complete absence of breakdown within an individual consultant's practice ensured that clinical audit played no appreciable role in identifying the problems that developed in Dr Watt's practice. This compares markedly with the approach taken by managers to measuring output by consultants. This was vividly described by Dr Ailsa Fulton in her evidence of 15th January 2019:

We started to get this generated email that came through, I think about three or four times a year, that showed the breakdown of the whole department and all of our clinics and what our waiting lists were like and the numbers of patients that we're seeing.

Michael was held up as a poster boy because he was seeing so many more patients than the rest of us.

- 3.47 Dr Michael Kinney, in his evidence of 8th May 2019 to the Inquiry Panel, highlighted the dearth of audits and his own ambition to see audits being utilised as a means of measuring progress:

**Dr Kinney:** Sure. I guess my thought on that is that audit would've been very sporadic, actually.

**Professor Mascie-Taylor:** Absolutely.

**Dr Kinney:** I can recall possibly a handful of audits presented in the five years that I was in the department. Now, in more recent times, just almost immediately prior to me leaving the Royal in 2017, there was, I believe, introduction of more kind of specific time for audit in our department. Although it was always a

hospital-wide audit day, clinics were cancelled, I don't recall there being any organised activity to actually audit things. Professor Mascie-Taylor: Just so I understand that. There was a hospital wide audit day, so were neurology clinics cancelled

**Dr Kinney:** Yes. I hope I am not wrong on that from a factual point of view but it was my ... recollection that you would come along to a clinic and find out that it had been cancelled because it was audit day across the site. I don't recall there being specific activities organised for us as a department in those areas until more recently – until probably the last year or two.

**Professor Mascie-Taylor:** But in most of the period you were a registrar the audit day, whilst it in some sense was an audit day i.e. clinics were cancelled in order to deal with it - in other sense it wasn't an audit day because no audit occurred.

**Dr Kinney:** That's correct, yes. Some consultants ran their clinics, so it wasn't that every single clinic was cancelled actually ... I mean, it's not an indicator of good practice, clearly. For me, as I start out on this path as a consultant, one of the big things I want to be able to do is measure things, to actually know what you're doing is good. I want to be able to prove that because I see that as being a method by which you can actually improve things and argue your case for getting more funding to improve things all the more. So, to not measure it and have no idea of disease burden and various things for prescribing practices seems almost unfathomable, actually. But I can understand why these things become difficult for consultants in practice because this takes time, and the systems for coding and various things are probably not set up ideally for this kind of work.

- 3.48 The Inquiry Panel agrees with Dr Kinney that the lack of any audit in Neurology on a hospital-wide audit day is not an indicator of good practice, nor does there appear to have been any concern raised in management that such action was problematic or explicable.
- 3.49 It is apparent from the documentation received by the Inquiry on the question of clinical audit, that audit records are held by individual consultants and registrars with the results being recorded in a red book. This is not ideal and points to the larger problem of audits not being individualised or strategically driven and centrally controlled.
- 3.50 In Dr John Craig's evidence to the Inquiry on 20th December 2018, he candidly considered how clinical audit might have been of assistance in relation to the dramatic rise in the diagnosis of spontaneous intracranial hypotension ("SIH"), which required blood patching. Dr Craig stated:

**Dr Craig:** Thinking about it, the way we might have got at it would've been to get an audit done. Audits always lag behind. They're usually six/12 months behind clinical practice, but, if we had done an audit and knowing what I know now, we would have realised that a lot of these patients that were getting blood patches had not had imaging done. We'd been told that imaging was a crucial part of the diagnostic process, but we —.

**Mr Lockhart QC:** So, at that lecture in 2014, at no stage were you given the impression that you could in fact diagnose without imaging or —.

**Dr Craig:** Well, I would — if I saw a case of this, I would be — as long as they didn't have a pacemaker or whatever — and I'd be asking for MR imaging of their brain and their spine 100% of the times, and, in fact, the diagnostic criteria rely very heavily on the MRI features. So, at our consultant meeting in 2015, if we had said at that time, "We have to have an audit of this. We haven't done this. We haven't gone back and looked at all those cases", but, you know, we might've found at that stage actually these people are having this done without imaging, and, clearly, that would've raised a question ... Yes, I mean, I certainly think that the way it was allowed to grow without proper balances and checks is certainly not something I think we'd be wanting to replicate in the future for anything.

- 3.51 The Inquiry Panel agrees with Dr Craig that clinical audit may have been especially useful in relation to blood patching. This is discussed further in the Blood Patching chapter but the lack of any clinical audit in this area was a clear opportunity missed.
- 3.52 The Inquiry Panel noted from the evidence of Dr Stanley Hawkins on 9th November 2018, that, when clinical audit was first started, it was meant to be a case note review and to occur on a monthly basis. In reality, this just did not happen as explained by Dr Hawkins:

**Dr Hawkins:** When clinical audit was first introduced there was a system of case note review. That was a long time ago. Then there was an audit department introduced in the hospital and it wanted to have control of clinical audit and they felt that case review was not sufficient. If there had been case note review over the last few years certain things might have come to light. Can I say that when a consultant's first appointed immediately that consultant would have a certain amount of autonomy.

**Professor Mascie-Taylor:** Indeed.

**Dr Hawkins:** One doesn't normally review someone else's case notes without a very good reason, and you would not normally systematically review case notes without a very good reason.

3.53 The Inquiry Panel agreed with Dr Hawkins' first observation about a case note review but was less impressed that review only normally occurred if there was "*a very good reason*". The Inquiry Panel considers that patient safety is the only reason needed, if it can be shown that regular case note review helps identify patterns of aberrant practice. The Inquiry Panel notes that a case note review initiative has now been taken up by Dr Jack in another specialty.

3.54 In her oral evidence of 28th February 2019, Dr Jack outlined a case note review process which had been implemented in Rheumatology:

**Dr Jack:** In the likes of rheumatology, what we're talking about with them is that, if they give a patient a – you are giving patients diagnoses and, if you give patients a life-changing diagnosis and you are about to start a biologic, you discuss it with a colleague and the two of you sign it off.

**Professor Mascie-Taylor:** And that's all that's required.

**Mr Lockhart QC:** And that is your answer to MDTs within outpatients.

**Dr Jack:** No. Then in MDTs as outpatients. You still need this, because you need to spot if somebody's doing an epidural blood patch, because it's not life-changing ... And those maybe that just have migraine headache, that are maybe being diagnosed with other conditions: you can either do a peer review, which is that you come once a year and pull a clinic, but my own feeling – and I've been talking to the lead in rheumatology – is that, once a month, a colleague randomly selects a case note from your clinic and looks at it, because then it is ongoing. Every month, one case is being reviewed independently. And so, if I look at your case, Brett, you'll look at Hugo's, Hugo will look at Mark's ... then you present it to the MDT.

3.55 From the evidence within neurology reviewed by the Inquiry Panel, clinical audit had a limited and negligible impact on the identification of aberrant practice. The failure in most audits to name individual consultants automatically limited the impact of the audit in identifying patterns or trends which might have given rise to further query or investigation. The impression of the Inquiry Panel is that a different approach to clinical audit could have a much greater potential in identifying possible aberrancy of practice.

#### **Neurosciences Grand Round Meeting:**

3.56 The Inquiry Panel took into account that a Grand Round meeting in respect of neurosciences had continued for many years throughout the relevant period and was undoubtedly helpful to individual consultants. The Inquiry Panel notes, for

instance, that colleagues working in hospitals such as Craigavon, Altnagelvin and the Ulster would attend the Grand Round meeting for neurosciences. This occurred on a weekly basis and provided an opportunity for specialists to discuss interesting cases and highlight clinical issues of common concern. The format was based on the idea of one consultant, often in collaboration with a registrar, introducing to the meeting a particular issue, which would then be discussed by colleagues. The Inquiry Panel formed the impression that consultants regarded the Grand Round meeting positively and both neurologists and neurosurgeons saw attendance as an important part of continuing professional development.

- 3.57 It was noticeable, however, that when the Inquiry specifically inquired with each neurologist, few doctors could recall being at the 3 separate meetings when Dr Watt gave presentations on spontaneous intracranial hypotension (“SIH”), even though there was sufficient evidence from enough doctors to confirm that the presentations had taken place. The issue of Dr Watt’s presentations is dealt with in the Blood Patching chapter but is mentioned in this section because there was no evidence before the Inquiry Panel that anything said by Dr Watt at any of the presentations caused concerns to be raised about the prevalence of SIH or the increase in blood patching. The Inquiry Panel concludes, therefore, that while the Neurosciences Grand Round has an importance in respect of training, it does not operate in a manner which would highlight potential problems or aberrancy.
- 3.58 In this regard, the Inquiry notes that, on the one occasion (of which the Inquiry is aware) that a Clinical Director (Mr Cooke) escalated a concern about a presentation by a neurosurgeon to the Medical Director, he was rebuked in writing by the then Clinical Lead, Dr Morrow. This is set out in greater detail in the 2006-2007 chapter. Dr Morrow’s reasoning was that the Grand Round meeting was not meant to be an opportunity where a concern about a specific colleague and his or her practice should be identified and acted upon. On 25th January 2008, Dr Morrow emailed colleagues when Mr Cooke had decided that, as Clinical Director, he should raise concern about a specific neurosurgeon’s competence with the Medical Director:

... never before have I heard the suggestion that following this meeting a colleague’s competence is called into question and that referral be made to the Medical Director.

I am afraid that if this is allowed to continue the Grand Round itself as a format for education will cease to function as we all start to practice defensive medicine. You therefore have my full support in questioning this decision of Steve’s.

- 3.59 Although Dr Morrow was not able to give evidence because of his medical condition, the Inquiry did receive a written statement from Mr Cooke on 26th November 2021 explaining the context to the emails. Mr Cooke stated that the presentation in question had not been attended by Dr Morrow and that he was not the only doctor present who was immediately concerned by his colleague's presentation. It appears that the doctor making the presentation which caused concern had subsequently corresponded with other members of the Grand Round explaining his position. It was that email which appears to have prompted Dr Morrow to respond as he did. Mr Cooke stated that when he explained the position to Dr Morrow and also gave a wider context that Dr Morrow understood and accepted Mr Cooke's position.
- 3.60 The Inquiry Panel understands that ordinarily a training meeting is not a forum, where one would expect issues of competence to arise. Nevertheless, when one does arise, a doctor and, especially, a Clinical Director, is required to act just as Dr Cooke acted.<sup>9</sup> There must be no impediment to such escalation. Dr Morrow was a highly respected and senior neurologist who was also Clinical Lead. The concern is that his views on the matter may have carried real weight with colleagues and contributed to a culture where it became more difficult to raise concerns.

#### **Mortality and Morbidity Meetings:**

- 3.61 The Inquiry Panel also recognises that Morbidity and Mortality meetings began to take place within the Belfast Trust Neurosciences Department in the last number of years. The Inquiry Panel commend this as the meetings can often be an effective way of analysing the treatment and aetiology of a patient who has died and may often present, particularly in some sub-specialties, a learning opportunity. The Inquiry Panel notes that neurologists spoke positively about the usefulness of these meetings. However, given that they were not taking place during a significant part of the time period under consideration, the Inquiry is not well-placed to reach any conclusions about the extent to which such meetings may have presented an effective means by which problems with individual consultants could have been discovered within neurology.

#### **Independent Sector:**

- 3.62 The difficulties with consultants operating in the independent sector without oversight are commented upon in detail in the Independent Sector chapter. Much of

<sup>9</sup> Section 25 (c) of the Good Medical Practice Guide states: "If you have concerns that a colleague may not be fit to practise and may be putting patients at risk, you must ask for advice from a colleague, your defence body or us. If you are still concerned you must report this, in line with our guidance and your workplace policy, and make a record of the steps you have taken".

Dr Watt’s practice was carried out within the independent sector, where he would have been working on his own. Given the magnitude of his private practice, the Inquiry Panel believed that reference should also be made in this chapter on Lone Working and Practice Visibility to the link between Dr Watt’s private practice and his NHS responsibilities. Many of the patients who were diagnosed with SIH, and advised to undergo a blood patch procedure, saw Dr Watt privately. Although there are at least three other Belfast Trust neurologists who carry out private work, the stark fact is that there is the barest of oversight. The Inquiry Panel noted that the difficulties with multi-disciplinary team (“MDT”) working in the independent sector were commented upon in the Paterson report<sup>10</sup>, which made the following recommendation:

We recommend that Care Quality Commission, as a matter of urgency, should assure itself that all hospital providers are complying effectively with up-to-date national guidance on Multi-Disciplinary Team meetings, including in breast cancer care, and that patients are not at risk of harm due to non-compliance in this area.<sup>11</sup>

- 3.63 The Inquiry Panel endorses that view. In the Paterson case, difficulties emerged, despite the fact there was both guidance and an established practice of MDT working in the independent sector. The difficulties arose in that the manner of MDT working was ineffective and decisions about surgery were often reached by one surgeon, without proper consultation with the other surgeons. In Northern Ireland, whilst there is a much smaller independent sector, there is a complete lack of guidance regarding MDT working in outpatient specialties such as neurology. The Inquiry Panel has concluded that, although there are difficulties, a form of peer review and MDT working in the independent sector needs to be the subject of guidelines, which are overseen by the RQIA. The fact is that the independent sector in Northern Ireland is increasingly commissioned to carry out NHS work by way of waiting list initiatives. Consequently, it is incumbent on those who both commission the care and provide the care to ensure that the same safety standards apply across both sectors.

#### **Draft Verita Report:**

- 3.64 Further to the Maintaining High Professional Standards (“MHPS”) process, the Trust appointed Dr Seamus O’Reilly, the Medical Director in the Northern Health & Social Care Trust as the Case Manager for the MHPS investigation. Verita were

<sup>10</sup> This was the Report of the Independent Inquiry of the issues raised by Paterson, a surgeon in the West Midlands who was convicted of harming patients in his care on a widespread scale. It was issued to the House of Commons on 4th February 2020.

<sup>11</sup> See page 219 of the Paterson report under the heading ‘Recommendations’.

appointed as the case investigators and Dr Watt was interviewed by an investigation panel, consisting of Kieran Seale, an investigator at Verita, Dr Michael Marrinan, Medical Director at the Royal Hospital for Neuro-disability, and Dr Chris Clough, Consultant Neurologist at Kings College Hospital, who provided expert advice.

3.65 In a submission to the Inquiry of 31st January 2021 commenting on the Verita report, the Trust pointed out that the report was a draft report produced as part of an MHPS process, which was never finalised. The Trust advised that there were a number of factual mistakes and errors of understanding and submitted that the report should be treated with caution. It was explained that Dr O'Reilly, the case manager, had intended to make the draft report available to Dr Watt and the Belfast Trust for comment, but that, when it was possible to do this, Dr Watt was not in a position to participate in the process. Consequently, the MHPS investigation was effectively paused.

3.66 In respect of clinical teams, Dr John Craig, Clinical Director, told the Verita Panel that the original 'Team A' was comprised of neurologists:

... with a more traditional general neurology background". He further stated that "all three neurologists in that team trained at a time before the number of neurologists increased and neurology became so sub-specialised so they would all have tended to practise more independently than others in the sense that they would provide care for a wide range of conditions without referring as many patients to others.

3.67 Dr Craig explained that although Dr Watt was in a team of one:

... he never indicated to me that he wished to join another team, nor did anyone suggest to me that the teams should be reorganised ... Whilst it would have been possible to reorganise the teams it would have presented serious logistical difficulties because they were arranged around other clinics in multiple different hospitals and Trusts which would have been very difficult to change. There was therefore no momentum to change the teams.

3.68 The suggestion that it was incumbent on Dr Watt to state that he wished to join another team somewhat misses the point. As set out in the Part A section of the Verita report, Dr Watt did state on 9th June 2017, in a meeting with Dr Mark Mitchelson and Mrs Bernie Owens, the Director of Unscheduled and Acute Care, that he had difficulties because of lone working outside an established team. There is no evidence that he had raised the concern prior to that, as noted by Dr Craig. The point is, however, that it was also the responsibility of management to both identify and address the situation, given the clear and obvious benefits of team working and the dangers of a consultant working on his own.

3.69 In his response to the Verita investigation, Dr Watt referred to the team that he had been on, Team A, reducing to 1. In his oral evidence to the Verita Inquiry on 28th May 2019, Dr Watt stated in relation to this point as follows:

... Since then a couple of others – a friend of mine who works on the ward thought that Stephen Hunt worked with me for a time, but that may have been when he was sort of an acting consultant or locum consultant, so when he was made consultant he opted to go with, as I describe it, the “movers and shakers” team, which was John Craig and Jim [Morrow] at that time, so the guys that had a particular interest in epilepsy and Stephen -

52. Q: So they're moving to specialism-based at that point?

53. A. A bit, but perhaps as much influence-based teams as – maybe also a team that was more of a work together team, so they maybe thought that they would get more support or maybe people that shared their own views; but for whatever reason, they were able to opt to work on a different team, rather than replacing someone who had left the team I was in. Then likewise, John McKinley I suppose could be viewed as a replacement for Mark Gibson, as he had expertise in movement disorders, and again, he ended up on the same large team, which I suppose even though none of them were professors had more of a professorial ward round feel.

54. Q : It sub-specialised, did it? You had teams around specialties, or not really?

55. A. The teams as they are now, John [Craig] and Stephen [Hunt] would be epilepsy, Seamus Kearney and John McKinley would be movement disorders. I'm not sure who else is in that team, there are about five or six of them

...

62. Q. You said something a few minutes ago, when these teams were forming a number of specialists said that they wanted to be in a team that shared their own views – that's an impression – so, were you ever in a team that shared your views?

63. A. I was comfortable working with Mark Gibson and Stanley [Hawkins, probably more comfortable with Mark than Stanley, we had always got on well. Stanley was always hard to know what his thoughts were –

64. Q. Did you have a pal, did you consult with anybody –

65. A. Because Stephen Hunt had been a guy that maybe should have replaced Mark Gibson, even though he didn't end up working with me, I still would have asked him to look after my patients when I was away, so that –

66. Q. In later years you were on your own –
67. A. Absolutely.
68. Q. So what was –
69. A. It was very difficult.
70. Q. You're going on holiday, what's the plan?
71. A. I had to ask Stephen [Hunt] if he would cover my patients.
72. Q. And the management didn't ensure that that had happened, or make an arrangement, or question it?
73. A. No
- ...
730. Q: You were talking about a guy from Bristol, Neil –
731. A. I probably got Neil wrong, it was a Professor in Cardiff, MS, talking about their MS MDT, and some of the other guys were also talking about it, maybe some of the ones from London, and they were saying that they had instituted an MDT to rein in some of their more maverick consultants or colleagues. I thought, why couldn't they have done that for me, or, if only they had done that for me, was my reaction to that.
732. Q. You wished you'd been part of an MDT –
733. A. Absolutely, or when this broke, rather than this being the consequence of it, it would have been –
734. Q. Did you raise that at all?
735. A. I did suggest that, in the course of the investigations in the Trust, before it got to this stage, but it would have been ideal if we had to have approval from an MDT for starting somebody – or if I had had to have approval, in fact, if we all had had to have approval equally, across the board, for starting somebody – MDTs for MS
- ...
740. Q. But there wasn't any mechanism in which you could tell people about –
741. A. No, that was coming - well, we had our monthly MS special interest group meeting which lasted an hour, and part of the reason for doing it was to bring along cases that you were wanting help with, with the diagnosis, but that didn't happen often, I didn't present anybody at that meeting. So there was a forum that you could potentially have done it, but it wasn't frequent enough and didn't last long enough.

3.70 On one view, the fact that Dr Watt raised his concerns about lone working for the first time in June 2017, suggests that he was not overly worried about the existing situation. The Inquiry Panel has not had the opportunity to hear from Dr Watt directly because of his medical condition, but the view of the Inquiry Panel is formed and shaped more by the evidence of the nurses, registrars and, to a limited extent, other consultants. Those who worked most closely with Dr Watt had the opportunity to contrast and compare his method of practice, as outlined above. The Inquiry Panel found that this was the most compelling evidence that Dr Watt working on his own for a number of years in Team A was unwise and liable to cause problems.

3.71 The Belfast Trust disagreed with the view of the MHPS case investigator. In its commentary, the Trust highlighted a number of matters. The Inquiry Panel has, in particular, taken note of the following points in the Trust's submission:

21. As Dr Watt himself explained, in-patient beds for neurology numbered less than 20. He had sometimes 10 patients, sometimes 2, sometimes no patients. The purpose of the in-patient neurology ward team structure appears to have been misunderstood and elevated to a level of importance that it does not bear. The in-patient ward team structure in neurology (neurology being predominantly an outpatient specialism, and with significant sub-specialisms) was not formed as some means to guard against the type of issues that have arisen in respect of Dr Watt, or any dangers associated with lone working. The structure was adopted in and around 2003 in response to the need to secure adequate nursing support for ward rounds, and in a way that fitted in with outpatient clinic schedules ...

23. The Belfast Trust was not asked about what it had to say on this issue before the comment was made by Verita. Had it been, or in response to seeing the comment in the report, the Belfast Trust would have made the following substantive points:

- a. Dr Watt was part of the Grand Ward Round each week and contributed to it;
- b. There is evidence that, when the situations arose, as they inevitably did, Dr Watt did work collaboratively with other consultants from different disciplines whose work intersected with that of the neurologist;
- c. The neurology in-patient team ward rounds were not a mechanism to manage risks;
- d. Had the neurology in patient ward rounds been a mechanism to manage risks, it is difficult to see how they would have identified any risks associated with Dr Watt.

3.72 The Inquiry Panel accepts that the genesis of the inpatient ward round and the designation of various neurologists into teams was not primarily as a result of pressure from neurologists but was a response to the need for adequate nursing support. Further, it is accepted that, particularly in the outpatient clinics, Dr Watt did work collaboratively with other consultants from different disciplines. The commentary later in this chapter in respect of the TIA clinic illustrates the point. Nevertheless, even taking all these matters into account, and viewing the question of isolation and lone working in a broader context, the Inquiry Panel believes that there were many signs of potential problems emerging, which went beyond just inclusion in the neurology inpatient joint ward round. The following salient factors have been identified by the Inquiry in this regard:

- (i) The Inquiry Panel struggles with the argument that the teams that were devised had a focus only on adequate nursing support. Evidence was received from Dr Hunt that before teams could be agreed, the neurologists had to attend an 'away day' and go through a mediative process because of the prior lack of agreement. When this meeting took place, Dr Hunt was a junior doctor and not a consultant. The Inquiry Panel can only conclude that the degree of contention was about far more than just adequate nursing support or the efficient running of clinics, but also included relationships between neurologists.
- (ii) The view of every consultant who appeared before the Neurology Inquiry was invariably that they were unaware of any significant problem with Dr Watt's clinical practice prior to November 2016. While there were a number of registrars who did raise concerns, these were not shared by the consultant body. At its height, the view would have been taken that Dr Watt was at one end of the spectrum of practice in terms of his approach to diagnosis and his reticence to accept that a patient was, for instance, suffering from a functional neurological disorder. Additionally, it was accepted that he would have been an outlier in terms of prescribing disease-modifying treatments ("DMTs") and would often wish to begin treatment in a more aggressive fashion than that of his peers. That analysis, however, did not lead to any degree of substantial concern on the part of his colleagues in their evidence to the Inquiry.
- (iii) When one then contrasts the views of Dr Watt's consultant colleagues with the evidence found by the RCP in its report, and the results of the recall process, it becomes apparent that a significant level of aberrant practice was taking place without the knowledge of his contemporaries. Either that means that consultants have not been forthcoming about their concerns or, alternatively, that they were so focused on their own patients and their own practice that they had limited interest or time to consider the work

of other consultants unless it directly impinged upon their own patients. The Inquiry Panel accepts the latter view on the evidence presented. In relation to Trust management, there needs to be a recognition that the extant systems in place failed to identify such a significant problem. The Inquiry Panel can only conclude that those systems did not operate properly. Dr Watt's problems did not emerge suddenly in late 2016. They were apparent throughout the relevant period, but despite referral to the DDCRM<sup>12</sup>, the invoking of the informal MHPS procedure and a disproportionate number of complaints, there was little evidence that anyone realised that there was a significant clinical practice issue.

- (iv) Dr Watt had a prodigious workload and saw more patients than perhaps any other neurologist. Though this was to some extent self-induced, it led to a plethora of problems illustrated by complaints from patients about delay and a failure to carry out basic administrative obligations including responding to requests for reports. Any analysis of the complaints being received, including a GMC warning in 2007, should have caused the Trust to question why there were so many complaints against Dr Watt as compared with other doctors. Despite the existence of a Complaints Department, a system for storing complaints and a detailed process for responding to complaints, there seems to be little evidence that anyone asked the most basic of questions or queried whether Dr Watt's administrative difficulties might have something to do with the extent of his practice. This is set out in detail in the Complaints chapter. The Inquiry Panel believes, on the evidence presented and the documentation provided, that Dr Watt was regarded favourably by management because he played a critical role in helping manage the chronic problem of neurology waiting times.
- (v) While the Neurosciences Grand Round may have been a useful and necessary forum for the discussion of interesting cases, it was not, it appears, an opportunity for variations in practice to be analysed. On three occasions between 2014-2017, Dr Watt gave presentations in respect of diagnosing SIH and of the use of epidural blood patching. No significant issue appears to have been raised at the Grand Round and indeed few neurologists remembered even being there.

3.73 It is undoubtedly the case that inpatient ward round teams did not, and could not, of themselves, provide an answer to the problems of overwork and isolation. There was, however, something conspicuous about the fact that between 2012-2016, Dr Watt was effectively the only consultant in Team A following Dr Hawkins' retirement. That he was alone in Team A was clearly picked up on by his colleagues, but, once

<sup>12</sup> The DDCRM is a reference to the Belfast Trust Doctors and Dentists Case Review Meeting. A separate chapter comments on the evidence relating to Dr Watt's involvement with the DDCRM.

again, no one believed that any step needed to be taken to rearrange the existing teams or to change the personnel. Colleagues referred often to Dr Watt's '*different way of doing things*'. This came across to the Inquiry Panel as being an impression of idiosyncratic behaviour rather than anything which would give cause for concern. When the various strands of information are put together, it is, however, abundantly clear that it is not safe for patients or reasonable for Dr Watt to have been working in the manner that he was with the volume of patients that he cared for and the level of complaint that was apparent. There was no evidence given to the Inquiry Panel, which revealed that this potential problem with the team structure was ever sufficiently analysed or addressed.

- 3.74 The *status quo* in which Dr Watt was working from 2012 on his own in Team A, was accepted without challenge as the Trust strove to confront the problem of patients having to wait, often for years, before they could get an appointment with a neurologist in the NHS. The Inquiry Panel fully accepts the pressures on the existing system were, and are, intense and may, at times, be almost overwhelming. Nonetheless, there are steps that could have been taken, which, if properly implemented, would have led to an analysis being carried out in the higher echelons of Trust management and a recognition that Dr Watt was isolated in relation to working with inpatient admissions. That did not occur and the questions around lone working, and potential problems arising, were never asked at any level of management. In written evidence of 10th December 2021, Mrs Owens submitted that action could not be taken if matters were not brought to her attention. This is a consistent theme in the Trust's submissions, but the Inquiry Panel does not agree with the premise that a senior manager cannot be accountable unless they know about an issue. Dr Watt first raised a concern about workload and isolation on 9th June 2017 in a meeting with Dr Mitchelson and Mrs Owens:

Michael volunteered that he felt that his workload was pressurised and possibly out of control. He also stated that he felt isolated. He noted that he was not part of a team in terms of his ward rounds (previous colleagues no longer practising), and that in his clinics (bar the TIA clinic which he felt worked well), he was again the sole consultant. He made the following suggestions:-

- That another consultant, or team, practiced alongside him in clinics.
- That he was integrated into a ward team.

Michael voluntarily admitted that he "pushed the boundaries" of practice but did so in good faith. He admitted that he was sometimes quicker to make diagnoses than peers and more aggressive in starting treatments. He felt that colleagues were maybe too conservative and that he had concerns that delays in treatment had the potential to cause harm.

3.75 The issue of isolation was referred to in a subsequent letter from Dr Jack on 22nd June 2017 to Dr Watt:

I understand that when you met with Mrs Owens and Dr Mitchelson you indicated that you felt your workload was “pressurised and possibly out of control”, that you felt “isolated”, and that you “pushed the boundaries of good practice”. I understand that Dr Mitchelson arranged for you to be seen by the Trust Occupational Health Service, and I await a report from that consultation.

3.76 While reference to Occupational Health was clearly an appropriate step, the issue of lone working and isolation was not further analysed by the Trust. The Inquiry Panel notes with some alarm that in the Trust’s explanation, which was given to the Inquiry alongside the draft Verita report, there was little evidence that this issue had been adequately reflected upon.

3.77 There seems to have been little or no analysis of why it was that in June 2017, Dr Watt felt isolated and that his practice was pressurised and out of control. In contrast, some registrars who worked closely with Dr Watt could see clearly that Dr Watt working on his own was unwise and was something which, in hindsight, should have been addressed. It was also apparent to some of his nursing colleagues that he had a different method of working and was isolated.

3.78 The reality is, at the time, no one addressed it or even saw the need to focus on the situation, primarily because they believed it was for the consultants themselves to agree how the teams should be comprised. The fact is that alarm bells should have sounded earlier and the matter properly reflected upon. This does not seem to have occurred, either at that stage or subsequently. The Inquiry Panel accepts that it was also partly Dr Watt’s responsibility to raise the issue before he did in June 2017 when he was on the cusp of being fully restricted from clinical practice, but it is equally the case that management are not absolved in their responsibility simply because a consultant fails to raise a working practice, which is obvious and apparent.

3.79 In its written evidence of 16th December 2021, the Belfast Trust submitted that by June 2017, given Dr Watt’s impending full clinical restriction, there was nothing further at that point to analyse regarding Dr Watt and working in a ward team. The Belfast Trust points out that in 2019 it initiated a scoping exercise to identify small clinical teams and to assess what support arrangements were in place for those teams. A further survey was also due to be completed in January 2022.

**The TIA<sup>13</sup> Clinic:**

- 3.80 Dr Watt was part of a weekly TIA clinic in which he did undoubtedly collaborate with other disciplines. It is noted that this factor is advanced by the Trust in its summary of 31st January 2021 (above) as evidence of team-working, at least in part. The Inquiry Panel did consider this but, while there was co-operation between various disciplines, the impression given by a number of witnesses, including registrars who participated in the clinic, was of Dr Watt being very much the ‘go-to’ person or central figure to whom other doctors deferred.
- 3.81 In her evidence of 11th December 2019, Dr Jack referred back to her own time as a geriatrician with an interest in stroke in the mid-2000s and recalled waiting outside Dr Watt’s room until he was free to discuss specific cases. Dr Jack stated:
- So, on the system [the patients] were all [Dr Watt’s] ... So, if you looked at my activity, they’d all be affiliated to him, even though I’d be there or Mark Magorrian would be there, but, actually, I’m responsible for those that I saw.
- ... if you had something that you needed to discuss, you’d just go and stand outside, and the next time he was free, you’d go in and talk, a bit like a reg would ... and you would see the new ones all ... He’d come in and he’d do reviews the whole time. We would see the new and then we’d start to pick off the review file.
- 3.82 Dr Mark Magorrian was a consultant in the care of the elderly with a special interest in stroke, which involved a TIA clinic once a week. In his evidence to the Inquiry Panel on 1st May 2019, Dr Magorrian explained:
- From 2006, that came to be, and I started doing the TIA clinic on a Thursday morning, and that was the clinic which Michael Watt had been the lead clinician at for years and had been there when I was a registrar in training. So, he was – he had been the main consultant at it.
- 3.83 Dr Cathy Patterson, who was also a consultant geriatrician with an interest in stroke, explained to the Inquiry Panel on 14th May 2019 that previously Dr Watt and, for a limited period of time, Dr Ailsa Fulton, had provided neurological input to the stroke clinic. She indicated that the clinic was now operating only with herself and Dr Magorrian and they would be presently seeing less than half the number of patients they would have done when Dr Watt had been a part of the clinic team.
- 3.84 Dr Karen McKnight, now a Consultant Neurologist in the Southern Health & Social Care Trust, was formerly a registrar working with Dr Watt in the TIA clinic and

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<sup>13</sup> TIA is an acronym for transient ischaemic attack.

highlighted in her evidence to the Inquiry Panel of 12th November 2019, just how busy the TIA clinic had been:

Initially, the TIA clinic was a very busy clinic, and probably the busiest clinic that I did. [Dr Watt] was supervising a lot of staff, so he had – there were stroke physicians, there were care-of-of-the elderly physicians there. I was there as a registrar. There was a nurse. So, there were a lot of doctors and quite a number of patients booked into each time slot, but then there were a lot of doctors to see them.

3.85 Dr Jamie Campbell, in his evidence to the Inquiry Panel on 9th January 2020, referred to his raising at a registrars' meeting of the busyness of the TIA clinic where Dr Watt was the lead consultant and the difficulties that that posed for training registrars. This meeting is discussed in the Concerns chapter, but in his evidence, Dr Campbell indicated that his colleagues would have discussed openly Dr Watt's clinics. Dr Campbell told the Inquiry Panel:

**Dr Campbell:** People would've said they disliked [the TIA clinics]. People would've said they, I think it's fair to say, hated those clinics – for various reasons ...

**Mr Lockhart QC:** Can you remember any of your colleagues using the word "hate"?

**Dr Campbell:** "I hate the TIA clinic" was common parlance. I must clarify not in any way the patients attending that clinic ... or the pathology being seen, but the running of that clinic. I think most of my colleagues – well, I would surmise that most of my colleagues would agree with that point.

**Professor Mascie-Taylor:** And had been party to that sort of discussion.

**Dr Campbell:** Yes ...

3.86 In the view of the Inquiry Panel, it is correct to point out that Dr Watt did co-operate and liaise closely with other consultants at the TIA clinic. The evidence, however, would suggest that Dr Watt was very much the lead consultant, to whom other physicians deferred on neurological matters. While Dr Ailsa Fulton was a fellow Consultant Neurologist who would have been present for part of the relevant period, Dr Watt was normally working as the only neurologist in the clinic. It is also significant that multiple witnesses gave evidence that Dr Watt tended to see the review patients whereas other consultants and registrars were seeing the new patients. This would have meant that the opportunity for colleagues to have sight of Dr Watt's practice as patients returned to the clinic over time would likely have been limited. The experience of the registrars suggests that the clinic was one that

they found particularly difficult because of its busyness. In that sense, therefore, Dr Watt's management of patients would not have been ordinarily challenged as one would expect in a peer review situation. The Inquiry Panel has, therefore, concluded that the fact that Dr Watt liaised with other consultants at the TIA clinic had limited relevance to the overarching problem of lone working and a lack of peer review.

### Management Attitude:

- 3.87 In assessing the management attitude to lone working and the recognition of a particular problem in Dr Watt's practice, it is essential to begin with an understanding of the context which managers faced. The overarching concern of the Service Manager, Mr Gerry Atkinson, and the Co-Director, Mr Frank Young<sup>14</sup>, was to address not just budgetary constraints, but the intense pressures on the neurology waiting list. In a very real sense, their effectiveness was assessed by the number of patients that were seen and whether waiting lists could be reduced. This, of itself, is perfectly understandable.
- 3.88 The Inquiry Panel noted that Service Managers did not feel sufficiently confident to impose team working on consultants, despite its obvious benefits. The approach taken was that team working was desirable, but not necessary. The Service Manager would not have regarded his role as considering how doctors arranged their working practices within their own specialty. In his evidence to the Inquiry Panel, Mr Atkinson recognised the benefit of working in teams, but made it clear that it was not really something that was part of his responsibility. In his evidence of 22nd January 2019, he stated:

**Professor Mascie-Taylor:** One retired and one died, as far as I understand it, which left a team of one for quite some time. So, why was that permitted? Why did Michael Watt carry on in a team of one?

**Mr Atkinson:** I don't know is the answer to that. I was only aware of that sort of fairly recently about sort of the team structure. I mean, I've heard about the teams before, but I didn't appreciate that Michael wasn't part of a wider team and was actually working on a team on his own.

**Mr Lockhart QC:** If you'd known about that, Gerry, what would you have done? You know, what I'm concerned about here is that everyone who has spoken to us who has information – any of the neurologists would've indicated that that was an issue, and some of them have said various things about him, but it seems to us that it's a pretty obvious thing that, if one consultant is working

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<sup>14</sup> Co-Director of Unscheduled & Acute Care.

on his own, while the other two have got two teams of five, there's a danger of someone who has got particular views or particular practices suddenly just veering off.

**Mr Atkinson:** No, I would agree, and, like I said earlier, there are benefits to be had from working in a team ...

**Professor Mascie-Taylor:** You can just take two views. You can either say that, given what I think everyone accepts about lone practitioners, they are more at risk of varying from the norm, let's put it like that. Is it for the practitioner, is it for the consultant, to say, "Please can I join one of these teams?" i.e. the onus is with the consultant, or is it for the organisation to say, "Well, we believe that this is an effective way of working and, therefore, you are going to join one". Do you see the point of my question, which is –

**Mr Atkinson:** I do see the point of the question.

**Professor Mascie Taylor:** - where is the responsibility for that?

**Mr Atkinson:** I don't know whether the team structure is one that is imposed or suggested by the organisation or if that is a way that the consultant body decides to organise themselves, but as I say, clearly there are benefits in working in teams in that way ... I think he should've been part of a bigger team. He should've been part of a team. He wasn't part of a team at all, because you can't be in a team if you're on your own.

- 3.89 The Inquiry Panel accepts that Mr Atkinson, in good faith, believed that the issue of team structure was a matter for the consultants themselves. The Inquiry Panel considers that this was a misunderstanding of the management system that was in place, although the matter was primarily within the province of the Clinical Director.
- 3.90 This issue was also explored with Mrs Owens, the Director of Unscheduled and Acute Care. As an individual who was, at that time, just one level below the Trust Board and who reported directly to the Chief Executive of the Trust, she carried a wide array of responsibilities, some of which included ensuring patient safety. How was it then that Dr Watt was working in a team of one consultant, while others were in teams of five? In written evidence provided to the Inquiry on 10th December 2021, Mrs Owens highlighted two examples of her dealing with problems in a clinical team when the issue was raised with her. She pointed out in her evidence that she could not deal with an issue of which she was not aware (as explained at paragraph 73 above, the Inquiry Panel does not agree with this premise). Mrs Owens recognised that there were obvious dangers with lone working in her evidence to the Inquiry Panel of 6th December 2018:

**Professor Mascie-Taylor:** What do you make of that then given you have said about multi-disciplinary teams?

**Mrs Owens:** Yes. Obviously that would be, and hindsight and everything, there's always risks where individuals are working on their own.

**Professor Mascie-Taylor:** What I really don't understand is how we got to a situation where we have that split one, five, five. Why did that happen? What caused that situation and then what allowed it to continue?

**Mrs Owens:** Again my understanding has been that Michael Watt in terms of how he operated and functioned within that was a bit more -- the others were meeting at various times and there was a discipline and a rigour around that and Michael wasn't as, what's word I want to say, as organised probably to be there. He didn't always start on time. I think, to be fair, he had more of an out-patient workload and less in-patients is my understanding, maybe because he was just one, and the others found it difficult to link in with his practice.

**Professor Mascie-Taylor:** In retrospect I suppose the answer is obvious really. It is hard to see, I think, from where we sit how anyone might have thought that was a sensible thing to do. It's easier to see it wasn't sensible in retrospect. I absolutely see that. Given what we know about lone practitioners there's usually a reason why they are lone practitioners. I think you're hinting at some of the reasons you think he might be a lone practitioner. It often relates to the way they want to work and may also relate on some occasions to other people's perception and not wishing to work with them. Is that the case here?

**Mrs Owens:** I believe so. I think there's an issue around his wanting to work in a team and then how he was more, I think from my understanding, chaotic in his practice and in his organisation around that, and others found that more challenging. Yes, on hindsight and whatever, and I have been obviously having conversations with John in particular around this and the learning would be a flag should go up.

**Professor Mascie-Taylor:** Do you think anybody ever took him on over it? This may or may not be fair, but one has the impression, you used the word chaotic; he chose to work in a particular way, he chose not to be appraised, he chose this and he chose that. That all seems to somehow be accepted or tolerated perhaps is a fairer word than accepted. Do you think that's fair?

**Mrs Owens:** Yes, although I do know that John (Craig) as his clinical director was having conversations with him around his way of working in particular for his out-patients, as I said earlier. I think John would obviously be the best to answer exactly the level of challenge and whatever.

- 3.91 The Inquiry Panel believes that it is too easy to introduce an artificial dichotomy between the managerial responsibilities of those in the higher echelons of the Trust and those who are medical managers. Those at Co-Director and Director level, such as Mr Young and Mrs Owens, as well as the Service Manager, Mr Atkinson, have a responsibility to consider and ensure patient safety. That responsibility cannot simply be referred to the Clinical Director.
- 3.92 A Clinical Director may have had the opportunity to consider the importance of team working but, as the Inquiry Panel has already noted, Clinical Directors were often attempting to carry out a managerial role with limited hours and the burden of their own practices. The Inquiry Panel recognises that, in Neurology, there was little scope for reflection. There was a 3-year waiting list and the focus of managers was on reducing waiting lists and obtaining access for patients.
- 3.93 It again needs to be stated that the pressure on the neurology waiting lists was intense and the strong impression given from the evidence of the Service Manager and others within the Neurology Department was that Dr Watt had an extraordinary work ethic and saw a vast number of patients. As pointed out by Dr Fulton, and referred to above, Dr Watt was held up as *“the poster boy”* by management, because *“he was seeing so many more patients than the rest of us”*.
- 3.94 The Inquiry Panel has concluded that no one in management saw it as their responsibility to ensure that a consultant was not working on his own. In hindsight, and having regard to what subsequently transpired, the point seems obvious, but the reality at the time was that those in authority believed it was ultimately a matter for the consultants to arrange. This was, in the view of the Inquiry Panel, unacceptable and unsatisfactory.
- 3.95 The Inquiry has not been presented with any evidence to suggest that the dangers of lone working were considered at any stage. The Inquiry Panel considers that this was a major governance failure and came about because of a laissez-faire approach by management to the working arrangements agreed between consultants.
- 3.96 The Inquiry Panel noted, for instance, the evidence of Dr Ken Fullerton, Associate Medical Director on 20th November 2019, who gave a strong view on the working arrangements within neurology. Dr Fullerton indicated that he was unaware that Dr Watt was working on his own:

I would have been concerned about it and the first thing I would have done would have been to talk to John Craig, who was the Clinical Director, and ask was he aware of it and did he think this was a good idea and implied rather strongly that I didn't think it was a good idea.

- 3.97 In his oral evidence on 14th November 2019, Colm Donaghy, Former Chief Executive of the Belfast Trust<sup>15</sup>, noted:

There are some areas where it [multi-disciplinary team working] is a requirement within the NHS systems or, actually, it's culturally a requirement: it's now become such an accepted practice that not to do it would be extremely unusual and probably wouldn't be tolerated by the individual's peers.

- 3.98 Professor Ian Young, then Assistant Medical Director, recognised, in his oral evidence on 9th April 2019, that there were some specialties, where team working would not be possible because of the limited number of specialists working in Belfast, but was strongly supportive:

I think all clinicians should work as part of multi-member teams. I've no doubt about that at all. I think, occasionally, there are some micro-specialties where there might be challenges in achieving that. However, I think, in that case, individuals should work as part of a multi-member team with other professionals as close to their area of practice as possible.

- 3.99 Professor Young did recognise, however, that all consultants should work in teams. He noted that no doctor's practice is so specialised that it cannot at least be sense-checked:

There's a constant check and balance and if anybody's practice was out of sync, you would very rapidly discover that.

- 3.100 He further proposed that if every doctor shared patients at clinics and built in a system of random audits and three-monthly swapping of clinics, this would be of enormous benefit. Commenting on the possible reluctance of some consultants to participate, he said:

I would be extraordinarily disappointed if any doctor would decline the offer – indeed, it would immediately raise concerns in my mind about their practice.

- 3.101 In his oral evidence on 16th January 2019, Mr Ray Hannon, Consultant Vascular Surgeon and Associate Medical Director in the Belfast Trust, commented on what one might term as the 'norming effect' of colleagues challenging each other to ensure good decision-making:

These are all retrospective. In other words, something has happened that the system has caught after it happens or gets recorded. I think probably the best way to try and keep practice safe is, in advance of the surgeon doing the wrong operation, a multi-disciplinary team. The more working you have and the more

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<sup>15</sup> Mr Donaghy was Chief Executive from 2010-2014.

people to sort of say, 'You're gonna do what? No, you don't want to do that do you?' And then if that sort of decision making comes up frequently, somebody, you would hope, somebody senior in the team would say.

- 3.102 In his evidence on 1st May 2019, Dr Ferghal McVerry, Consultant Neurologist in the Western Trust, recognised the difficulties with solitary practice, but highlighted the importance of consultants being proactive in seeking out team working. The Inquiry Panel noted that Dr McVerry's job plan did not include team working, but, nevertheless, he gave evidence that the importance of working alongside colleagues was essential to ensure efficiency:

We should be aiming to work with multi-disciplinary teams to reduce, in your words, aberrant practice ... so the way to do that would be to work with oversight and to have mechanisms enshrined to allow that to occur. We do that currently because we're aware of the fact that working in solitary practice is something that you would want to avoid, but it's something that requires, in my experience, something proactive ... by the consultants. I never had an MDT in my job plan or whenever I started working as a consultant but it's something that I realised a while ago we should have to make our work practice more efficient for ourselves ... but that was something that required initiative on my part and Dr McCarron's part, who I worked with. So that's not something that was an assumption on any job description whenever I started as a consultant.

- 3.103 Beyond putting effective team working in place, the Trust requires appropriate processes and mechanisms to ensure that concerns can be raised and acted upon. The system in place during the relevant period was such that, as much as various managers may have thought that team working was valuable and effective, no one appeared to believe that it was their responsibility to take action. This was true at every level of management.

#### **Job Planning:**

- 3.104 Each consultant was required to agree a job plan with the Clinical Director. The extent to which Dr Watt perceived himself to be subject to this requirement as he continued on what was referred to as "*the old contract*" is unclear. The arrangement placed Dr Watt on less programmed-activity hours, but it did not absolve him from having a job planning meeting with the Clinical Director and Service Manager. The issue was raised in 2009 when the following written interaction took place between Dr Watt and Dr Morrow, the then Clinical Lead:

As I am still on the old contract I do not need a job planning meeting.

Michael Watt

3.105 Dr Morrow responded:

Michael

I think you do need a job planning meeting-but don't worry we have no control over you (it is a formality)

Jim

3.106 Given that in 2009 Dr Morrow was the Clinical Lead for Neurology and had responsibilities in relation to helping provide a safe and efficient neurology service, his attitude to job planning by Dr Watt was surprising. It is unfortunate that the Inquiry has not had the opportunity to hear from Dr Morrow because of a medical condition. On the basis of the documentation, the extract above suggests that Dr Morrow had a low view of the value of job planning and reinforces the perception that it was a matter of little importance compared to the more pressing challenges of providing for and seeing patients.

3.107 The Inquiry Panel also considered job planning with Mr Atkinson, the Service Manager:

**Professor Mascie-Taylor:** So, job planning: how did that work?

**Mr Atkinson:** Dr Craig and I would've sort of met with individual consultants.

**Professor Mascie-Taylor:** Right. So, the two of you did that together.

**Mr Atkinson:** We did that together.

**Mr Atkinson:** In my previous service manager post in dentistry, I wasn't involved in the meetings with individual consultants, nor with the previous Clinical Director in neurosciences, but it was something I did with Dr Craig. Whether I offered to help him with that or whether he asked me, I can't remember. But certainly, I was very happy to get involved in the job plan meetings.

Best practice is to do those on an annual basis. Now, we never really got there in terms of succeeding in meeting with every consultant over a 12 month period. And, for a time, we did have a programme in place, where we did have regular meetings. We gave over every Tuesday morning, or whenever it was, to job plans, or every other Tuesday. But then there's other pressures, and we're pulled in various directions, and other priorities so we always got a bit behind with the job planning.

**Professor Mascie-Taylor:** And how much did job plans change from year to year?

**Mr Atkinson:** Most of them would've changed.

**Professor Mascie-Taylor:** They would've done, yes.

3.108 Mr Atkinson confirmed that it had been some years since a job planning meeting had taken place with Dr Watt:

**Mr Atkinson:** The last job plan meeting with Michael, Dr Craig and myself was in 2014; I think June. And this was sort of different to the other consultant staff. He was part of the old consultant contract. So it was basically a sheet of paper with you know, there's the sort of diary for the week and it didn't change from year to year. So that was the difference there.

We did try and have another job planning meeting with him around the end of 2015 but the dates did not suit Michael and we never got around to actually doing it again \_ Professor Mascie-Taylor: What was the implication of him being on the old contract?

**Mr Atkinson:** I don't know. I mean. I know there's very few consultants remaining in the Belfast Trust— they were given a choice to move on to the existing contract. I don't know what benefit was to be had for either of them but given that the vast majority of consultants moved to the new contract, I would've assumed that there was benefit in moving to that contract. So I don't know and I don't know whether he declared to anybody or understood why he wanted to remain with the old contract, but nevertheless he did\_

**Professor Mascie-Taylor:** Do you think the Trust's attitude towards people on the old contract and the new contract were any different? What do you think more?

**Mr Atkinson:** Well it didn't make any difference to me He still had his clinic sessions, you know, his week carved out in such a way that we knew where he was for different parts of the day and each day of the week —

**Professor Mascie-Taylor:** Right, so in effect —.

**Mr Atkinson:** — and a process was in place to change that, you know, if he decided to change it. I mean, most of the changes to job plans would be in relation to one of the consultants taking on a new role, maybe they would take up educational supervisor, audit lead, whatever that was, and coming with that would've been additional PAs or parts of PA to account for that, but Michael didn't, you know — his didn't change.

**Professor Mascie-Taylor:** It didn't change in your view. The process was pretty much the same.

**Mr Atkinson:** No, it didn't change at all.

3.109 The Co-Director, Mr Young, was equally clear that the issue of job planning was a matter for the consultants, despite the fact that his own job description covered all aspects of management within the division. He told the Inquiry Panel on 22nd April 2021:

**Mr Lockhart QC:** Sure. Similar kind of questions about workload and job planning, he had no job plan since 2014. Were you aware of that?

**Mr Young:** No.

**Mr Lockhart QC:** Right. Should you not have been aware of that?

**Mr Young:** The job plans were agreed very much by the CD and the team themselves when they looked at the available slots that they had ...

**Mr Lockhart QC:** Do you not need to be kept informed of the fact that job plans are outstanding or somebody hasn't completed a job plan, because presumably they all have a template they are meant to work to. There's all sorts of concerns about who is going to the private sector. There were issues about over work, or concern like that. Is that not something that you would have been informed about on a regular basis?

**Mr Young:** No. Job plans isn't something that I would have been briefed on, on a regular basis, because, generally speaking, most of them worked very well.

**Mr Lockhart QC:** It is the whole idea again, I am sure Hugo will come in on this, but it is aware of being responsible for something and ensuring that a system is in place. Yet, here we find with Dr Watt there was no, it was very difficult to get him to do that, and yet you are responsible for it but nobody tells you about it.

**Mr Young:** Yes.

- 3.110 What is striking is the lack of job planning involving Dr Watt throughout his consultant career and during the relevant period between 2006-2018. There is also a dearth of documentation. In contrast, Dr Watt's work ethic was such that he was highly valued by those in management who were increasingly concerned about addressing huge waiting list pressures. In his evidence of 18th November 2020, the Service Manager, Mr Atkinson, stated:

**Mr Lockhart QC:** As I understand it, at no point, prior to Dr Watt going off in July '17, was there ever a discussion about the heaviness of his workload, or the fact he was doing too much?

**Mr Atkinson:** No.

**Mr Lockhart QC:** There was a discussion, at one stage, about his clinic and that was looked at, they brought him down to a, kind of, normal template, and he wanted to put it up again because he got bored.

**Mr Atkinson:** There was. That's right. Dr Craig and I met with him, or was it done through email, I can't remember. I do remember that his clinic template was reduced and he stopped seeing as many patients. I can't remember what

the background to that was, was it raised as a problem by him or by someone else, or what the issue was, but certainly, yes, that was done.

**Mr Lockhart QC:** Then it went up?

**Mr Atkinson:** Then it went up again, yes.

**Mr Lockhart QC:** It would be fair to say, you were personally never concerned, and I don't mean this in any way a pejorative sense.

**Mr Atkinson:** No.

**Mr Lockhart QC:** In some ways your stellar man?

**Mr Atkinson:** Salvation.

- 3.111 The issue of clinics that were overbooked was a periodic problem, which emerged at various relevant points between 2006-2016. It was the source of a significant number of complaints and, at certain points, efforts were made to try and impose a clinic template, which would have restricted the number of patients attending a particular clinic. Unfortunately, any efforts in this regard provided only a temporary fix. Dr Watt preferred to be busy and found the restrictions on the number attending reduced his sense of professional fulfilment, as explained by his secretary in her evidence to the Inquiry Panel of the 29th August 2019. It was Dr Watt who unilaterally increased the numbers attending his clinics following a reduction that had been agreed, although Dr Watt's secretary could not recall the precise date when this had occurred. The issue of Dr Watt exceeding agreed clinic templates was never properly addressed. Dr Watt appeared to lack insight although, in the days prior to his restriction in June 2017. He began to talk much more freely in formal meetings about the difficulties that he had encountered, the pressures he endured because of his workload and the number of patients who were seeing him at clinics.
- 3.112 Job planning is meant to be a way in which the obligations and responsibilities of the consultant can be planned in a manner which is efficient for the Trust and manageable for the doctor. In this regard, when taken seriously, there is much more a performance management dimension to the process than, for instance, appraisal. Dr Watt stayed on the old contract for whatever reason. He was reticent to attend job planning meetings and the Inquiry Panel notes that at no point does any individual within the management structure address this. As outlined above, Dr Morrow seems to have tolerated the situation. When Dr Watt did attend, the meeting, in the view of the Inquiry Panel, it appeared to be a formality and no job planning had taken place since 2014. There was, therefore, no appreciable benefit to the meetings, nor was there any real opportunity to discuss pressures of work or a concern that

Dr Watt was seeing too many patients at his clinics. In contrast, Dr Watt was clearly viewed as a real asset to the Neurosciences Division because of the huge number of patients he saw. This dynamic was prevalent throughout the relevant period and, in the view of the Inquiry Panel, contributed to the perception that certain contractual obligations for consultants were not mandatory.

### Conclusions and Findings:

- 3.113 The consensus view among both neurologists and managers was that working in consultant peer review and multi-disciplinary teams had proved to be an effective and efficient method of working. The Inquiry Panel heard evidence of how teams B and C sat down together and discussed each other's patients before conducting a joint ward round.
- 3.114 Despite an apparent acknowledgement of the theoretical efficacy of team working, this does not appear to have been recognised as a professional obligation within the Neurology unit in the Belfast Trust. Although there was evidence that those at Associate Medical Director level would have been surprised if they had been aware that Dr Watt was working on his own, the Inquiry Panel is not satisfied that there was insufficient knowledge for Trust managers to act. If there was insufficient knowledge on the part of management, then the Inquiry Panel considers that this, in itself, was a basic failure to inquire and understand the team setup. On the basis of the evidence received, the Inquiry Panel is satisfied that a culture had evolved where the focus was almost entirely on managing patients and dealing with demand. In this context, there was little or no consideration at any management level of the dangers of lone working.
- 3.115 It is not, however, the case that those who were working alongside Dr Watt at a more junior level, failed to notice the problem of isolation. Evidence from registrars revealed that they were fully aware of the practice and there were numerous examples of registrars comparing the experience of working alongside consultants in Teams B and C, as compared with the experience of working alongside Dr Watt.
- 3.116 Although Dr Watt was respected for his acumen, his style was palpably different. This was recognised by a number of the nursing staff who commented on the unusual dynamic. The fact that registrars would tend to gravitate towards Teams B and C was also noticed and commented upon by nursing staff.
- 3.117 The Inquiry Panel concludes on the basis of the evidence that:
- (i) Peer review has a clear normalising effect.

- (ii) The sharing of opinions in real time contributes to improved diagnosis and management of patients.
- (iii) Peer review also contributes to learning and keeping practitioners up to date.
- (iv) Team working had an overall beneficial effect on patient safety.

- 3.118 The Service Manager, the Co-Director and the Director of Acute Services reflected in their evidence that the absence of team working in respect of Dr Watt was a problem, which needed to be addressed. They did not, however, consider that team working or indeed job planning were within their purview. At the same time, the Clinical Director, who would have had responsibility, together with the Service Manager, to discuss consultant job plans, had limited opportunity to alter existing working arrangements. The fact that there was no job planning meeting with Dr Watt since June 2014 illustrates the point. The practice which seemed to be, as far as Dr Watt was concerned, a “*formality*” appeared to have negligible value in his case. The communication between management and the Clinical Directors was focused on the ever-growing demand for neurology services as well as addressing budgetary constraints. In this regard, Dr Watt would have been perceived as a significant asset. He saw as many, if not more, patients than anyone else and helped alleviate the chronic problem of waiting lists. Little thought or reflection was given to the fact that he was working on his own in Team A, and that such an arrangement was unwise and, as it transpired, ultimately problematic. It would also have increased the opportunity for other health professionals to have observed Dr Watt’s practice.
- 3.119 Dr Watt clearly did not see value in job planning. At various points he believed that he was not required to carry out same. Nobody at any level of management ensured that he fulfilled what was a contractual obligation to the Trust. The seemingly optional nature of peer review working permits the endurance of a culture where lone working is still accepted without comment. The dangers of lone working were recognised by various witnesses and yet the Inquiry received little evidence that the existing arrangements within neurology were a matter of immediate concern to Trust managers.
- 3.120 Consultant neurologists, for the most part, were incurious and, although recognising that peer review and MDT working was helpful, saw little need or requirement to insist on same. The Inquiry Panel noted that Dr Hunt, although initially assigned to Team A, was quite free to transfer to another team on the basis that he preferred working with Team B. In that sense, consultants were somewhat autonomous and could decide unilaterally to change their team-working arrangements without

management interference. In this regard, consultants tended to perceive themselves as members of what might be better described as a voluntary coalition, rather than participating in an assigned team. Dr Hunt's experience illustrates this well.

- 3.121 A further difficulty was that, within Neurology, the Clinical Director or Clinical Lead did not view their role as managerial, or at least not in the sense that would be consistent with common conceptions of management within an employment structure. Relationships within Neurology still echoed earlier times, where the consultant's responsibility for a patient tended to occlude analysis and management. The fact that Dr Watt could continue working on his own in Team A for a period of 6 years is, of itself, evidence that there was a problem.
- 3.122 A dynamic existed in the relationship between general managers and clinicians that allowed a gap to develop between what managers were held to be responsible for and what happened in practice, as illustrated by the following exchange between Professor Mascie-Taylor, the Co-Panellist, and Mr Frank Young:

**Professor Mascie-Taylor:** Did you ever say to any of the doctor managers, 'I am a senior general manager and I am responsible for the safety of my patch, that is part of my job. I am looking to you to assure me that the consultant practice is safe'. Was that conversation ever had?

**Mr Young:** No.

- 3.123 Later in the interchange, Mr Young was asked about the way in which he was reassured about patient safety:

**Professor Mascie-Taylor:** The general manager has to make it explicit to that doctor manager that they are looking to them to reassure that manager about the safety of the practice, because that's where the gap appears to be. The general manager says, as you have said, 'I am frenetically busy. I am running around all the time. I am trying to look after the beds. I am trying to look after the staffing. I am trying to look after the budget. I am working 12 hours a day on a good day', and the doctors are saying 'well, we are not the managers'. So, somehow there is a hope, an optimistic hope that everything will be safe, which is not the sort of optimistic hope that you apply when you are thinking about beds or budgets ... But the same sort of rigour doesn't seem to apply to patient safety. Is that a fair analysis?

**Mr Young:** In hindsight, yes. It was a broken system. People were working extremely hard. People were doing the very best that they could in the time that they had, but, and I will say it again, I don't think there was enough protected dedicated time that these kind of things could be worked through, not just within my area, but for all of the clinical services where you have so many

consultants who are single handed or specialists, so that we can actually audit it properly ...

- 3.124 The fact is that the pressures on the system were such that a disconnect developed between a manager's formal responsibilities and what occurred on the ground. If the focus was on seeing patients and reducing waiting lists, then that was how a manager invested their time. The question of patient safety was to some extent taken on trust. In the majority of instances this may not have been problematic, but the absence of scrutiny made it difficult to identify aberrancy when it arose.
- 3.125 It is the case that establishing peer review in outpatient clinics, where most neurology patients are assessed is a much greater challenge than doing so in an inpatient setting. Where arrangements for shared clinics are put in place many of the advantages of peer review can be appropriated.
- 3.126 The Inquiry Panel understands that there was, and is, a particular focus on reducing waiting list times. It is unsurprising that doctors like Dr Watt, who demonstrated a remarkable work ethic, are applauded. There is a danger, however, that over-confidence in the ability or acuity of a Trust consultant can lead to obvious anomalies being overlooked or accepted without comment.
- 3.127 In the Belfast Trust Neurology Department, audit appears to have been sporadic and lacking structure. The picture which emerged from the evidence was one where clinicians audited areas of interest to them, rather than performing a structured audit as part of a coherent plan driven by safety and quality. During the course of the Inquiry, when sight of the neurology audits was requested, it was noted that they were not readily available within the Neurology Department, or indeed within the Trust centrally. If audit is going to be part of a consultant's job plan, then it should be carefully thought out and part of a joined-up team approach within departments.
- 3.128 The Inquiry Panel is required under the Terms of Reference to review "participation in processes to maintain standards of professional practice". After the retirement of Dr Hawkins in 2012, Dr Watt was essentially working on his own in Team A over a period of years. The teams that were devised were to assist nursing staff working in the neurology unit (Ward 4E) in the Royal Victoria Hospital. Over those years, there was no clinical audit, which was targeted or specific enough to identify any problem with Dr Watt's practice. Peer review was not a feature of neurology practice and though the Grand Round Meeting for Neurosciences had an important educational role, there appears to have been nothing that raised any concern about Dr Watt. While Dr Watt was co-operating with other consultant colleagues in the TIA Clinic, the evidence would suggest that he was being deferred to on any neurology matter.

- 3.129 The reality is that Dr Watt was working for a large part of the time on his own and this was not identified as a problem by management. The Inquiry Panel is satisfied that, had Dr Watt been working alongside his consultant colleagues, unusual practices could have been identified and discussed. Dr Watt had, himself, complained in June 2017, during his interview with Mrs Bernie Owens and Dr Mark Mitchelson that he was struggling because of lone working outside an established team. He repeated the observation in his November 2017 appraisal.



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