Independent Neurology Inquiry

Report
June 2022

Volume 2

(Revised – 28th June 2022 at Chapter 4 – 2006/07 Missed Opportunities)

www.neurologyinquiry.org.uk

CONTENTS

CHAPTER 4 – 2006/2007 MISSED OPPORTUNITIES

4.1 A requirement of the Inquiry's Terms of Reference was to review the Belfast Trust's handling of relevant complaints or concerns, identified or received prior to November 2016. The Inquiry Panel was tasked to determine whether there were any related concerns or circumstances, which should have alerted the Belfast Trust to instigate earlier and more thorough investigations over and above the extant arrangements for raising concerns and the existing complaints procedure. Arising out of that investigation the Inquiry Panel was then asked:

> to identify any learning points and make recommendations to the Department in relation to points (a) and (b) above . In particular to consider the application of any learning arising from the Inquiry to the framework for clinical governance, the current balance between problem sensing and assurance seeking in the extant system and its underpinning processes.

4.2 The Inquiry considered three time periods, in particular – 2006/2007, 2012/2013 and 2016 on the basis that events occurred during those time periods, which should or could have alerted the Trust, and its predecessor the Royal Hospitals Group, to instigate an earlier and more thorough investigation.

4.3 The time period being examined by the Inquiry in this chapter, 2006-2007, spanned the merger of the 6 legacy health trusts into the Belfast Health & Social Care Trust, which was established on 1st August 2006 and became operational from 1st April 2007. It was a time of significant change within the health service in Northern Ireland.

4.4 The new Belfast Trust had a budget of £1.1 billion and c. 20,000 staff with 800 career grade doctors when it became operational. It was one of the biggest employers of doctors in the UK. This presented significant challenges in introducing a single system of integrated governance that included professional and clinical governance. Dr Stevens the then Medical Director was working on these issues during 2006 and 2007.

4.5 Because of its size, the Belfast Trust had a federated structure comprising services groups, led by a director. Each director was accountable to the Chief Executive for the business of their service group and was supported professionally by an Associate Medical Director, who was a doctor with 50% of their time allocated to management. Dr Stevens noted that within a year of establishing the Belfast Trust, the number of consultants in the leadership roles had increased from one in nine to one in six.

4.6 The questions that arise in this chapter should be viewed through the lens of management and its effectiveness, the identification of aberrant practice and the triangulation of relevant data in relation to the practice of Dr Watt.

Dates of significant incidents explained within the chapter:

(i) 7th April 2005 – INI 408 complaint received by the Trust;

(ii) 5th October 2005 – General Medical Council contacted the Trust regarding Dr Watt;

(iii) 9th June 2006 – INI 222 complaint received by the Trust;

(iv) 4th September 2006 – INI 87 complaint received by the Trust;

(v) 20th December 2006 – Dr Watt attended a meeting with the Medical Director and HR Director of the Trust;

(vi) 22nd February 2007 – Dr Watt received a 5-year warning from the General Medical Council.

Relevant Background 1996-2005:

4.7 Dr Watt was appointed a consultant neurologist with a Multiple Sclerosis ("MS") subspecialty on 5th June 1996. A search carried out in 2018 recorded 34 complaints amongst "legacy records", 14 of which had been destroyed legitimately, in line with extant Trust policies. It is, therefore, impossible to discern whether there were any significant clinical or governance issues arising in respect of those documents that had been destroyed. The Inquiry Panel has sought to try and piece together the general nature of the complaints from the limited documentation available on an updated version of the RVH Legacy Datix. For further information please see the Complaints chapter.

4.8 Certain material relating to handling of complaints does exist from this period and one can discern a number of general themes, which emerge. An early complaint was received by the Royal Hospitals Group in February 2001 from INI 403. This complaint concerned a lumbar puncture and specified a lack of communication from Dr Watt. There was significant delay in getting a response from Dr Watt and various individuals at different levels of management attempted to obtain a response, to no avail.

4.9 Documentation from 2006 summarises the sequence of events and that the Medical Director's Office became involved as follows: *"On 21 June 2001 it was considered*

whether the Medical Director should become involved … On 3 August 2001 the Medical Director wrote to Dr Watt that the delay in responding to the complaint was unacceptable, and he requested that it be dealt with within the following week … the Medical Director was written to on 3 October 2001 and asked to further intervene. On 23 October 2001 the Medical Director wrote to Dr Watt advising that he had asked [Peter Walby] *to assist him in his response."* On 30th October 2001, Mr Peter Walby, the Associate Medical Director, had to speak to Dr Watt to explain that the matter *"needed to be dealt with to avoid it developing into a more difficult situation for all concerned"*. A letter from Mrs Pauline Webb, the Patient Liaison Manager, of 30th January 2002 confirmed that Dr Watt had met successfully with the patient.

4.10 In February 2003, a complaint was received by the Belfast Trust from INI 404 regarding a private consultation with Dr Watt at the Hillsborough Private Clinic. An MRI had been undertaken and the results were posted to Dr Watt. The substance of the complaint was that urgent hip surgery was almost delayed because Dr Watt had not forwarded the results of the MRI scan or, until just before the operation, made the results of the scan available to the anaesthetist. The Patient Liaison Manager explained to INI 404 that the Trust could not investigate the patient's complaint because it was a private consultation and, therefore, outside the Health and Personal Social Services Procedure. The Patient Liaison Manager, nevertheless, forwarded the information to the then Medical Director of the Royal Hospitals Trust, Dr Michael McBride[1], (now Sir Michael McBride) because *"you may like to have this information in light of the number of similar NHS complaints we have received in this office"*.

4.11 Dr McBride confirmed to the Inquiry Panel that the handwritten note on the complaint document was his. Dr McBride's note at the time recorded:

1. *File re Michael Watt – I need to meet with him*
2. *Copy to Jim Morrow[2] & David Adams.*

4.12 In his evidence to the Inquiry Panel on 7th November 2019, Dr McBride did not recall the complaint or meeting with Dr Watt. Mr David Adams, Divisional Director in the Royal Hospitals Group, during his evidence to the Inquiry Panel on 8th January 2020, was asked if he recalled this meeting with Dr Watt. He replied *"no, not at all but*

1 Dr McBride was the Medical Director of the Royal Victoria Hospital Trust between August 2002 and September 2006. In September 2006, Dr McBride was appointed the Chief Medical Officer for Northern Ireland and continues to hold that position. Dr Tony Stevens was subsequently appointed Medical Director by the Trust in place of Dr McBride and was initially appointed as Acting Medical Director in September 2006.

2 At the time of this complaint, and other events referred to in this and other chapters, Dr Jim Morrow was a Consultant Neurologist and Clinical Lead for Neurology. He was invited to give oral evidence to the Inquiry but on 2nd October 2019 his legal representative sent replying correspondence declining the invitation on medical grounds.
Medical evidence was also received explaining why Dr Morrow was not fit to give evidence. All references in the report to Dr Morrow have, therefore, had no direct comment or input from Dr Morrow himself.

I am sure it happened because you know, we were all at Michael, myself, and Peter Walby, everybody."

4.13 Dr McBride confirmed that the note referred to at paragraph 4.11 was his handwriting and believed that he would have had a meeting with Dr Watt at or about that time. Reflecting on the material disclosed to him by the Inquiry in advance of his oral evidence, Dr McBride stated:

> **Dr McBride:** When I was in the Belfast Trust or when I left the Belfast Trust, was Dr Watt on my radar as a doctor of concern? No, he wasn't. Now, with the benefit of hindsight, looking back now from where we are to looking at what you may consider as early indications of an issue in relation to record keeping, in relation to the provision of those reports, you know, it is hard not to say, "well, could there have been something here?" but, again, that is with the benefit of hindsight …
>
> **Mr Lockhart QC:** There seems to be a dichotomy, really, between, say, a failure to carry out appraisal or to provide reports in a timely manner and then clinical concerns, so that you may well have had a doctor who was tardy in his paperwork and very poor in responding to obligations that he has and really did not have much time for appraisal or whatever and then a doctor who was giving grounds, you know – and part of what we're trying to piece together is the extent to which - .
>
> **Dr McBride:** I think the question, when I looked at this and considered this over the past couple of weeks, was – because one cannot not reflect upon it – is I certainly had no concerns in terms of, as I can recall, Dr Watt's clinical practice or the clinical care that he was delivering at that point in time, to the best of my knowledge and recollection. What I have been reflecting upon is whether or not these complaints in relation to record-keeping and provision of reports was perhaps symptomatic of something –
>
> **Mr Lockhart QC:** An attitude?
>
> **Dr McBride:** - which, perhaps, was of more significance than, perhaps, at the time, I attributed to it …

4.14 Dr McBride's recognition that consistent problems in meeting appraisal and other practice obligations may have been symptomatic of a deeper problem was a question that the Inquiry Panel also reflected upon during the Inquiry. The approach taken by management throughout the relevant period suggested that a dichotomy persisted between administrative and clinical in relation to Dr Watt, which was never properly considered.

4.15 On 10th October 2003, the Royal Hospitals Group received a complaint from INI 405. Again, there was some delay in Dr Watt responding, with various individuals

attempting to get Dr Watt to engage. As with the INI 403 complaint, this matter was raised with the Medical Director as noted in correspondence from 2006 as follows; *"on 8 January 2004 the Patient Liaison Manager emailed the Medical Director asking for his input into the issue."*

4.16 On 6th October 2005 and 28th November 2005, complaints from INI 406 and INI 407, respectively, were received by the Royal Hospitals Group. Both could be characterised by a delay in reply by Dr Watt and the failure to provide necessary medical reports for legal purposes. On 5th October 2005, however, the General Medical Council ("GMC") wrote to Dr McBride, as the Medical Director, regarding a complaint received from Bogue & McNulty Solicitors. That letter dated 19th August 2005 stated:

> You will note from the attached documentation that we have been writing to and telephoning Dr Watt/Dr Watt's secretary regularly between the 7 October 2003 and the 8 August 2005, a period of some one year and ten months, and we would further ask you to note that at **no time** was **any** of the telephone calls or letters responded to, either through a telephone call or a letter from Dr Watt.
>
> You will appreciate that our client's claim for compensation for what was and is very serious injuries has been delayed for one year and ten months and counting and we find it totally unacceptable that not only has such a delay taken place but even more concerning is the fact that Dr Watt has at all times refused to answer any of our attempts to contact him.
>
> We wish to complain in the strongest possible terms regarding Dr Watt's behaviour and would refer you to our most recent letter to Dr Watt dated 8 August 2005 confirming that we would be lodging a complaint with yourselves within seven days from the date of that letter if he did not contact our offices (needless to say as was the case with all previous letters and telephone calls this was completely ignored).

4.17 The GMC letter of 5th October 2005 sought from the Belfast Trust:

- Details of any other concerns or previous complaints (if any) regarding Dr Watt's practice.
- Any audit findings (or other quality assurance measures), which might indicate problems with Dr Watt's practice.
- Any data (e.g. in relation to prescribing patterns), which might indicate poor practice.
- Any other information, which may be relevant to inquiries.

4.18 In correspondence of 25th October 2005, Mr Peter Walby, Associate Medical Director, confirmed that the Trust had *"no concerns about Dr Watt's practice or other audit finding, which might indicate problems or other data, which might indicate poor practice."* Mr Walby did, however, state:

> The Trust has, however, in the past had to speak to Dr Watt at Medical Director and Associate Medical Director level regarding his slowness in providing medical reports in two previous similar types of situation to the present one.
>
> There is also concern that Dr Watt failed to complete his first consultant appraisal three years ago and has not been appraised since.
>
> He does not give these matters any priority to his clinical work.

4.19 Mr Walby followed this letter up on 31st October in an email to Mr Paul Bridge of the GMC, in which he stated in response to an email seeking elaboration from Mr Bridge of 28th October:

> I do not know what more elaboration I can provide.
>
> In cases of 2 patient NHS complaints, response within the statutory time limits was not possible because reports from Dr Watt could not be obtained. I had cause to speak to Dr Watt in one of the cases in 2001 and Dr Michael McBride, Medical Director, had to do the same in the other case.
>
> Dr Watt has failed to comply with the Trust's appraisal scheme.
>
> He tells me that "I do not give these matters any priority to my clinical work".
>
> This seems to me to be completely consistent with the complaint you have before you currently. Whether it falls inside your remit under fitness to practise is for you to decide.
>
> Please let me know if I can help further.

4.20 At the same time as Mr Walby had forwarded his views to the GMC, he sent a memo to Dr McBride following a discussion he had with Dr Watt:

> I enclose a copy of my letter to the GMC. I spoke to Michael Watt before I sent it as we discussed and he accepted it is all correct.
>
> He has no apparent concerns in this regard and I counselled him that this is not a wise approach to take. He had not even thought it necessary to consult his Defence organisation about the matter but I have suggested he does so and that he should obtain their advice whether it is appropriate to handle paperwork in the way he does.

The copy of this disclosed memo contains a handwritten note produced by Dr McBride, which records *"confidential copy to David Adams"*. In his oral evidence on 7th November 2019, Dr McBride stated that he *"wasn't copying to Davy Adams just out of interest,"* but with the clear expectation that this matter would be addressed in the Division. Other than referring or delegating the matter to Mr Adams, the Inquiry is not aware of any further steps taken by Dr McBride. Mr Adams, in his evidence from 8th January 2020 indicated that he had no recall of this but that he would *"almost certainly have acted on that. I would have seen him [Dr Watt] and I would talk to him. And I would have talked to the other people involved"*. The Inquiry Panel observed that there was no file note of any conversation between Mr Adams and Dr Watt. If there had been such a file note available to the Inquiry, then the issue could have been followed up with Dr McBride as to what further steps (if any) were taken or ought to have been.

4.21 On 1st February 2006, the GMC, through Mr Bridge, responded to Mr Walby requesting that further information was required *"regarding the previous similar situation in which you had to speak to Dr Watt about his slowness in providing medical reports"*. Mr Walby responded to this in some detail on 14th March giving a much more comprehensive and frank summary in relation to INI 403 and INI 405. Following further consideration, the GMC gave Dr Watt a 5-year warning effective from 22nd February 2007, as discussed further below and in the GMC chapter.

4.22 The Inquiry Panel noted that several further complaints, including two complaints received contemporaneously with the GMC correspondence and concerning the same subject matter (INI 406 and INI 407), were not included in the letter to the GMC. This was raised with Mr Walby when he gave evidence to the Inquiry on 8th January 2019:

> **Mr Walby:** I have separated the complaints that you sent me, the pages that you sent me. I knew about [INI 403], because that's one I dealt with. I'd no involvement in [INI 405]. "SK on behalf of GW" is the GMC one. I'd no involvement in [INI 406], no involvement in [INI 407], and I'd no involvement in [INI 222] until a negligence claim came in, and then the complaint file was sent to me and it stopped functioning then .
>
> **Mr Lockhart QC:** It does entirely fit. So, the focus of our concern is to ensure that the silos, effectively, which can develop —. For instance, with Dr Watt, there were a whole range of not just administrative complaints but a number of other clinical complaints, and, for various reasons, the system doesn't seem to have been — nobody seems to have had the complete picture.

> **Mr Walby:** Well, I quite see, because those are episodes that, as I just said, I'd no involvement in and I didn't know about because they were being managed in a parallel route by the complaints department. There was a clinical governance steering group, and, I think, summaries — annual summaries — from each department would have been sent or were being coordinated.
>
> **Mr Lockhart QC:** Would those summaries name individuals?
>
> **Mr Walby:** Would they name?
>
> **Mr Lockhart QC:** Individuals. You see, what we're trying to work out here is–
>
> **Mr Walby:** Probably not. No, they wouldn't, because they're going to be circulated to the trust board and everybody in the executive.

4.23 Part of the evidence quoted above from Mr Walby is now known to be incorrect, in light of other documents subsequently disclosed, which revealed that Mr Walby was, aware of the INI 406 and INI 407 cases by at least 14th March 2006. Mr Walby was asked to comment on this and provided the following evidence in a witness statement dated 15th March 2021:

> I should make clear at the outset that on the 8 January 2019 I gave evidence to the Inquiry to the best of my knowledge and belief. It was based on my own limited recollection of the historical events under consideration, and on the documents that were provided to me to prompt and assist my memory. Had the additional material (now shown to me) been available to me in advance of 8 January 2019 then I would have given different evidence on some issues.

4.24 Mr Walby went on to explain in his statement the method utilised to respond to the GMC correspondence of 25th October 2005:

> In order to prepare the reply to the GMC dated 25 October 2005 I would have had to have been in contact with the Complaints Department, and the Neurosciences Directorate, to obtain the information contained in that letter. Therefore, personnel in the Complaints Department would have been aware that I was asking for information in relation to complaints in the weeks before Pauline Webb's file note of 4 November 2005. I have asked myself why, if I was told about this similar complaint, did I not seek direction from the Medical Director to communicate it to the GMC, given I was very direct with the GMC about Dr Watt's general approach to administrative matters . I am afraid any answer I now give would only be speculation. It may be I was told that the report was being provided, and therefore considered this did not justify being referred to the GMC, but I am afraid I just cannot be sure. What I can say, without any question, is if I had been informed about a complaint that related to my engagement with the GMC, and I considered it merited reference on to

> the GMC, then I would not have had the slightest hesitation in seeking direction from the Medical Director to do that.

4.25 The Inquiry Panel accepts that Mr Walby did not seek to mislead in his initial evidence, but the fact remains that, for whatever reason, the information given to the GMC was inaccurate. This was a management failing by Mr Walby. The GMC as regulator is entitled to be confident that the information sought in relation to a doctor is accurate. The situation is mitigated in part by the fact that, in his correspondence of 31st October 2005, Mr Walby is blunt and candid with the GMC regarding Dr Watt's attitude. Nevertheless, the previous reassurance about Dr Watt's clinical practice was inappropriate and misleading.

4.26 In his evidence to the Inquiry Panel on 7th November 2019, Dr McBride recalled his time as the Medical Director of the Royal Victoria Hospital Trust. He explained that Maintaining High Professional Standards was introduced in 2005 at or about the same time as the Reform of Public Administration, which reduced the number of Trusts in Northern Ireland from 18 to 5. He referred to the changes that occurred following the introduction of the Medical Director's post in 1995. Dr McBride gave a history of how matters had evolved, which was of particular interest to the Inquiry Panel. Asked by Professor Mascie-Taylor to describe the structure that supported his role as Medical Director and the lines of accountability in place, Dr McBride stated:

> Yes. I mean, I think that – I mean, it is worth reflecting on that, because I think it's commonly misunderstood, the accountability to the Medical Director in the organisation as it was at that time, and, in some instances, probably still remains the case.
>
> I think we were – You know, going back to 1995 saw the establishment of the posts of Medical Director in Northern Ireland, probably around the same time as those posts were being established in the rest of the United Kingdom. And it was an attempt to, basically, better align the work that consultants and the clinical care that was provided to patients with the organisational responsibilities and accountabilities. So, as you'll have been familiar with, Hugo, there was a general management structure put in place. There was an attempt to also mirror- image the model in the US at that time, but that sort of dual leadership, with, you know, a doctor and a big manager, was felt to be too expensive, and we ended up with sort of a management structure supported by part-time Clinical Leaders, whether those were in Clinical Director roles or in Medical Director roles.
>
> The individuals that you've named, their appointment predated my appointment, in the main, as Medical Director, as I recall. The job descriptions

> of the individuals – I think, from memory, again – if looked at, will demonstrate that the line of accountability was to the Chief Executive of the Trust.
>
> There was this sort of, you know, dotted line professional relationship with the Medical Director. The role of the Medical Director at that stage was to seek to, yes, inform – and it's well documented in my job description at the time - in terms of inform corporate decision-making; corporate priority setting; the strategic direction and vision of the organisation, with specific responsibilities outlined within that.

INI 222:

4.27 On 9th June 2006, INI 222 wrote to the Chief Executive of the Trust complaining about her neurology care over a period of two years with Dr Watt. She did so as a member of medical staff *"so that perhaps some lessons may be learnt from my misdiagnosis, unsatisfactory management and the level of communication"*.

4.28 INI 222 believed that she had been inaccurately diagnosed by Dr Watt with MS and inappropriately advised to commence Beta-Interferon in December 2004. INI 222 had arranged to see Professor Michael Hutchinson in Dublin for a second opinion, but because of an unexpected inpatient stay, eventually consulted another local neurologist, Dr Gavin McDonnell.

4.29 INI 222 was initially hospitalised in August 2004 and, following an MRI scan, was diagnosed with acute transverse myelitis. Although many blood tests were administered to understand the underlying aetiology, this remained uncertain. Dr Watt informed INI 222 that she had a 50% chance of developing MS. INI 222's condition worsened in November 2004, and she subsequently saw Dr Watt in late November 2004 when a specialist nurse indicated that she had been diagnosed with MS. She requested a repeat MRI scan but was told that this was not necessary. According to INI 222, *"the diagnosis was made entirely on 'temporal separation' of two similar episodes with incomplete recovery in between"*. For the avoidance of any doubt, the Inquiry Panel reiterates that it is not the purpose of this report to determine these clinical issues.

4.30 In December 2004 Dr Watt advised Beta-Interferon therapy, which was paid for privately at a cost of £13,750. INI 222 subsequently developed dizzy spells associated with a marked drop in heart rate and significant reduction in blood pressure. Her complaint raised concerns about the patient/client relationship, in addition to clinical issues, summarised in June 2006 as follows:

> While, unlike a non-medical person, I can actually appreciate that I have a disorder on the demyelinating spectrum and may develop a second lesion at a

> later date, I always worried that Dr Watt was too rapid to diagnose MS without a second MRI to look for evidence of disease dissemination. 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…

4.31 Given the age of the complaint, the documentation, in terms of email traffic, is far from complete. However, it appears that each of the consultant neurologists involved in INI 222's care, Dr Watt, Dr McDonnell and Dr Hawkins, were asked to provide their view on the complaint.

4.32 Dr Hawkins was the first to respond to the Patient Liaison Manager on 29th June 2006. He indicated that he remembered the patient as he worked with a family member, but that he had *"never been asked formally by Dr Watt or Dr McDonnell for a medical opinion on her. I have only ever spoken to [INI 222] once about her condition, as far as I recall … I defer to Dr Watt and Dr McDonnell for a detailed response to all the allegations in the letter of complaint. I am not the subject of any items of complaint"*.

4.33 In a letter to Mr Gerry Atkinson, the Service Manager within Neurosciences, of 5th July 2006, Dr Gavin McDonnell, who had been involved in INI 222's care, indicated that he believed that the complaint involved a *"very difficult and complex case with a very unusual presentation"*. Because of that, he concluded: *"I feel that the criticisms levelled at Dr Watt in particular are unfair. Clinical issues often become clearer with benefit of hindsight and the passage of time"*. The Inquiry Panel noted, however, that Dr McDonnell did not concur with Dr Watt's diagnosis and that his view was restricted to a short paragraph, which stressed the complexities of the case.

4.34 Dr Watt initially responded to each of the points made in the letter of complaint on 18th July 2006. He continued to believe that INI 222 was suffering from a relapsing / remitting MS, stating that the diagnosis was made on clinical grounds supported by the results of the investigations. Dr Watt outlined that a second MRI would have made no difference to his thinking, even if this disclosed no further lesions.

4.35 At that stage the issue was being dealt with by the Patient Liaison Manager and the Neurosciences Division. The focus from the Patient Liaison Manager was on responding promptly to the complaint. The Neurosciences Division was seeking to get a response to the issues raised and Dr Gavin McDonnell, who had also been involved in the care of INI 222, was asked to comment on the question of diagnosis. The upshot is that although Dr McDonnell and Dr Watt disagreed on diagnosis, there was a limited understanding at management level of what to do in such a situation.

4.36 Dr Stevens, then Acting Medical Director in the Trust, became aware of the INI 222 complaint when he was appointed Acting Medical Director in September 2006. Prior to that, the matter was considered within the Neurosciences division.

4.37 Subsequently, Mr Atkinson, the Service Manager within Neurosciences, wanted to follow up on a number of issues that had not been commented on by Dr Watt. On 3rd October 2006, Mrs Webb, the Patient Liaison Manager expressed her frustrations as this complaint was *"now well overdue"*. She indicated further that she was *"at a loss"* and would *"not be held responsible at a later date when we are criticised for poor complaints management"*. Mr Atkinson, in response, indicated he was still waiting on further information from Dr Watt. Mr Watson, then Divisional Manager for Head and Skeletal Division, sought to arrange an urgent meeting between Mr Cooke, Clinical Director for Neurosciences, and Dr Watt to resolve things. Dr Stevens, indicated he may have to intervene and subsequently did become involved.

4.38 At this point the focus moved beyond this particular complaint. Dr Watt had failed to respond to additional questions in relation to the INI 222 complaint and also not completed his appraisal. It is apparent that various matters become conflated and that the previous focus on the difference in medical opinion appears to be subordinated to concerns about Dr Watt not fulfilling his obligations regarding appraisal and answering correspondence.

4.39 On 4th October 2006, Mr Cooke, the then Clinical Director, indicated in an email to Dr Stevens, Mr Watson, Mr Atkinson and Mrs Webb that he had discussed the matter with Dr Watt again and that he had told him that he would be *"in some difficulty if he did 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"*. Mr Cooke concluded:

> The difficulty is that I don't think there is an understanding among some medical staff of the need to comply with complaint/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.

4.40 When asked about this email by the Inquiry Panel, Mr Cooke stated in his evidence of 4th March 2019 that:

> I suppose it comes back to "As a CD, what sanction do you have?", and, in a way, it comes back to what I said in that email at the time: you have to go and talk to them, and you rely on your good relationship with a colleague. Because that, in a way, is what a CD was: it was more a first-among equals-type of role.

4.41 In his oral evidence on 8th January 2020, the Divisional Director Mr Adams did not demur:

> Clinical Directors, they are to make sure that the services happens but one of the first things you'll always try is persuasion. And to encourage them to point out to them the difficulty of not doing it and the difficulty they find themselves in if they don't do it … these people are colleagues they have to work together.

4.42 Dr Stevens, giving evidence on 3rd September 2019, recognised that ultimately it was a matter for him as the Medical Director:

> I think he did reflect that view that, if explanation and persuasion couldn't work, it was really your problem, Tony, and therefore, it came up the line.

4.43 The sentiments expressed by Mr Cooke are, in the view of the Inquiry Panel, significant. The email encapsulates an understanding, which was exemplified by various doctors in relevant management in the years ahead. The fact that Mr Cooke believed he could only 'explain and persuade' was not in any way unique to him in his role as Clinical Director. It is noticeable that he was not corrected in his view. He stated what others also understood. It appears that the formal obligations of the post were entirely subordinate to the prevailing culture of the time. A Clinical Director was merely *primus inter pares* (first among equals). He did not exercise a traditional management role, nor was he expected to do so, particularly by his colleagues or indeed by the management of the Trust. While it may not be surprising that medical colleagues dislike management, this is the model that had been adopted by the NHS and the acquiescence by the management of the Trust to what was a former model, where consultants could expect little interference with their practice created confusion and inertia.

4.44 On 4th October 2006, Dr Stevens in an email to Mr Adams, Mr Watson, Mr Cooke, Mr Atkinson and Mrs Webb stated: *"if local resolution is not successful we are close to handling Michael down a formal line. He needs to understand this and the implications"*. Despite this, Dr Watt still failed to respond to the complaint as required.

4.45 On 12th December 2006, Mr Adams, Divisional Director, wrote to Dr Watt insisting that he provide a response in relation to INI 222's complaint by 15th December. Mr Adams concluded his letter as follows:

> Given this is a further instance of your failure to comply with the complaint procedure I have copied this letter to Dr Stevens and will be discussing with him the action that we should take.

There is no file note of this discussion.

4.46 A meeting was subsequently held between INI 222, family members, Dr Stevens and Mrs Webb on 18th December 2006. The typed notes of the meeting disclosed to the Inquiry record as follows:

> Dr Stevens said that following his recent review of the complaint file, he did not feel that Dr Watt accepted her criticisms regarding her investigation, diagnosis or treatment … Dr Stevens indicated that there may finally be a difference in medical opinion in the clinical aspects of this case and that this may be difficult to resolve entirely through the complaints procedure. He was however committed to resolving issues as far as possible.

4.47 Following the meeting on 18th December, Dr Stevens emailed Mr Watson, then Divisional Manager for Head and Skeletal Division. Mr Watson had reviewed the file. He concluded that Dr Watt was not particularly eager to resolve issues of concern and that the delay was totally unsatisfactory. Dr Stevens's response stated: *"the lesson is that such complaints need to be actively managed and reviewed. MA's [sic] behaviour will need to be addressed in the round and I will deal with this"*.

4.48 On 3rd January 2007, Dr Stevens reviewed a draft complaint response letter and copied the draft to Mrs Webb, Dr Watt, Dr McDonell, Mr Watson and Mr Adams. Dr Stevens noted that: *"I think a paragraph on potential for difference of medical opinion is needed, given Gavin's letter, perhaps Gavin/Michael would suggest wording"*.

4.49 Dr Watt reviewed the proposed reply and responded on the same date. He considered whether the patient had, in fact, had MS:

> The difference in medical opinion comes down to interpretation of the events after her initial presentation. I feel that she 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 that that led me to conclude that she had 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 believe 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 not 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.

4.50 Dr Gavin McDonnell responded to Dr Stevens on the same date at 13:56 and stated:

> I am not sure that I have anything useful to contribute here. I do not believe that the various complaints were directed to me. My dealings and discussions with [INI 222] are clearly laid out in the relevant medical 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 the benefit of hindsight and the follow-up MRI.

4.51 Dr McDonnell, although sympathetic to Dr Watt, was entirely clear that INI 222, having had one attack, one lesion on MRI and no further attacks on follow up, did not meet the existing criteria for a diagnosis of MS or prescription of disease modifying therapy. The caveat, that clarity on diagnosis is easier with hindsight is, of course, understood, but it is not clear to the Inquiry Panel that the explanation provided by Dr Watt above, necessarily answers or addresses the concern.

4.52 On receipt of Dr McDonnell's views on INI 222, Dr Stevens emailed Mrs Webb and reflected:

> Pauline
>
> I am not sure where this leaves us. It may be wise to get help in a final draft from a 3rd neurologist. What do you think about meeting with Jim Gilmore [sic, believed to be a reference to Dr Jim Morrow]
>
> This is getting into the realms of difference of medical opinion and has med legal overtones. Is it worth a discussion with peter walby? (sic)
>
> Can you check is Michael in this week. If so hassle him. If need be I will tell him to respond.
>
> Tony

4.53 The evidence suggests that Mrs Webb was a respected Patient Liaison Manager, who took seriously the obligation to respond timeously to complaints lodged. Mrs Webb was, however, not qualified to consider the medical dimensions of a complaint. As much as Mrs Webb may have been helpful, the Inquiry Panel takes the view that the decision as to whether or not a further neurological opinion should have been obtained was for Dr Stevens to decide.

4.54 Dr Stevens' initial instinct was correct. There was undoubtedly a difference in medical opinion, as illustrated above. To obtain the view of another neurologist was certainly one way in which a medical director could seek to determine who was right. It was critical that a decision was made, recorded and was accessible to the Medical Director when other potential issues arose. Unfortunately, the matter was allowed to drift. No decision was formally taken and the failure to record an actual decision (whatever that might have been) meant that the entire incident was not useful or accessible in the future. Whilst the Inquiry Panel is not in a position to take

a view on the merits and demerits of the alleged misdiagnosis and mistreatment, it, nevertheless, believes that this case may have been a key indicator whenever other similar issues arose regarding the diagnosis of MS by Dr Watt. In the event, the case was closed and not reviewed or regarded as significant between 2007-2018.

4.55 The formal reply from the Acting Chief Executive, Mrs Deirdre O'Brien, was provided on 9th January 2007. The letter noted that: *"your complaint has been investigated by senior management in the Neurosciences Department with input from Dr G McDonnell, Dr M Watt, Dr S Hawkins and Dr A Stevens"*. From the evidence outlined above, it is apparent that Dr Hawkins' involvement with INI 222 and drafting of the letter was minimal.

4.56 The letter records Dr Watt's response and confirms that he continued to believe that INI 222 was suffering from relapsing/remitting MS. The letter does record Dr McDonnell's contrary opinion. No determination is made on the complaint, apart from apologising for the delay and the concerns of both INI 222 and her family. The salient parts of the formal response dealing with the issue of diagnosis of MS states as follows:

> Dr Watt continues to feel that you have relapsing/remitting MS. The diagnosis was made on clinical grounds supported by the results of 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…
>
> 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.

4.57 Dr Stevens clearly contemplated getting a further view but decided not to do so, leaving the issue unresolved and, as per the above, outlined the two contrary opinions in the final response. The question arises as to whether a further view may have caused the uncovering of a larger problem with Dr Watt's practice? Dr Stevens was candid in his assessment of the case when he gave evidence to the Inquiry on 3rd September 2019:

> Dr Watt came into my orbit, I think, three times: in 2006-07, when we dealt with the [INI 222] case, the [INI 87] case and the complaint via the GMC from

> that led to the warning. Of those cases, I actually think the [INI 222] case is probably the most important, because, I think, it was a very early sign that he was taking a shortcut to a diagnosis of MS and being fairly innovative in his treatment, working outside the guidelines as they were then. However — I think it's important — I believe we did challenge — take a fairly challenging approach to dealing with that complaint, and the clinicians were very much in his support; in fact, although it's not in my pack, one of the consultants wrote a letter saying we were treating him unfairly in our scrutiny of that case . But I think, nevertheless, it was an important case, and, for me, arguably that was the first time that we might have had a hint.

4.58 Dr McBride in his oral evidence on 7th November 2019 agreed:

> I don't recall it… I was troubled reading this complaint, if I'm honest. You know, this is an experienced doctor herself raising and articulating concerns in relation to a number of aspects.
>
> 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 others?"

INI 408:

4.59 In September 2021 the Belfast Trust sent a further 5 lever arch files of materials that had not been identified previously[3]. On examination of the files a significant clinical complaint was discovered, which brings into focus the comments of both Dr McBride and Dr Stevens. On 7th April 2005 Mark Robinson MLA wrote to Mr William McKee, Chief Executive, about his constituent INI 408 and the decision to discontinue his regular does of Beta Interferon. This was the same disease modifying therapy referenced in the INI 222 complaint above. INI 408 had suffered from MS since his late twenties and had reached the advanced stages of his illness. INI 408 had been under the care of Dr Stanley Hawkins who, in 2003, had advised that Interferon was no longer working and following discharge after a hospital admission stopped the prescription of the drug, which the patient had first been prescribed in 1996. The patient subsequently saw Dr Watt privately and was re-prescribed Interferon at a cost of over £3,000.00. The complaint emanated from the fact that INI 408 was on

3 In and around early spring of 2021 the Inquiry was reviewing emails disclosed to it by the Belfast Trust. The emails contained references to relevant complaints documentation that had not previously been disclosed to the Inquiry. The Belfast Trust itself also discovered complaints documentation that was relevant to the Inquiry and had not previously been disclosed. The Inquiry made clear to the Trust that it was unnerved by the discovery of additional complaints documentation. The Trust subsequently commenced a manual trawl of all neurosciences complaints. Any complaints that referenced Dr Watt in any capacity were to be disclosed to the Inquiry. This disclosure exercise was completed in September 2021 with a further 5 lever arch files of materials being identified.

benefits and could not afford the medicine privately. In a report prepared on 9th June 2005 and addressed to Mr Peter Watson, then Divisional Manager for Fractures and Neurosciences, in The Royal Hospitals Trust in response to the complaint Dr Hawkins, after outlining in detail the history of INI 408's care, made his views clear:

> I cannot account for how the Interferon has been prescribed privately since he is well outside the prescribing ABN[4] Guidelines for Interferon as recommended by the ABN.

4.60 On 16th June 2005, Mr Watson forwarded Dr Hawkins' report and a draft response to Councillor Mr Robinson MLA, on behalf, of his constituent to Mrs Webb in the Patient Liaison Office and copied to Dr Hawkins, Dr Watt and Dr Morrow. The draft omitted any reference to the view of Dr Hawkins that the continued prescription of Beta Interferon was outside the guidelines and this draft reply was then incorporated into a formal letter from the Director of Nursing, Mrs KMD O'Brien in a letter of the 28th June 2005.

4.61 The Inquiry asked Mr Watson to explain the removal of the views of Dr Hawkins from the initial formal response. In a written statement dated 3rd November 2021, Mr Watson explained that he could not recall back so many years later the specific complaint but pointed out that not all of the information is now available. He posited several explanations for what may have happened and was clear that he *"did not leave out the sentence from Dr Hawkins to turn a blind eye to some matter of concern relating to Dr Watt"*.

4.62 Mr Watson further stated:

> I should say, even on the limited information available, that I do not believe Dr Hawkins was suggesting there needed to be an investigation. This could be for a myriad of reasons; such as it was not actually unacceptable to prescribe Interferon beyond the guidelines. I am reasonably certain that I would remember if either Dr Hawkins or Dr Morrow ever raised with me a need to undertake, or cause someone else to undertake, an investigation into prescribing. As they did not do that, my assumption is this was not something either of them considered was warranted at the time.

4.63 The fact that what appeared to be the most significant aspect of Dr Hawkins' report was omitted from the response to Councillor Robinson MLA, was a matter of concern to the Inquiry Panel. The Inquiry Panel accepts that there could be an explanation for the omission of Dr Hawkins' statement and recognise that the information now available is incomplete. It further accepts that Mr Watson did not deliberately turn

4 ABN is an acronym for the Association of British Neurologists.

a blind eye to some matter of concern regarding Dr Watt. Nevertheless, it cannot be sure at all that the matter was properly investigated or considered and notes that this complaint which appears highly relevant to other complaints such as INI 222 was not easily accessible, nor does it appear to have been brought to the attention of the Medical Director when he was considering the INI 222 complaint.

4.64 To his credit, Councillor Robinson did not let the matter rest. He wrote to Mrs O'Brien on 27th July 2005 reiterating the complaint. The matter went through the same essential process and, once again, Mr Watson wrote to Mrs Webb, copying in the earlier report of Dr Hawkins to Dr Watt, Dr Morrow and Dr Hawkins. On this occasion there is a reference to the prescribing guidelines in the draft response:

> Dr Watt has advised that when he last saw [INI 408] he was unable to stand and unable to walk and was outside the prescribing guidelines for Interferon.
>
> This observation was retained when the final response was forwarded and signed by Mr William McKee, then Chief Executive of the Royal Hospitals, on 5th October 2005. On the same day, the complaint file was closed with no further action being required.

4.65 Councillor Robinson was once again undeterred and brought the matter to the attention of the Northern Ireland Ombudsman on 5th December 2005, who commenced his own investigation. Unfortunately, the focus shifted to the Neuro-rehabilitation Unit at Foster Green Hospital with some encouragement from the Patient Liaison Service. By 7th September 2006, the Ombudsman's office had decided not to proceed further with the complaint, as they were not empowered to look at clinical matters.

4.66 The question to be investigated was never focused upon by anyone. Was Dr Watt operating outside the guidelines of the ABN in prescribing Interferon privately to INI 408, as alleged by Dr Hawkins in his report of 9th June 2005? If he was acting outside the guidelines, could this be justified or was it inappropriate? One can perhaps understand why the Patient Liaison Service, who were not medically trained, did not pick up on the statement, but Dr Morrow and Dr Hawkins would have been aware that this issue would need to be considered.

4.67 Crucially, the INI 222 case also involved a complaint about the prescription of Beta Interferon. Dr Hawkins had also been asked to comment on same but was peripherally involved and had little input. No one recognised that there may be a pattern in terms of Dr Watt's diagnosis. Certainly, both Dr Stevens and Dr McBride, in their evidence to the Inquiry, approximately 15 years later focused on INI 222 as a significant case. At the time of their evidence the Inquiry was not aware of the

INI 408 complaint. Given the candour of both Dr McBride and Dr Stevens on the potential significance of INI 222, one is left to speculate what would have occurred if the INI 408 complaint had also been highlighted at the same time .

4.68 A further question arises in relation to the case of INI 408. It was not referred to when Mr Walby was asked by the GMC to comment on other issues of concern or complaint in their letter of 5th October 2005. This was the same day that the Trust issued their second response in relation to INI 408 and suggests that the complaint was not filed in a way that could be accessed or had been forgotten or possibly ignored. In the view of the Inquiry Panel, disclosure of the complaint documentation in respect of INI 408, when considered alongside in particular INI 222, may have led to an investigation into Dr Watt's clinical practice by both the Trust, as Dr Watt's employer, and the GMC as his regulator. Unfortunately, the GMC was never made aware of this complaint and no such investigation was carried out by the Trust. This was a clear example of poor management by the Trust.

INI 87:

4.69 On 4th September 2006, the family of the late INI 87, who died on 18th January 2006, wrote to the Chief Executive of the Trust seeking clarification on a number of issues, including inter alia concerns about the review and monitoring of their son's medication and progress. The letter further stated: *"[INI 87]'s death was a particular shock to us as at no time in his treatment was it ever indicated to [INI 87] or ourselves that [INI 87]'s life could have been at risk or that his condition was life-threatening"* . On the face of the complaint alone, it is not apparent that there was any issue with regards to the diagnosis of epilepsy in this case.

4.70 The letter of 4th September was treated as a complaint and on 19th October 2006, Dr Watt, responding to the Chief Executive's Personal Assistant, stated that *"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 which I was not responsible for"*. It appears that Dr Watt had had a previous discussion with Mrs Webb, where he indicated that he believed that responding to this complaint was Dr Morrow's responsibility. Mrs Webb had indicated that she was aware that Dr Morrow had seen INI 87 once privately and that the questions, according to Dr Morrow, related to care which had been given under Dr Watt's management. Mrs Webb raised this matter with Mr Cooke, the Clinical Director, and Mr Atkinson, the Service Manager, on 25th October 2006 for them to follow up. It is clear from correspondence that Dr Morrow, the Clinical Lead, and Mr Adams, the Divisional Director, were also

involved in discussions with Dr Watt to get him to respond during the course of October 2006.

4.71 Subsequently, Dr Morrow produced a detailed response on 27th October 2006. Dr Morrow recorded the fact that he had seen INI 87 shortly before his death on 5th January 2006. He had 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. Dr Morrow observed that INI 87 had a continuing tendency to seizures and that he had been treated by Dr Watt for epilepsy with anti- epileptic drugs. He also recorded that Dr Watt had suggested to him that he had *"MS tendencies"*. Following the review, Dr Morrow undertook to obtain INI 87's previous notes and review them before embarking on any change of therapy.

4.72 Dr Morrow reviewed the neurology notes and wrote to INI 87's GP on 12th January 2006, while at the same time writing to INI 87 and arranging a review. Dr Morrow stated in a letter of 27th October 2006 to Pauline Webb, the Patient Liaison Officer:

> 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 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 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 try to withdraw him from all 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 re-attendance.

4.73 Dr Morrow did answer the questions raised by the parents of INI 87 on a general basis. In a letter of 27th October 2006 to the Patient Liaison Manager, he expressed his disappointment that Dr Watt, had declined to reply to the complaint as follows:

> I understand my colleague Dr Michael Watt has declined to rely to the complaint and I am somewhat disappointed by this response given that [INI 87] was a long terms patient of his and that he alone would be in a much better position to address the issues raised by Dr Watt. In my opinion this lack of engagement can only contribute to their ongoing distress.

4.74 Further, Dr Morrow enclosed correspondence he had written to INI 87's General Practitioner on 5th and 12th January 2006 and to INI 87 on 12th January offering an appointment on 30th January at the Ulster Independent Clinic. In his letter to the General Practitioner of 5th January, Dr Morrow stated:

> From discussions with colleagues previously about [INI 87], it is my impression that there has always been suspicion that a lot of his problems are psychological rather than physically mediated.

The Inquiry has received no evidence to indicate with which colleagues these discussions took place or in what context they occurred.

4.75 In his subsequent letter to the General Practitioner of 12th January, Dr Morrow stated:

> 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, seemed to be based on abnormal EEG and odd behaviour. Certainly 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 seems 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, i.e. psychogenic or 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 primarily and certainly in the large part, if not completely, psychologically mediated. Whether he has an underlying tendency to epilepsy remains uncertain. It would be more important to try to ascertain some of his earlier notes and records and MRIs if possible to try to see on what grounds the original diagnosis of epilepsy was muted [sic] …
>
> **Emphasis Added**

4.76 The Inquiry Panel noted that although the original complaint from INI 87's parents did not raise a concern regarding the diagnosis of epilepsy, Dr Morrow is unequivocal in his letter to Mrs Webb of 27th October 2006, and in his correspondence to INI 87's GP, of 12th January 2006, in which he wondered: *"why this diagnosis was entertained in the first place"*, noted *"compelling evidence that the attacks were non epileptic"* and that his symptoms were very *"atypical"* of epilepsy.

4.77 The point noted is that, from receipt of Dr Morrow's detailed and considered correspondence of 27th October 2006, the Trust had received concerns about the diagnosis of epilepsy raised by the Clinical Lead for Neurology who was an expert in the sub-speciality. This concern is apparent from an email dated 3rd November 2006 from a junior member of staff to Mr Watson, Mr Atkinson, Mr Cooke and Dr Stevens which stated that: *"following receipt of Dr Morrow's report it is obvious that we need answers from Dr Watt as a matter of urgency"*.

4.78 Email correspondence in October/November 2006 involved the Medical Director's Office, Dr Morrow and the Patient Liaison Manager. Efforts were clearly being made to ask Dr Watt to provide his own report and eventually, on 12th December 2006, a report was prepared by Dr Watt and addressed to the Sub-Divisional Manager. Dr Watt accepted that he made recommendations about INI 87's epilepsy treatment to his General Practitioner, but also suggested that his General Practitioner was largely responsible for prescribing outside the hospital context, albeit guided by the hospital consultants attended as an outpatient. It is noted, however, that Dr Watt does not address at all, the concerns regarding the diagnosis of epilepsy raised by Dr Morrow and confined his response to the question of responsibility for prescription. This does not appear to have been analysed or picked up on by those dealing with the complaint. The Inquiry Panel noted that on 21st December 2006 Dr Watt wrote to Mr Watson:

> 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 it 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.

4.79 What is noticeable after this email is that there was, what would appear to be, a change in the tone of the draft responses to the complaint prepared by the Trust. The initial draft stated:

> It was noted 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 on the basis of continuing events which were felt to be epileptic.
>
> Despite surgery he continued to take events which as described to Dr Morrow, were very unusual and not at all typical of epilepsy …
>
> Dr Morrow's own review of the case suggested that the use of these drugs may have been somewhat inappropriate in [INI 87] 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 in the Walton Hospital for Neurology and Neurosurgery and Dr Pang Consultant Neurophysiologist the suggestion that most if not all of [INI 87's] attacks were non epileptic in nature. Following this review, it was Dr Morrow's intention to review [INI 87] to try to withdraw him from anti-epileptic medication.

4.80 Dr Morrow provided his comments on the draft letter on 20th December 2006:

> . . . there is, I feel a degree of think [sic] diagnostic uncertainty regarding the nature of [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.

4.81 Dr Watt stated on 3rd January 2007 that he 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 have been living with uncertainty for years and managing his symptoms pragmatically.

4.82 After several drafts, a letter responding to the complaint was eventually forwarded to INI 87's parents on 17th January 2007. The letter was signed in the name of the Acting Chief Executive, Mrs O'Brien and stated, on the question of the epilepsy diagnosis:

> 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 Neuropsychologist 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 .

4.83 Subsequently, Dr Stevens and Dr Morrow, together with Mrs Webb, met with INI 87's parents on 1st February 2007. Informal handwritten notes of the meeting were made by Mrs Webb and subsequently typed up and shared with the family on 14th February 2007.

4.84 The Inquiry Panel noted that the informal handwritten notes and the typed notes following the meeting with INI 87's parents also suggested a change in emphasis by Dr Morrow. The notes record that Dr Morrow stated:

> Attacks look/sound what are epileptic attacks also had pseudoseizures. How much was true epilepsy?
>
> Dr Morrow's comments contrast somewhat in tone with his earlier statements to INI 87's General Practitioner and the earlier draft of the response to INI 87's parents.

4.85 At the meeting, Dr Stevens stated that he had to reassure himself that the doctors in the Royal were competent practitioners and undertook to establish why INI 87 had died and what contributed to his death. The Inquiry Panel noted that Dr Stevens had indicated to the parents of INI 87 at their meeting that Dr Watt's clinical skills were not a concern and that the communication issue was being addressed. It was noted that Dr Morrow was to speak to Dr Watt at his appraisal regarding communication issues.

4.86 The issue of whether INI 87 raised a clinical concern was discussed with Dr Stevens at his attendance at the Inquiry on 3rd September 2019. The following interaction took place with the Chairman:

> **Mr Lockhart QC:** And those specific issues again relate to confidence in diagnosis and queries, you know, giving rise to at least a train of enquiry. "We had a meeting with the [INI 87's parents] Dr Morrow was there." And 96 across the page "Dr Stevens told the parents of [INI 87] that he'd addressed communication issues with Dr Watt and was grateful to Dr Morrow for the leadership role he provided . Dr Stevens [sic] indicated that Dr Watt's clinical skills were not causing concern and that the communication issue was being addressed." I mean, looking at it now, Tony, you know, was there not a clinical concern here that Jim Morrow had identified? He'd clearly come to a different diagnosis. You know, the treatment with anticonvulsants over quite a significant period of time. Query: … to what extent had Dr Watt looked at other diagnoses?
>
> **Dr Stevens:** Well, I suppose, a couple of things about this case. The first is that epilepsy, or not, pseudo seizures was one feature of a very complex case. We were dealing with somebody who'd died. The anaesthetist or pain specialist… was at least as much an issue here —.
>
> **Mr Lockhart QC:** Exactly. That was what was focused on by the coroner.
>
> **Dr Stevens:** It was. Michael, in this case, had not, I think, made the initial diagnosis and had been the one who had referred [INI 87] to the Walton Centre, so he was demonstrating a reasonable amount of good professionalism in that .

> In his own statement, he said, "Look, I could never persuade [the parents of INI 87], that he might not have epilepsy". I was clearly getting an assurance from Jim. I can't remember now why I made that statement, but I would not have made that statement without the support of Jim in this. And in the meeting with the family, Jim Morrow to some extent backtracked. I'm just trying to find the line. He stated: "There was a complex mixture of things going on with [INI 87]. He may or may not have been able to give the family all the answers". He says somewhere else, I think. Just looking for it. Yes: "Dr Morrow stated that it may be difficult to take [INI 87] off the drugs. Dr Morrow said [INI 87's] attacks look sound what are epileptic attacks but that you also had pseudo- seizures. It was difficult to say how much true epilepsy was".

4.87 On 14th February 2007, Dr Stevens called an *"urgent meeting re [INI 87] … sometime next week to speak with Peter Walby, Jim Morrow, Michael Watt & Pauline"*. This reflects what is contained in an undated handwritten document entitled '[INI 87] – Action' which states *"set up mtg – URGENT Tony, Peter W, Jim M, Michael W, Pauline W"* and another note which says *"Find out what Jim said to Michael ."* The Inquiry Panel has no evidence as to what comments this final note is referring to. The Inquiry Panel considers that this email, note and the minutes of the discussions with the family at the meeting, indicate that there was a high level of concern within the Medical Director's Office regarding the handling of the INI 87 case, notwithstanding the assertion that clinical skills were not in issue.

4.88 However, before such a meeting could take place, Dr Stevens received word on 15th February 2007 that an inquest was to be held in relation to INI 87. In an email of that date sent to Dr Morrow, Mrs Webb, Mr Walby, Mr Adams and Mr McAlister, Human Resources, Dr Stevens outlined that: *"this should give us enough to prepare a letter to [INI 87]'s parents . We could defer meeting. I will however follow up with division on communication issues."* Mr Walby responded on 16th February 2007 noting that an inquest *"may ease your [Dr Stevens'] task of replying." In a response of the same date, Dr Stevens indicated that "I feel the likelihood of an inquest clarifies things in terms of how we respond to [INI 87's] parents"*.

4.89 On 23rd February 2007, Mr Peter Walby, Associate Medical Director, wrote to Dr Watt advising him about the preparation of a statement for the Coroner and inviting him also to consult with his professional body or legal adviser. Dr Watt required several reminders to complete the statement, which was eventually signed off on 11th May 2007. The Coroner then took time to decide whether an Inquest was going to proceed.

4.90 It is noted that Dr Morrow had also provided a letter to the Coroner on 28th September 2009. The wording of this letter gives rise to a concern that the previous

clarity of Dr Morrow, when he had stated to INI 87's GP: *"One wonders why this diagnosis was entertained in the first place"* was, in tone, quite different.

4.91 Dr Morrow's report to the Coroner does indicate that the Walton Centre for Neurology and Neurosurgery had felt that many of INI 87's events were non-epileptic in nature. In relation to his own view, he stated:

> Following this review of his medical notes and my initial interview with him I had felt that overall he was taking quite large quantities of medication and without apparent success either in controlling his pain nor indeed the events that had been labelled epileptic. It was my firm intention to review him with a view to trying to reduce his drug load. However, unfortunately circumstances supervened and [INI 87] died prior to his reattendance with myself.

4.92 It was not until October 2009 that the Coroner's office confirmed that an Inquest had been arranged for 8th January 2010, at which Dr Watt was expected to attend.

4.93 On 16th October 2009, Mr Peter Walby wrote to Dr Watt enclosing the witness list for the Inquest and stating:

> … As you can see from Mrs [INI 87's] letter there is potential for this Inquest to cause you some difficulty and I am writing to ask whether you wish to be represented by the Trust's solicitors at the Hearing or by your Defence Organisation? …

4.94 In a note prepared by Mr Walby to the Medical Director, Dr Stevens, Mr Walby stated on 11th January 2010 as follows:

> The Inquest proceeded satisfactorily on 8th January hearing all the witnesses' evidence. I obtained Dr Watt's attendance in advance of the Hearing and Counsel went through his evidence with him. In the event the management of the epilepsy/pseudo-seizures by him was not the thrust of the Court's concern but rather the level of [INI 87]'s opiate pain relief which was in the hands of the Pain Clinic anaesthetist and the GPs. The family were not legally represented and were very civil with all the clinicians without the former rancour that had attended the earlier complaint process. The differences in views of the clinicians and the Pathologist however led the Coroner to adjourn the Inquest to allow him to obtain an expert opinion on the toxicological aspects of the case. The issue is whether this was an unexplained epilepsy death or opiate related in a man who was tolerant to high does of opiates but who had had his overall dosage reduced by the hospital just prior to his death. There was no evidence of suicidal intent. I will report again when the Inquest resumes. There was no press interest.

4.95 The Inquest also received evidence in the form of a written report dated 19th April 2010 from Professor Dennis Johnston, Consultant Physician. Professor Johnston

concluded that the cause of death was a morphine overdose in combination with a number of drugs, which are known to cause respiratory depression.

4.96 In his judgment of 15th June 2010, the Coroner concluded:

> [INI 87] had died from Combined Morphine, Clobazam and Nordiazepam intoxication. [INI 87] had been prescribed all 3 medications complicit in his death: morphine for pain and clobazam for epilepsy. The day prior to his death [INI 87] had embarked on a new source of pain-relief, MST, in place of Transtec patches. There is nothing to suggest that [INI 87] was careless or incompliant with his drugs regime. However, it is well recognised that even when such medications are properly prescribed (as in this instance) and where proper information is at hand, a patient can be overwhelmed by medication of this order and in this combination.

4.97 On the eve of the resumed hearing of the Inquest on 15th June, Mr Walby informed Dr Stevens that Dr Watt had not been recalled, but he promised to let Dr Stevens know and *"did not expect difficulty"*. On 28th September, Mr Walby informed Dr Stevens that the Inquest concluded satisfactorily. The issue of whether Dr Watt had misdiagnosed epilepsy was not addressed in the Coroner's findings and the issue did not appear to have been considered at the Inquest..

4.98 The fact that the issue of the diagnosis of epilepsy was not focused on at the Inquest did not exculpate the Trust from considering the matter. Nothing had essentially changed as far as the Trust was concerned since Dr Stevens had sought to convene an emergency meeting to discuss the INI 87 case. The judgment of the Coroner, though relevant, did not dislodge the obligation of the Trust to properly investigate the complaint and consider whether there was a clinical issue which may be relevant to Dr Watt's competence as a clinician. In reality, the matter was dropped, ignored and not utilised in any subsequent investigation. That was a failing of management.

Governance Actions in Addition to Index Complaints:

4.99 Mr Adams had indicated to the Medical Director on 13th October 2006 that he had written to Dr Watt regarding an outstanding complaint and the need to arrange an appraisal. He stated that no response had been received to either request, and that *"we now need to consider what action might be appropriate"*. On 24th October 2006, Dr Stevens requested that Mr Walby send some detail on the GMC Inquiry into the delay in providing a medical report to a solicitor as he intended to meet with Dr Watt *"re his lack of appraisal and poor cooperation with complaints management"*. This was forwarded to the Medical Director's Office on 26th October and consisted of copies of all correspondence that Mr Walby had received and sent to the GMC. Mr

Watson indicated on 27th November that there had been no progress on the INI 222 issue and had no update on the progress of an appraisal. On 15th December 2006, Dr Stevens sought an update on the appraisal from Mr Cooke, the Clinical Director.

4.100 On 11th December 2006, the Complaints Department forwarded a report of complaints. The Inquiry Panel has not been provided with the actual attachment to this email of 11th December 2006. There is a handwritten note on the email, seemingly in Dr Stevens' hand, which notes *"-[INI 222], -[INI 87]"*.

4.101 The Inquiry has received an undated handwritten summary of various complaints. Enquiries with the Trust have identified the handwriting as belonging to Mrs Webb and outlines that: *"it may be reasonable to speculate that the note was prepared in connection with Dr Steven's interactions with Dr Watt around this time"*[5]. This summary included reference to the following complaints, recording a brief summary and the time taken to respond:

- [INI 409], for which the documentation has been destroyed but the issues are recorded as follows *'Attitude – rude, superior, breakdown in communication. No physical examination wishes to attend another consultant. Dr W never replied – Jim Morrow did so as he was the CD'*
- [INI 410] on behalf of [INI 406]
- [INI 407]
- [INI 411], for which the documentation is limited but the issues are recorded as follows 'Doctor's attitude & behaviour'
- [INI 222], and
- [INI 87], for which there is a summary of correspondence and actions taken by the Patient Liaison Office.

4.102 The compilation of the material appears to be an attempt to collate relevant information for Dr Stevens prior to his meeting with Dr Watt in the presence of Mr Damian McAlister, Acting Director of HR, on 20th December 2006. Following that meeting, Dr Stevens wrote to Dr Watt on 11th January 2007 confirming what had taken place. The correspondence is extensively set out in full:

> Dear Michael
>
> Thank you for attending the meeting with myself and Mr Damian McAlister, Acting Director of HR, on Wednesday 20th December. I am writing to confirm the discussions we had and to outline the steps I require you to take to address the matters that were discussed.

5 Email from John Johnston, the solicitor from DLS representing the Belfast Trust, dated 26 May 2020.

At the outset of the meeting I indicated that I wished to discuss the following matters with you:

- Consultant Appraisal
- CPD
- Responding to Complaints
- Responding to Medical Legal requests
- Ongoing GMC Enquiry

I have detailed below the key points discussed and the actions agreed in respect of each.

Consultant Appraisal

You are aware of the requirement to be appraised as detailed in the Departmental Circular HSS (TC8) 11/01, and that a failure to comply may lead to future issues around re-licencing with the GMC. This would of course have significant consequences and impact on your ability to practice as a consultant neurologist. While I am assured that you have now participated in the appraisal process for the first time, I must advise you that participation once in five years is not acceptable and that I will expect you to participate more fully henceforth.

I attach for your attention the aforementioned DHSSPS circular and would ask you to familiarise yourself fully with the content.

CPD

It was disappointing to learn that you had not registered with the College for CPD and I would encourage you to take urgent steps to address this. Failure to do so may lead to problems with both the College in terms of re-certification and for future re-licencing with the GMC. It is also a cause for concern for your employer as the college provides a useful assurance role in this respect.

Responding to Complaints and Medical Legal Requests

I highlighted certain patient complaints, to which you had not provided a timely response or that the response provided was deemed insufficient. You indicated that you sometimes found it difficult to translate onto paper what would be deemed a suitable response, but as I advised you in reply the Trust has trained staff who can assist clinicians in developing appropriate responses.

There is also a similar concern with requests for medical reports from legal/ insurance companies, one of which had led you to being reported to the GMC for poor practice.

You indicated that you sometimes found it difficult to prioritise patient administration because of your substantial clinical practice both for the HPSS and privately. You acknowledged that in many regards you needed to engage more proactively in face of such requests as failure to do so often only compounded the situation, increasing the workload and putting at risk your relationship with patients and other parties.

You also gave as a reason for delays in responding to a complaint a failure to be provided with adequate resources, specifically a broken computer and broken window in your office. Whilst these deficiencies need action by management I do not accept that they amount to a substantial explanation for the difficulties you have had in dealing with the issues highlighted at our meeting. Paradoxically you would have had an opportunity to raise such matters regarding resources if you had participated in annual job planning and appraisal, but I will nevertheless discuss these matters with your divisional management team.

Ongoing GMC Enquiry

You advised me during the meeting that you have been informed unofficially by the GMC that you are likely to receive a 5-year warning in respect of their ongoing investigation. This is very significant for a doctor, and I would ask you to act appropriately in future to ensure there is no further jeopardy brought on your fitness to practice. I would ask you to make yourself familiar with the GMC Good Medical Practice document, which I have enclosed.

General

We also discussed your working practices, and you advised that since the introduction of the partial booking system, you had noticed a significant increase in the numbers attending your clinics. Indeed you indicated you were seeing up to 125 patients a week, with sometimes at least 40 being seen at one clinic for which you have little or no junior medical support. This is something you indicated you have raised as an issue in writing with your Divisional Director, Mr D Adams, and I will be pursuing this with Mr Adams.

As our meeting concluded we discussed the status of your contract as you had chosen to remain on the old contract rather than transfer to the new contract. While this is your right, I do believe you should give this further consideration to ensure you are not suffering a detriment.

Equally I should remind you that irrespective of what contract you are on, there is a requirement to participate in an annual job plan review and I will be asking your Divisional Management team to provide me with an assurance that a job plan review is carried out urgently. It is via such a medium that many of the issues you accepted you had been struggling with are best raised and dealt with.

> I trust our meeting will prove productive in the long term. I will be asking your Divisional Management team for an update on each of these matters by the end of March 2007 so I trust progress will be made as was agreed at our meeting.
>
> Yours sincerely
>
> Tony

4.103 What is noticeable about the conversation between Dr Stevens and Dr Watt is that there did not appear to be any reference to the policies of the Trust in respect of the obligations of an employee. A GMC sanction was referred to,[6] but, apart from pointing out the existence of an obligation, there was no reference to disciplinary action or other internal sanction, which, in the view of the Inquiry Panel, would have been the appropriate tool of management when one was facing a straightforward breach of an employment contract. That said, the letter demonstrates that Dr Stevens wished to deal with the situation that had arisen.

4.104 Dr Stevens, on the following day, wrote to the Divisional Director, Mr Adams, drawing to his attention the importance of Dr Watt participating in a job plan review and indicating that he would like an update by March 2007 regarding all the other issues raised in the letter. Dr Stevens also highlighted matters with regards to Dr Watt's office facilities.

4.105 It is noteworthy that within the 5 lever arch files delivered by the Trust in September 2021, there is material from in or about this time period, which highlight the problems with the numbers at Dr Watt's clinic. On 18th January 2007, a senior manager in the Medical Records Department emailed Mrs Webb in the Patient Liaison Service about a complaint regarding delay in Dr Watt's Review Clinic. The email included the following:

> 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 are set for four patients. Consequently (sic) patients are being asked to attend at the same time with inevitable long waits for patients.
>
> I understand that Dr Watt has been making efforts within the Division to have his clinics changed to a more appropriate template.
>
> In the circumstances this complaint is best responded to by his Divisional Manager.

4.106 A draft response referring to a review was sent to Mr Atkinson, who in turn referred the matter to Mr Watson, the then Divisional Manager. The formal response from the

6 Dr Stevens did state in respect of a likely 5-year warning: "This is very significant for a doctor and I would ask you to act appropriately in future to ensure there is no further jeopardy brought on your fitness to practice".

Trust was sent out on 16th February 2007 and referred to a review of the structure of Dr Watt's clinics. On the same date, a file note referred to Dr Watt's concern about the large number of patient appointments. Within days, the complaint was closed.

4.107 Shortly thereafter, Dr Watt then received the GMC formal warning on 26th February 2007. The warning stated as follows:

> … The Case Examiners concluded that the allegation of failing to provide a medical report represented a significant departure from Good Medical Practice. They decided, therefore, that we should issue Dr Watt with a warning under Rule 11(2) of the General Medical Council (Fitness to Practise) Rules 2004 …

4.108 The formal warning, which was effective from 22nd February 2007 and expired on 21st February 2012, was set out in Annex A and stated as follows:

> If you have agreed to prepare a report, complete or sign a document or provide evidence, you must do so without unreasonable delay.

4.109 Commenting on the warning on 2nd March 2007, Mr Walby stated in a memo to Dr Stevens:

> This is the first case on my watch where the GMC has upheld a complaint against a doctor in the Trust and I do not know what procedure the Trust uses to record this matter. I expect you will need to hold a formal meeting with Dr Watt to discuss things and so mark his file.

4.110 The fact that Dr Watt had received a 5-year warning seems to have been known about only by a small group of people, including the Medical Director, Dr Stevens; the Divisional Director, Dr Adams and the Associate Medical Director, Mr Walby. While Mr Walby pointed out that this was the first doctor *"on his watch"* who had received a GMC sanction, there was a limited understanding of what a 5-year warning actually meant or what action if any should be taken by the Trust, nor did the Trust make any inquiry of the GMC as to what the warning entailed, or ask the GMC to seek to explain to the Trust the effect of the warning.

4.111 On 20th March, Dr Stevens wrote to Dr Watt. He noted the warning, emphasised the importance of their previous discussion in December 2006 and reminded Dr Watt that he was to participate in a job plan review before the end of March 2007.

4.112 On the same date, Dr Stevens wrote to the Divisional Director, Mr Adams, indicating that Dr Watt had received a warning and seeking reassurance that the job plan review would be carried out. On 29th March 2007, Mr Adams, wrote to Dr Stevens confirming that he had been informed by Dr Morrow that Dr Watt had had his appraisal and a job plan review carried out . This turned out to be incorrect. An

email of 29th March 2007 from Dr Watt to Dr Stevens indicated that the job plan review was to take place in another 4 weeks because Mr Cooke, the Clinical Director, was not able to complete it at that time. Email correspondence suggests that the review was planned on 14th May 2007. In a written answer on 4th August 2020 to questions posed by the Inquiry, Mr Cooke stated that he did recall a job planning meeting at or about this time and believes it would have been on or about 14th May in his office. He told the Inquiry.

> A new and more detailed timetable was drawn up and discussed with Dr Watt … My recollection is that the purpose of the meeting was to agree a more specific timetable than was in place, within the limits of his contract ie to document his activities in an hour to hour format, rather than the previous timetable based on notional half days. It also included a detail on his on-call commitment. It was not a job plan review in the sense of how job plan reviews now take place under the 2004 Consultant Contract. I do not have a signed copy of this new timetable and assume this would have been placed in his file held in the directorate office. I have no other record of this meeting that I can find.
>
> I do not believe that I had any other job planning meetings with Dr Watt after that.

4.113 A partially completed clinic template was forwarded to the Inquiry from Mr Cooke's computer, but there were no other documents available from Dr Watt's file in the Medical Director's Office.

4.114 Subsequently the Inquiry Panel noted the following interaction on job planning in 2009 between the then Clinical Lead, Dr Morrow, and Dr Watt. The initial invitation to a meeting with Dr Morrow was forwarded to Dr Watt by Dr Morrow's secretary. Dr Watt responded:

> As I am still on the old contract I do not need a job-planning meeting.
>
> Michael Watt.

4.115 Dr Morrow responded:

> Michael
>
> I think you need a job planning meeting but don't worry we have no control over you (it is formality).
>
> Jim

4.116 There was a degree of flippancy in Dr Morrow's response, but the interaction revealed to the Inquiry Panel that the then Clinical Lead's approach to management

was inappropriate and may also give a helpful insight into the approach, not just of Dr Watt but also to those who failed to manage him .

2006/2007 FINDINGS:

4.117 Before commenting on discrete aspects of this time period and the problems that emerged, it is essential to highlight that in the overall hierarchy of concerns, it is the clinical issues, which are the cause of the greatest concern to the Inquiry Panel, as they have the most relevance to patient safety. That is not to say that the so- called administrative and other issues are not important. The Inquiry Panel noted complaints where timely referrals were not made, or investigative reports were misfiled.[7] It is both artificial and wrong to categorise such issues as purely administrative since they undoubtedly would have had consequences for patients. Similarly, a warning from the GMC or a failure to complete appraisal or undergo job planning may not, by definition, lead to the conclusion that a clinician is in difficulties or is sub- standard in his clinical abilities, but they may lead to a train of inquiry, which cause other aspects of a doctor's practice to be considered .

4.118 The Inquiry Panel noted that, as explained in more detail in the GMC chapter, the 5-year warning imposed by the GMC was not understood by relevant management within the Trust. Apart from the matter being on a doctor's record, no one, even within the GMC, could explain the significance of the sanction. Unsurprisingly, the penalty was effectively ignored and ironically the GMC wrote to the Trust in 2011, within the 5-year period, complaining about the absence of a report they had asked Dr Watt to provide. No one seemed to have realised that there was a 5-year warning in place for a similar failure to provide a medical report..

Managing Consultants:

4.119 The Inquiry Panel recognises that the concept of managing doctors was only slowly evolving. Doctors and consultants, had been used to operating a different model where hospital administrators saw their role as one of supporting clinical practice. It is noted, from the evidence of Dr McBride that the American model of having both a full-time doctor and a full- time administrator in exclusively management roles was deemed to be too expensive for the NHS and, in Northern Ireland, the Department of Health. The Inquiry Panel accepts that medical managers had to undertake their managerial work within significant time constraints and with limited training and

7 This is set out in the Complaints chapter.

managerial experience. If however, the safety of patients is to be ensured then they must do so competently. The Inquiry Panel accepts that the culture of consultants, particularly historically, may have made their management more difficult. Because it was difficult did not mean that consultants should have been managed less effectively.

4.120 Those difficulties were compounded because, while the new structures may have been based on a more traditional management model, consultants, particularly those who had been in post for many years, would have been unused to such a model. Consequently, as demonstrated by a number of revealing comments, such as those from Mr Cooke and Dr Morrow[8], the perceived ability of those in management to actually manage was limited and huge amounts of time seem to have been invested in trying to persuade, cajole and warn Dr Watt to meet his administrative and contractual obligations. The idea of escalation, action and sanction were rarely demonstrated, not just at this time, but throughout the relevant period. The end result of management inaction was that patient safety may have been compromised.

4.121 Problems with completing appraisal, responding to requests for medical legal reports and complaints about general attitude were clearly present during the time period 2006/2007. In addition, there were early signs that Dr Watt was resistant to management action. These are matters of governance. A management system cannot operate if those who are being managed feel free to routinely ignore those who are charged with management. During this time, for instance, the GMC upheld a complaint and issued a formal warning against Dr Watt for not responding to a request for a medical legal report and, based on the evidence of Mr Walby, the very fact of a consultant having such a warning, was an unusual occurrence in the Belfast Trust.

4.122 In the event, the warning seems to have been ignored and has largely not been referenced or considered in other subsequent investigations. The warning does not seem to have diverted Dr Watt from continuing to give any priority to appraisal or the completion of medical reports. Management failed to address this continuing problem in any meaningful way. Further, the then Sub-Divisional Manager, Mr Watson was not aware of the warning, nor was the Patient Liaison Manager, Mrs Webb, nor were staff like Mr Atkinson or Ms Lundy, who subsequently took on the investigation of complaints within the Neurosciences Division.

8 See "I really only have explanation/persuasion to use to resolve such problems." Email from Mr Stephen Cooke 4th October 2006. In 2009 Dr Morrow noted in relation to Dr Watt …"As for Michael, you know the score, he has only ever been appraised once and despite regular reminders des not cooperate". With regard to job planning Dr Morrow stated in 2009 "Michael I think you do need a job planning meeting-but don't worry we have no control over you (it is a formality)".

The Keeping of Records:

4.123 The Inquiry Panel became aware of a policy, which saw the routine destruction of complaints material after several years.[9] This made it difficult to access material prior to 2006, although the Inquiry has been able to piece together from other material, a partial picture of earlier complaints against Dr Watt. The Inquiry Panel was concerned that records were not kept but recognised that other factors may have been relevant including data protection and confidentiality. The Inquiry Panel, therefore, sought a formal legal opinion from David Scoffield QC (now Mr Justice Scoffield) and Alistair Fletcher BL. The opinion considered specifically the retention of complaints data:

> 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.

4.124 Dr McBride, in his evidence on 7th November 2019, agreed with the idea of a policy much more focused upon retention, stating as follows:

> 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 the thing that strikes me about this when I look at it is the numbers of complaints. It shouts out to me in terms of just the numbers, sheer numbers 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.

4.125 The Inquiry Panel agrees and has concluded that the policy of retaining documentation, which involved destroying documents after a number of years, was insufficient and inadequate to address patient safety concerns and more specifically to help identify patterns of aberrant practice. In a situation such as the present, where a traumatic and extensive recall process has occurred against a background of

9 For the avoidance of doubt, the Inquiry accepts that the destruction of material was carried out pursuant to a document retention policy.

earlier concerns, it may well be the case that such unsubstantiated concerns can later be recognised as missed opportunities for intervention, or indeed reconsidered in the light of subsequent events. Retaining information about past complaints, unless they have been properly investigated and dismissed, could significantly improve patient safety in the longer term.

The significance of Administrative and Contractual Obligations:

4.126 As recognised by Dr McBride, with the benefit of hindsight, evidence of a poor attitude with regard to administrative and contractual obligations may be a symptom of an underlying malaise. Unfortunately, the dichotomy between administrative and clinical, in relation to Dr Watt, emerged at or about this time. The Inquiry Panel notes, for instance, that in October 2005 Mr Walby informed the GMC that there were no concerns about Dr Watt's practice, but there were specific issues about his slowness in providing medical reports and appraisal. This perception continued throughout Dr Watt's consultant career and whenever clinical issues arose, the strength of the perception was evident and influential. The Inquiry Panel believes that this perception, an example of "group think" led to clear opportunities being missed.

INI 222 and INI 87:

4.127 In considering related concerns or circumstances, which should have alerted the Belfast Trust to *"instigate an earlier and more thorough investigation over and above the extant arrangements for raising concerns"*, [10]the Inquiry Panel considered the cases of both INI 222 and the INI 87 family both in terms of the manner in which the clinical concerns were addressed and the wider administrative concerns. INI 222 and INI 87 were both complaints of a clinical nature, which were considered by other consultant colleagues and, in the case of the death of INI 87, the subject of scrutiny by the Coroner.

4.128 The Inquiry is not in a position, nor is it required, to come to any clinical judgment on the above complaints. The Inquiry Panel noted that in the INI 222 case, the then Medical Director, Dr Stevens sought and obtained the view of Dr McDonnell, a recognised specialist in MS and a colleague of Dr Watt who was at the time also involved in INI 222's care. Dr McDonnell provided a view both in July 2006 and later in January 2007. In fairness to both Dr Watt and Dr Stevens, on both occasions,

10 From the Inquiry Terms of Reference.

Dr McDonnell felt that the criticisms of Dr Watt's approach were unfair even if, in retrospect, he had come to the view that there was insufficient evidence to come to a definitive diagnosis of MS.

4.129 The Inquiry Panel notes that at one stage Dr Stevens considered obtaining an independent view. This would have been a positive step, which may have reinforced Dr McDonnell's view and led to a greater scrutiny of Dr Watt's diagnosis. Unfortunately, this step, though mooted, was not taken. It is significant that both Dr Stevens and a former Medical Director, Dr McBride, thought, in retrospect, that the INI 222 case was an early sign of a pattern emerging in diagnosis by Dr Watt which involved speed in reaching a diagnosis, inadequate testing and an alacrity in prescribing medication.

4.130 The later emergence in the Inquiry of the INI 408 case highlights the depth of the structural problems that were, in fact, apparent throughout the period reviewed by the Inquiry. INI 408 was a highly relevant case, which does not appear to have been brought to the attention of the Medical Director or to Mr Walby. At no point is there any reference to the case by those involved with INI 222 and INI 87. This is despite the fact that neurologists and, Dr Morrow, the then Clinical Lead, had been copied into correspondence in the INI 408 case, which revealed Dr Hawkins' conclusion in his letter of 9th June 2005 to Mr Watson that Dr Watt was operating outside the guidelines in his prescription of Beta-Interferon.

4.131 The Inquiry Panel has not been able to discuss this with Dr Morrow because of his ill health, but is concerned, based on other comments [11]made by Dr Morrow that there was within neurology, a prevalent view, which did not see the necessity of escalating concerns up the management line. This may have been a throwback to earlier times, where such escalation would have been regarded as unhelpful or unnecessary. The problem was that such an approach prevents patterns of aberrant practice from being identified or actioned. Each case appears to have been dealt with separately and on its own terms. The Inquiry has seen no evidence at this time of one case raising concerns about an earlier case, even though neurologists such as Dr Morrow, the Clinical Lead, would have had either involvement or knowledge of each of the relevant complaints. If patient safety is to be paramount in management, then issues, which arise must be properly investigated and determined. They cannot

11 In 2008 Dr Morrow wrote to other attendees of the Grand Round questioning the decision of the then Clinical Director Mr Steve Cooke to raise a concern about a colleague's presentation with the Medical Director. Dr Morrow wrote: "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. In 2009 Dr Morrow noted in relation to Dr Watt…" As for Michael, you know the score, he has only ever been appraised once and despite regular reminders des not cooperate." With regard to job planning Dr Morrow stated in 2009 "Michael I think you do need a job planning meeting-but don't worry we have no control over you (it is a formality)".

be left in limbo or ignored because a court or other body answering a different question does not include the relevant issue in its judgment.

4.132 It is also clear that the Trust was so concerned following the meeting with INI 87's family that an emergency meeting was called by Dr Stevens and legal advisers were consulted. Before the meeting took place, however, the Coroner's Inquest was called and the momentum, urgency and concern appeared to evaporate. The Inquiry Panel believe that the Coroner's inquest resulted in the Trust not investigating or addressing the issue of the epilepsy diagnosis. In effect, the Trust waited for the inquest to take place, presumably in the hope that this would sort and clarify matters by identifying or addressing any concerns. However, the issue of epilepsy diagnosis was not focused upon at the Inquest and any concern the Trust had with regards to the diagnosis and treatment of INI 87 was left unresolved and effectively ignored. The error was to lose sight of the problems with Dr Watt's diagnosis.

4.133 After a careful analysis of the relevant documentation, the Inquiry Panel has concluded that the decision of the Coroner, which did not deal with the underlying diagnosis, but only the cause of death, effectively resulted in the issue regarding the diagnosis of epilepsy being forgotten and not further referenced when other problems emerged.

4.134 The Inquiry Panel accepts that the three cases, where clinical complaints arose in and about 2006-2007, are complex and do not lend themselves to being classified as straightforward examples of misdiagnoses by Dr Watt . There were, however, more than sufficient questions to be addressed, which were eventually glossed over and missed.

4.135 Dr Stevens indicated to INI 222's family that he was *"committed to resolving issues as far as possible"* but failed to do so. He acknowledged the need for a third consultant but did not go down this route. His final response is lacking and incomplete, in just letting the two contrary opinions sit there unresolved. In fairness, Dr Stevens was candid in his assessment of the INI 222 complaint during his oral evidence of 3rd September 2019:

> Yes, I mean I think the thing I've taken out of this is that [Dr Watt] 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 to proceed to treatment . And it's really in 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. And as I've also said had already made the comment that we were treating this guy unfairly.

4.136 The situation in relation to INI 87 was more contentious. Dr Stevens felt that Dr Morrow was not criticising Dr Watt's clinical practice. In his evidence to the Inquiry Panel on 3rd September 2019, he felt that there had been a reasonable approach taken at various stages and in his reflections felt that INI 87 was different from INI 222. The Inquiry Panel does not agree. Having gone through the contemporaneous material, Dr Morrow significantly softened his initial criticisms, which were straightforward and gave rise to the need for further investigation. Dr Morrow was medically unfit to give evidence to the Inquiry, and there was, therefore, no opportunity for Dr Morrow to provide an explanation for the clear change in tone in his assessment. The Inquiry Panel has concluded that INI 87 was a significant case and that Dr Morrow's initial assessment should have led to a much more in-depth investigation being carried out.

Failure to Manage Administrative Poor Performance, Appraisal and Job Planning:

4.137 Much of the focus, however, of involvement by the Medical Director's Office and the Divisional Director, Mr Adams, and the Clinical Director, Mr Cooke, with regard to both the INI 222 and INI 87 complaints, is centred on issues surrounding Dr Watt's administrative tardiness, a failure to participate in appraisal and job planning and occasional communication issues with patients. It also marks the first time that the view of an investigation is that there are no issues with Dr Watt's clinical competence. This perception, if anything, grew and re-appeared regularly at other critical junctures, including the investigation in 2012/2013.

4.138 The Inquiry Panel accepts that Dr Stevens made repeated efforts to address a range of concerns regarding the practice of Dr Watt in 2006/2007. The consistent pattern was that complaints were made, Dr Watt was spoken to and often written to by the Medical Director or Assistant Medical Director, direction was given for compliance and then largely ignored. This pattern was presumably behind Dr Morrow's whimsical but inadequate response in 2009:

> As for Michael, you know the score, he has only ever been appraised once and despite regular reminders does not cooperate.

4.139 A failure to participate in appraisal or respond to reasonable requests for reports, is not just an administrative matter, it is also a contractual obligation and something,

which the Trust is required to manage. When such failings are juxtaposed alongside clinical complaints, the importance of more anxious scrutiny is reinforced.

Triangulation of Information:

4.140 A key and obvious manifestation of the problem in 2006/2007 was the triangulation and proper sharing of information. The pattern set at this point continued and further obvious problems re-emerged in 2012/2013 and also in early 2016. When a clinical issue was considered, it was reflected upon without reference to earlier incidents for a variety of reasons.

4.141 The inability to identify the volume of complaints, which was evident in Mr Walby's response to the GMC, and the problems in triangulating information ensured that, the Medical Director often only got a partial picture of evolving concerns. The handwritten report from Mrs Webb, received by the Medical Director in advance of meeting with Dr Watt in December 2006, which only included reference to 6 complaints, and no reference to INI 408, is another example of these issues with regards to identification.

4.142 Dr Stevens, the former Medical Director, in his second appearance before the Inquiry Panel, demonstrated commendable evidence of proper reflection and his candour was both noted and helpful to the Inquiry Panel. He clearly recognised that an opportunity was missed in the INI 222 case and although more reticent to accept that INI 87 was also poorly dealt with, the Inquiry Panel has identified a problem with Dr Morrow changing his view or toning down his initial opinion . The Inquiry Panel is concerned that this change in view or tone may have caused the Medical Director and the Coroner to miss an important facet of INI 87's care and treatment prior to his death.

4.143 Other difficulties emerged because incomplete information regarding complaints was given by Mr Walby to the GMC. Mr Walby should have been more careful in ensuring accuracy in his dealings with the GMC. Other complaints, including INI 406 and INI 407, of which he was aware, were omitted. This may have been because collating the complaints was not straightforward or that he simply focused on the ones, which he had more carefully considered. The Inquiry was unable to establish the status of INI 404, INI 408 and several complaints, which have now been destroyed. There is no evidence, however, that Mr Walby was aware of these complaints. The Inquiry was unable to ascertain what communication took place between Mr Walby and the Complaints Department so as to establish exactly how

or why these complaints were not brought to the attention of the GMC. It appears to be the case that systems were not in place, which could have made the collation of relevant information a straightforward exercise.

4.144 This example reinforces the inadequacy of the system in existence and the inability of those with relevant responsibility to obtain a verifiable record in relation to a specific doctor. The disappointing aspect of this development is that had all the information been available and triangulated at this time, and, the clinical complaints considered in a compendious form, it may have caused the Trust to take stock and conduct an earlier and more thorough investigation.

4.145 The Inquiry Panel notes that matters pertaining to triangulation and dissemination of information continued to be an issue going forward. For example, many Trust staff with responsibility for the management of Dr Watt or the complaints processes, including Mrs Webb, the Patient Liaison Manager, gave evidence that they were unaware that Dr Watt had received the GMC warning in February 2007. This is despite a number of similar or relevant complaints coming to the attention of the Trust during the period in which the GMC warning was in effect.

The Prevailing Management Culture:

4.146 The combination of a failure by doctors to escalate concerns with a complaints system that was unable to easily identify the relevant complaints for a particular doctor, resulted in complaints being dealt with ineffectively and prevented the emergence of a clear pattern regarding Dr Watt, which should have been investigated.

4.147 A false perception emerged that Dr Watt's problems were solely administrative and resulted in several incidents not being properly investigated. That perception continued and re-emerged at other key times, such as 2012/2013 when Dr Stevens wanted a review of Dr Watt's practice because of another GMC investigation. Throughout the period, the storage of relevant information within the Patient Liaison Service and subsequently within the Belfast Trust, both in Neurosciences and the Complaints Department, was such that identifying patterns of concern was difficult and overly relied on memory. A medical director must have the ability to easily access relevant information about a doctor in a compendious and coherent manner. What actually transpired was almost the antithesis of this ideal.

4.148 The fundamental difficulty is that complaints received were the only potential repository of relevant information concerning a doctor. There was no evidence given which suggested that concerns arising from any other source were contributing to

the overall picture. When colleagues were asked to comment, which they were in INI 222, INI 408 and INI 87, initial clarity was replaced with nuance and qualification, which does not now appear to have been justified, based on the earlier comments. In such a context, it was difficult not to come to a conclusion that those involved in complaints, and the doctors who were 'investigating', were focused on managing the complaint and not in addressing the clinical issue or potential problem..

4.149 The impression given to the Inquiry Panel is that disagreement between doctors is a regular occurrence and that there is little one can do to determine who is right. This dilemma raised significant management and governance issues. It is perfectly reasonable in some circumstances for a medical director or other manager to decide that a disagreement between doctors is to be expected. It is critical, however, that if that is the decision, it is recorded as such. Alternatively, a manager may decide to seek an independent opinion and that again can be used to ascertain whether one of the views is medically not sustainable. Whatever decision is taken, it needs to be recorded and signed off. The decision also needs to be accessible so that if other similar cases arise, the matter can be viewed as part of a potential pattern. None of this seems to have been intrinsic to addressing conflicts of opinion in 2006.

4.150 The Inquiry Panel recognised that in 2006/2007, changes were evolving and that it was perhaps overly optimistic to expect that change would occur quickly. What is striking, however, is how the mistakes made at this point regarding investigating potential clinical issues with regard to Dr Watt, were repeated frequently in the years ahead. Allied with this problem was a downplaying of administrative failings as a significant issue. Rather than seeing the failure to provide reports and complete appraisal or job planning as being a serious problem or one that justified further investigation, these matters were not seen as important; nor did they result in effective management action. Some initial allowance can be permitted for the change in structure and the introduction of governance driven by a management process. By this stage, however, those in management must accept their responsibility to manage and the failure to do so in this instance allowed unacceptable practices by Dr Watt to continue without sanction throughout the relevant period.

Job Planning and Overbooked Clinics:

4.151 In addition to the needs of patients, the Trust also owes a duty of care to its employees, including its doctors. According to various complaints responses, in early 2007, Dr Watt himself was concerned about the system for booking patients into his clinics. The Trust had an obligation to both the patients and Dr Watt to address

these issues. Although there was one job planning meeting in May 2007 between Dr Watt and Mr Cooke, and the Inquiry Panel is aware of a temporary reduction in the number of patients being seen by Dr Watt, the situation soon reverted (with Dr Watt's encouragement) to where it had been previously. Many witnesses gave oral evidence and numerous written complaints viewed by the Inquiry highlighted, that Dr Watt's clinics continued to be handling patient numbers well in excess of the agreed template in the ensuing years. This issue is discussed further in the Complaints chapter.

4.152 Although complaints about delay at his review clinic were common place and the Inquiry had received, at a highly relevant period, in January 2007, evidence of Dr Watt's clinic template being reviewed, there is little sense that the matter had been adequately addressed.

4.153 The introduction in comparatively recent times of more proactive management has not always been welcomed by the employees. The attitude taken to appraisal and job planning by Dr Watt was not unique and management have faced a major challenge in seeking to change the pre-existing culture. In this regard, however, it is noted that the present rate of appraisal within the Belfast Trust is close to 100%.

4.154 The impression given, however, was of a system of management that was locked in various silos, where information was never synthesised to the point where a decision-maker could have viewed the entire picture. Further, there was an air of resignation amongst some managers during this period that Dr Watt would simply do his own thing and pay scant attention to advice and warning. Others did not seem to perceive that management was an appropriate method of governance. The reality is that such an approach was accepted and acquiesced to by those in management.

Questions Posed by Terms of Reference:

4.155 To revert to the original questions posed at the outset of this chapter, the Inquiry Panel has concluded that 2006-2007 has taken on a much greater significance than was initially thought to be the case. It was during this period that the perception developed that the problem was not in Dr Watt's skills as a clinician but was rather in his approach to administrative and other obligations. This was highlighted during Dr Stevens' interview with the INI 87 family, attended by Dr Morrow, the then Clinical Lead. Dr Morrow was requested by Dr Stevens to speak to Dr Watt about communication problems, even though it was Dr Morrow who had first queried how a diagnosis of epilepsy had even been entertained in the first place in

the INI 87 case. The index cases (INI 222, INI 87 and INI 408) had all ironically been the subject of questions raised or observations made by Dr McDonnell, Dr Morrow and Dr Hawkins respectively and yet, despite this, the comments were ignored, qualified or excised.

4.156 Juxtaposed alongside the clinical issues raised in the index cases, there were a series of other issues which gave rise to concern. If a consultant was contractually obliged to submit to an appraisal and a job planning review and consistently failed to live up to other administrative obligations, to the point, where he had received a GMC warning, the need for proper management of the situation becomes critical . In the case of Dr Watt, the attitude of management seemed to be one of resignation and acquiescence rather than holding Dr Watt to account.

4.157 Concerted efforts made by Dr Stevens for a period, seemed to have slowly been forgotten about and the practices that had been the subject of complaint continued without effective challenge.

4.158 Commenting on this Dr Stevens stated on 3rd September 2019:

> At the time in 2007 I had just taken over as Acting Medical Director in Belfast, I dealt with that. There is a letter on file, I think a very robust letter from dealing with - I met him - all the aspects the GMC raised, and at that time I passed it back into the service group to address those issues … if there is a criticism of me at that time it is that I put it back into the service group to follow that up.

4.159 The then Divisional Director, Mr Adams was also forthright in his evidence to the Inquiry Panel on 8th December 2020:

> **Mr Adams:** I think that we all hoped, that you would be able to persuade this chap to change his ways, to see the error of his ways and change them. And I think, unfortunately, we failed.
>
> **Professor Mascie-Taylor:** Sure, now.
>
> **Mr Adams:** -- and you're right, we were probably tolerant for far too long.

4.160 Nevertheless, the Inquiry Panel views the gaps that clearly appeared in the management of Dr Watt as revealing a concerning level of dysfunctionality within the management structure itself. Instead of the Medical Director's Office developing a clear picture of an ongoing and emerging problem of aberrant administrative practice, the evidence suggests that issues were considered at the time and then not followed through. When the next incident or issue emerged, there was little analysis of pattern. The danger in such a development is that management tended to falsely

reassure itself that a problem had been addressed. In the developing confusion there was no effective challenge to Dr Watt.

4.161 A key and obvious manifestation of the problem in 2006/2007 was the triangulation and proper sharing of information. The pattern set at this point re-emerged in 2012/2013 and in early 2016. When a clinical issue is considered, it is reflected upon without reference to earlier incidents.

4.162 The inability to identify the volume of complaints, which was evident in Mr Walby's response to the GMC, and the problems in triangulating information, ensured that the Medical Director often only got a partial picture of evolving concerns. Dr Stevens, the former Medical Director, in his second appearance before the Inquiry Panel, demonstrated commendable evidence of proper reflection and his candour was both noted and helpful to the Inquiry Panel. He clearly recognised that an opportunity was missed in the INI 222 case, although he was more reticent to accept that INI 87 was also poorly handled. He was not aware of the INI 408 complaint, which he should have been informed about.

Conclusions and Findings:

4.163 A striking feature of the evidence in this chapter is that the criticisms made of management are almost entirely of *medical* management. The Inquiry Panel is struck by the fact that it is as though the Trust Board, the Chief Executive and their management structure had no part to play in the index cases. To be clear, the view of the Inquiry Panel is that the ultimate responsibility for the safety of patients must sit with the Board of the Trust. The Chief Executive of the Board is the accountable officer, and the Board collectively was responsible for the governance systems that were in place. The fact that the Board was unaware of specific problems did not absolve the Board of responsibility. It was the Board who had to ensure that there were systems in place, and adhered to, which allowed for effective management at all levels.

4.164 Additionally, those who were involved as non-medical managers within both Neurosciences and at more senior levels within the Trust, also had a responsibility to ensure that management was effective.

4.165 Although the Inquiry Panel accepts that the development of a management system with a Medical Director in place was evolving at this time, the failure of the governance system to connect clinical complaints and collate all of the issues in such

a way as the person charged with the responsibility of judgment can assess all of the relevant material, was striking.

4.166 The problem was recognised retrospectively. In his evidence of 7th November 2019, Dr McBride reflected:

> If I think back on that, we had islands of governance … I mean I could see the gaps between, you know, litigation, coroners, complaints, SAI's and everything else in between, and we were no different than anywhere else, but it was immensely frustrating, where one governance structure or line of learning or intelligence was not necessarily linked into and sharing that information and intelligence with another aspect of — or another relevant sphere of the governance domain.

4.167 The evidence suggests:

(i) Management failed to follow its own policy with regard to appraisal;

(ii) The Trust failed to ensure Dr Watt regularly carried out job planning which was a part of his contractual obligation;

(iii) The Trust failed to address the overbooking of Dr Watt's clinics in a long-term manner;

(iv) The Trust failed to adequately collate, record and investigate those complaints, which may have been relevant to a doctor failing clinically;

(v) The Trust failed to ensure that Dr Watt's administrative obligations regarding medical and other reports were fulfilled;

(vi) The Trust failed to identify the potential for these administrative failings to have clinical consequences for patients;

(vii) There was no sanction by management and, apart from the GMC warning in 2007, no specific step was taken to ensure that Dr Watt complied with his obligations.

4.168 Throughout this period, Dr Watt was frank and unabashed in his approach. There was no question that he sought to hide his views or give the impression of altering his practice. As Mr Walby put it in his letter to the GMC in October 2005, *"He does not give these matters any priority to his clinical work"* and Dr Watt's own Clinical Lead, Dr Morrow, thought it appropriate to inform Dr Watt that he had no control over him whilst referring to professional governance procedures as being *"a formality"*. The Inquiry Panel is concerned that the failure to challenge Dr Watt's attitude by

medical managers encouraged Dr Watt to continue to disregard Trust policies and ultimately contributed to a failure of governance.

4.169 There was a marked failure to learn from the complaints that were made. The focus was on managing and satisfying the complainant rather than identifying a potential underlying clinical problem. Without a foundation of knowledge and understanding, there was little prospect that the problems identified in one complaint would be considered in another. The Inquiry Panel was struck by the clarity of the initial opinions that were obtained from other consultant neurologists in the 3 complaints that have been focused upon in this chapter.

4.170 There was no collation, synthesis or triangulation of the data that was available. This was a failure of management. If there is a weak managerial approach to a particular doctor and poor collation of evidence then the opportunity to identify a potential problem is limited. Unfortunately, the problem of integrating governance structures persisted, as will become apparent in subsequent chapters.

4.171 While these events happened many years before the events in late 2016, the Inquiry Panel believes that the die was cast in 2006/2007. It was during this period that the perception of Dr Watt as being a competent physician who did not give priority to administrative and appraisal obligations was formed and ultimately influenced future analysis.

CHAPTER 5 – 2012-13 MISSED OPPORTUNITIES

Introduction

5.1 This chapter deals with complaints and concerns and related circumstances identified by the Inquiry Panel prior to November 2016, which should have alerted the Belfast Trust to instigate earlier and more thorough investigations over and above existing arrangements. The material should be read in conjunction with the 2006/2007 and 2016 chapters and the issues that arise have a degree of overlap.

Evidence

5.2 By 2012/2013 there should have been a substantial volume of information available on Dr Watt's practice. In particular, he had been the subject of a 5- year warning from the GMC in 2007 and had been the focus of a number of index complaints in 2006/2007, including INI 222, INI 87 and INI 408.

5.3 The focus of the evidence section is on events during 2012/2013 and the question of whether this period revealed a missed opportunity or identified a pattern, which should have been considered in relation to Dr Watt. Some limited earlier evidence prior to that period is also included to give context to the issues that arose in 2012/2013.

Appraisal and Job Planning:

5.4 On 21st September 2009, Dr Jim Morrow, then Clinical Lead for Neurology, responded to a query or question from Mr David Adams, the Associate Director for the Head and Skeletal Division, in relation to the rates of appraisal within Neurology. In 2009, all consultants were contractually required to complete their appraisals and, after outlining that 8 out of 10 appraisals in neurology were complete or in the process of completion, Dr Morrow stated: *"as for Michael Watt … well you know the score, he has only ever been appraised once and despite regular reminders does not co-operate. Hope that's helpful"*. While Dr Morrow was unable to give evidence because of his medical condition, the Inquiry Panel viewed this comment as indicative of an attitude by some in management that there was little that could be done if a consultant refused to co-operate, even if it was a contractual obligation. The Inquiry Panel accepts that the level of engagement with the appraisal process has increased to the point where all doctors, apart from in exceptional circumstances, do now participate, but the

prevailing climate in 2009 was such that Dr Watt could miss his appraisals over a number of years without sanction.

5.5 On 21st January 2010, all consultant neurologists were emailed by the Specialist Services Group to arrange job planning meetings with Dr Morrow. Dr Watt responded outlining that: *"I am still on the old contract I do not need a job plan meeting."* Dr Morrow responded, stating: *"I think you still do need a job plan meeting – but don't worry we have no control over you (it is a formality)"*. The comment by Dr Morrow seems to reinforce a perception that job planning had to be completed to fulfil an obligation rather than as a means by which a consultant's performance could be managed.

5.6 The Inquiry Panel has not had the opportunity to ask Dr Morrow about this documentation as he was medically unfit to attend. It is unclear whether any job planning meeting occurred at this time. In a written statement to the Inquiry dated 26th November 2021, Mr Cooke, the then Clinical Director, indicated that he recalled a job planning meeting with Dr Watt *"in and around May 2007"* and a draft template from that period from Dr Watt was provided to the Inquiry with work activities specified. The Inquiry has seen an email from Mr Cooke dated 12th January 2011 enclosing a job plan identical to the 2007/08 version to Dr Watt, which asked him to *"sign and return the attached timetable"*. The Inquiry has seen no evidence that a meeting to review the job plan took place at this time and, in written evidence to the Inquiry dated 4th August 2020, Mr Cooke was of the belief that he conducted no further job planning meetings with Dr Watt after 2007.

INI 417 Complaint:

5.7 On 3rd August 2010, the Trust received a complaint from the mother of INI 417. INI 417 had seen Dr Watt, initially privately, and had subsequently attended the Royal Victoria Hospital and undergone treatment with human immunoglobulin ("HIG"). She had been prescribed with strong pain relief by her GP. The substance of the complaint was focused on Dr Watt's alleged attitude and delays in organising treatment. Dr Watt did not implement the medical approach suggested by a Consultant Neurologist from Queen Square in London, who had seen the patient following an earlier referral and recommended that an epidural blood patch be performed. The Queen Square Consultant appears to have raised concerns about a second HIG treatment proposed by Dr Watt, which led to the complainant cancelling a second course of HIG.

5.8 The Service Manager, Mr Atkinson, was asked to obtain Dr Watt's views and a letter drafted by Mr Atkinson was approved by Dr Watt. Dr Watt's views focused on the appropriateness of performing an epidural blood patch and made no reference to the stated concern regarding the course of HIG. Dr Watt did agree to perform an epidural blood patch but noted that he did *"not feel the procedure is urgent as this has been going on for several years and no investigations to date have shown any evidence of low CSF pressure"*.

5.9 The response from Mrs Patricia Donnelly, Director of Acute Services in the Belfast Trust, dated 7th September 2010, formalised the draft prepared by Mr Atkinson and recited the history of attendance and further apologised for any distress. Regarding the treatment suggested by the Queen Square Consultant, the response noted that while Dr Watt did not completely agree with their conclusions, a blood patch procedure was to be arranged for later in September 2010. The medical aspects of the complaint were not analysed, save for acknowledging that the doctors treating the patient disagreed. The letter contained no reference to the issues relating to HIG[1] flagged by the complainant.

5.10 It is important to note that the issue here is not to determine whether a Consultant Neurologist in Queen Square was correct or whether Dr Watt's view was reasonable or appropriate. The concern of the Inquiry Panel is that there is a process in place so that when a clinical issue is raised, there is a means by which it can be determined and assessed at that time. It may be an issue where neurologists can reasonably disagree, or it may be that one or other of the doctors is wrong. The critical step is to ensure that the matter is evaluated and a determination made. If, for instance, Dr Watt's use of HIG at this point was questionable, then that is something that should have been logged and referred to for future reference, particularly in light of the subsequent correspondence from Mr Dean Sullivan, Director of Commissioning at the Health & Social Care Board to the Trust Chief Executive of 7th June 2011 (as discussed at paragraph 38 below) That letter had pointed out that HIG was being prescribed, particularly in neurology, in situations where there was a limited evidence base. What the Inquiry Panel was interested in was whether a link was made or could have been made between the complaint and HIG use generally. This aspect of the complaint was not answered, nor was sufficient action taken by the Trust to follow up on Mr Sullivan's observation in his letter that *"the area where there is the greatest need to review indications for use is in the field of neurology"*. Coming from this source, the Inquiry Panel takes the view that greater curiosity would have been appropriate, and some form of benchmarking or case note review undertaken.

1 The prescribing of HIG is considered and commented upon in more detailed within the chapter on prescribing.

5.11 Reflecting on the complaint, after a review of the papers, Dr Tony Stevens, the then Medical Director, told the Inquiry Panel in his oral evidence of 3rd September 2019:

> … the [INI 417] [complaint], 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, [Dr Watt] 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, 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.

Complaints regarding report writing 2010-2011:

5.12 On 26th November 2010, INI 418 made a formal complaint to the Trust regarding the failure by Dr Watt to provide a report, which was necessary to invoke a critical illness policy. The report had been requested on 6th August 2010 and followed up every few weeks. By the time a formal response from the Complaints Department had been sent on 27th January 2011, a reply to the insurers had been forwarded by Dr Watt.

5.13 While investigating the complaint from INI 418, Ms Katrina Hughes, Assistant Service Manager within Neurosciences, emailed the Clinical Director, Mr Cooke, the Clinical Lead, Dr Morrow and the Service Manager, Mr Gerry Atkinson, on 22nd December 2010 to state that:

> 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 of the NHS work however this still does not look good from a Trust perspective and [Dr Watt's secretary] has let me know that there are dozens of calls per week in relation to this issue but with other patients.
>
> I would be grateful for advice please.

The Inquiry has seen no evidence of any response to Ms Hughes' email.

5.14 On 15th December 2010, the Trust received a complaint from INI 419. It was alleged that Dr Watt had not forwarded to the Driver and Vehicle Licensing Agency the information necessary for INI 419's driving licence, which had been revoked, to be restored. The original form for completion had been handed in to the Trust in mid-August. An internal Complaints Department email of 15th December, forwarded

to Mr Atkinson amongst others on 16th December, noted that this complaint was *"similar to the INI 418 one about Dr Watts [sic] I believe …"* The Trust believe that Dr Morrow also spoke to Dr Watt at this time. There is no file note of this conversation, and no documentation has been provided to the Inquiry to clarify the content of the said conversation. Dr Morrow was unable to give evidence to the Inquiry due to ill-health.

5.15 On 26th January 2011, the Neurosciences Service Manager, Mr Gerry Atkinson prepared a draft response to the complainant as follows:

> 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 this matter has been resolved to your satisfaction.

5.16 A Manager in the Complaints Department, replied on 27th January 2011 to say that: *"I am not sure this will suffice given that she had her licence revoked and is waiting on a further form to be completed. Does Dr Watt need to comment?"* On the same date Mr Atkinson responded, stating: "I am 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 and I think that should be sufficient."

5.17 A response from Mrs Patricia Donnelly, then Director of Acute Services on 31st January 2011 noted that the *"documentation you require has since been processed"* but took the view that the delay *"was a private matter between yourself and Dr Watt"*. This interaction revealed the dilemma of the Belfast Trust. On the one hand, the issue had arisen during the doctor's private practice. On the other hand, the Trust was anxious to assist patients and the tendency may have been for patients to assume that all complaints should go to the NHS.

5.18 It is correct to say that it was not part of a doctor's contractual obligations with the Trust or indeed part of the responsibility of an independent care provider to ensure that reports or letters to insurers or statutory bodies were responded to within a reasonable time. It was a matter which came under the oversight of the GMC as Regulator, and to a lesser extent the Medical Director as Responsible Officer, who was charged with making a recommendation on a doctor's whole practice to the Regulator in respect of revalidation, which commenced in 2012. What was apparent from the large number of complaints that were received by the Trust was that this issue needed to be clarified and addressed. Dr Watt was routinely asked to complete such and struggled to fulfil this professional obligation.

5.19 On 23rd September 2011, Mr Gregory Campbell MP wrote to the Chief Executive of the Trust regarding a constituent, INI 431, who required an occupational health report to be completed by Dr Watt before being able to return to work as a taxi driver. This had been outstanding for 3 months.

5.20 Mr Atkinson drafted a response to the complaint indicating that he had forwarded this to Dr Watt for his attention, but the draft response stated that: *"this is a private matter between Dr Watt and the DVLA. It is not part of Dr Watt's contract of employment with the Trust"*.

5.21 There is no evidence that the matter was subsequently discussed with Dr Watt. It is not clear whether Dr Watt was ever informed that these complaints had been made or that these matters were being investigated, save for the INI 431 correspondence being forwarded *"for Dr Watt's attention"*. There is no further documentary evidence of Dr Watt being asked for his input or being informed of these complaints and no evidence that these matters were subsequently addressed by management, save for whatever Dr Morrow stated to Dr Watt in and around December 2010 (see paragraphs 13 and 14 above).

INI 5:

5.22 On 13th December 2010, INI 5, then a Non-Executive Director on the Health & Social Care Board, met with Mr Colm Donaghy, the then Chief Executive of the Trust, and raised concerns regarding her treatment and care by Dr Watt, both as an outpatient of Dr Watt and a subsequent in-patient stay under the care of another consultant in hospital in October–November 2010. INI 5 indicated that she had subsequently been diagnosed with Lyme disease, which would not have justified the prescribing of steroids by Dr Watt. Mr Donaghy prepared and circulated a typed-up note of the meeting the same day. For the sake of completeness, it should be noted that the INI 5 complaint also raised matters which related to nursing care, the RVH switchboard and specific wards within the hospital. These matters were investigated and addressed in the response to INI 5 but are outside the Terms of Reference for the Inquiry.

5.23 An investigation was subsequently commenced, involving the Medical Director, Dr Stevens. Dr Watt was asked for his comments and responded promptly on 17th December 2010 as follows:

> As you know the clinics are overbooked and often run late.
>
> At the first consultation I discussed the differential diagnosis, which included syringomyelia and a tumour.

> [INI 5] was keen to get the scan quickly and I offered to arrange it for her privately (I have no financial interest in Northern MRI).
>
> The MRI was normal and when I reviewed her things had changed and her the story was more suggestive of inflammation in the cervical spinal cord.
>
> I recommended a five-day course of oral Methylprednisolone. Unfortunately, this caused an episode of psychosis, which is a recognised but luckily infrequent complication, and has now resolved with treatment.
>
> I cannot comment on the other points raised.

5.24 The Service Manager, Mr Atkinson responded on 21st December 2010 on behalf of the Neurology Department. He summarised the views of Dr Watt expressed on 17th December 2010 and noted that: *"Dr Watt's clinics are usually very busy due to demands on the neurology outpatients service"*.

5.25 On 31st January 2011, Mr Colm Donaghy, then Chief Executive, responded to the complainant. The correspondence set out the interaction with medical and nursing staff and the difficulties encountered in painstaking detail. What is conspicuously absent is an answer to the specific issue of diagnosis, which was at the heart of the complaint. The penultimate paragraph of the letter from the Chief Executive stated:

> I am disappointed to learn that on this occasion you felt your care and treatment fell below the standard you would have expected from the Trust and for this I sincerely apologise. I appreciate and thank you for bringing these issues to my attention as it provides the Trust with the opportunity to review our services from a service user perspective and where possible take the necessary action to ensure standards are maintained.

5.26 In a reply of 8th February 2011, INI 5 strongly refuted the suggestion that her complaint had been properly investigated, stating that she was *"shocked and frustrated as the investigation and response did not address the issues I raised with you"* and forwarded an extensive diary and chronology of events. In reiterating her main concerns, she emphasised, in particular: (i) the lack of urgency when there was a possible diagnosis of brain tumour; (ii) long waiting times at Dr Watt's clinic; and (iii) the incorrect diagnosis by Dr Watt. The third paragraph of the letter from INI 5 stated:

> 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 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 if 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.

5.27 Following receipt of the February correspondence, Mr Donaghy offered to meet with INI 5 along with Dr Stevens. Prior to that meeting, Dr Stevens met with Dr Watt and Dr Sara Hedderwick, a consultant in general medicine with a specialist interest in infectious diseases, who had seen INI 5, reviewed her records and communicated with her by email on 25th March 2011. The Inquiry has had sight of Dr Stevens' handwritten notes of the meeting on 25th March 2011, which were also provided in typed-up form to assist the Inquiry. Dr Stevens' notes record as follow:

> [Michael Watt] feels course of steroids reasonable.
>
> 500 mg for 5 days, Methylprednisolone
>
> To settle inflammatory myelitis.
>
> Reasonable to have thought of Lyme disease – but does not have Lyme Disease**
>
> Dr Hedderwick believes she does not have Lyme Disease

5.28 On 28th March 2011, the then Chief Executive and Medical Director, Dr Stevens met with INI 5. At the meeting, INI 5 made it clear she did not wish to see Dr Watt again and criticised his lack of open mindedness. The Medical Director drew up an action plan after the meeting, which included the following steps:

(i) A letter dated 3rd May 2011 was sent to INI 5 by the Trust and stated:

> As we discussed, Dr Watt has tended to book more patients into his clinic than would routinely be expected … Dr Watt has, with his managerial colleagues, already reviewed this matter and will be working to an agreed clinic template.

With regards the diagnosis, the letter notes that:

> we recognise and accept that you feel that Lyme disease should have been considered at the earliest stage … we recognise your concerns about Dr Watt's approach and communication with you and Dr Stevens will undertake to discuss this further with Dr Watt.

(ii) On 17th June 2011, Dr Stevens met with Dr Watt and in subsequent correspondence of 21st June 2011 recorded:

> 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 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 be a cause of alarm.

The Inquiry has seen no further documentation with regards to this meeting.

5.29 The Inquiry Panel noted that the issue of Dr Watt working to an agreed outpatient template had also surfaced and been identified in the 2006/2007 chapter. It is apparent that the problem remained in existence some four years later and the issue had not been properly addressed. It is fully understood that the pressure on neurology lists was intense, and the Inquiry Panel understands that this is part of the context. Nevertheless, the volume of complaints was such that the overbooking of clinics was also having a direct impact on the care given to patients.

5.30 INI 5 did not formally respond to the letter from the Trust dated 3rd May 2011. She did, however, write an article on her experience for the British Medical Journal and in 2016 was invited by the Health & Social Care Board to speak at a training day about her experience in hospital in 2010. According to the oral evidence of Mr Peter Watson, Senior Manager within the Medical Director's Office, on 29th October 2018, the documentation regarding INI 5 contained within the Medical Director's Office file was incomplete. It subsequently transpired that Dr Stevens retained his own records in a drawer in his office, mostly consisting of notes of meetings, with regards to this complaint. These records did not appear in the file held by the Belfast Trust Medical Director's Office or the Complaints Department but were disclosed to the Inquiry by Dr Stevens in advance of his attendance to give oral evidence.

5.31 A great deal of time was spent during the early part of the Inquiry in looking at the INI 5 complaint and hearing evidence from various witnesses. Whether or not INI 5 was suffering from a form of Lyme Disease or whether she should have been prescribed steroids misses the essential point. It is not part of the Inquiry Terms of Reference to make clinical determinations. In any event, to do so in this case would have required additional evidence from various other independent experts. Dr Stevens did state in his evidence of 3rd September 2019 that he believed he would have also checked with Dr Morrow about the appropriate prescription of steroids in this treatment and was reassured in this regard.

5.32 Unfortunately, there is no note of this interaction but the main concern that the Inquiry considered was the method by which the complaint was dealt with and evaluated. Her complaint was reviewed by the Medical Director and involved several meetings with the Trust's Chief Executive.

5.33 Despite the seriousness with which the complaint was taken, the Inquiry Panel has still concluded that the process adopted did not address the fundamental question. This was emphatically pointed out in some of the correspondence from INI 5. Part of the substance of her complaint was the manner in which she was examined, the speed with which she was diagnosed and the alacrity with which she was prescribed steroids by Dr Watt. While actions were taken by Dr Stevens to evaluate whether INI 5 was suffering from Lyme Disease by liaising with Dr Hedderwick or whether the prescription of steroids for acute myelitis was reasonable the issues about the consultation with Dr Watt were not addressed.

5.34 The fact is that coming to a firm view at an early stage on diagnosis and being willing to prescribe drugs with significant side effects, were a feature of other cases involving Dr Watt although this may have been a case where swift action was appropriate.

5.35 The Inquiry Panel accepts that if this complaint had been independently assessed, it might have been determined that Dr Watt's view was reasonable, and his treatment correct. As stated, however, this complaint is of interest for other reasons. It was a well-articulated but complex complaint requiring a thorough and robust investigation, where; (i) there may have been possible evidence of a pattern, which could have been relevant to other complaints, regarding Dr Watt's examination, diagnosis and prescription, and (ii) the records were not properly collated or stored in the appropriate manner.

Prescription of Human Immunoglobulin ("HIG"):

5.36 Relevant evidence concerning HIG usage was received by the Inquiry from a number of witnesses. This issue is also commented on in the Prescribing chapter. It was apparent from 2006 that Dr Watt was prescribing significantly more immunoglobulin than any other consultant following an audit presented to the neurosciences group. Dr Aisling Carr, who in 2006 was a relatively junior registrar, responsible for carrying out the audit. In her oral evidence on 11th November 2019, she told the Inquiry Panel:

> 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.

5.37 Dr Carr sought, however, to put the findings in context:

> 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 has become tighter and tighter and tighter.

5.38 On 7th June 2011, Mr Dean Sullivan, then Director of Commissioning in the Health & Social Care Board, wrote to the Trust Chief Executive, pointing out that an audit report on the prescription of HIG had been carried out by GAIN in 2010 and that the *"early indications are that immunoglobulin is being prescribed for particular conditions where there is a limited evidence-base"*. The letter did not refer to Dr Watt. However, the letter did state that: *"the area where there is the greatest need to review indications for use is in the field of neurology"* and that the Trust was asked to *"put in place arrangements to ensure that all relevant clinical staff, especially in neurology, are aware that the HSCB does not commission use of immunoglobulin for patients with other neurological conditions out with these guidelines, other than in exceptional circumstances."*

5.39 The Prescribing chapter sets out an analysis of how the Trust handled and addressed issues concerning the prescription of HIG and of the governance issues relating to the same. However, as from 7th June 2011, there were concerns regarding the prescripton of HIG in neurology, where Dr Watt was the outlier in relation to such prescription.

5.40 The Inquiry Panel notes that the prevailing view among some neurology consultants was that the approach being taken by Dr Watt was not unusual or alarming. Then Clinical Director Mr Steve Cooke, in his written statement to the Inquiry Panel on

26th November 2021, explained the issue thus:

> … in relation to the use of human immunoglobulin (HIG). I cannot be precise about when this occurred, but think it was before 2010. I remember it being queried, I think by the immunologists or the Blood Transfusion Service, about the amount of HIG being used in Neurology, and whether there were recognised reasons for the use to which it was being put. It is a specialist neurology area, so I sought the assistance of Dr [Jim] Morrow, then the Clinical Lead. Dr Morrow reassured me that the practice was acceptable and there were articles in the literature supporting the approach being taken.

5.41 It is important to highlight the fact that whether Dr Watt was justified in prescribing HIG in the manner that he did, was not a question for the Inquiry to determine. The evidence suggests that for many years Dr Watt was an outlier in respect of the prescription of HIG. This fact of itself, when combined with a relevant complaint, should have caused the Trust to examine more carefully whether there was an issue and then come to a determination. What, in fact, transpired was that each piece of information, whether it be Dr Carr's audit, a relevant complaint where HIG was a feature or the letter from Mr Sullivan, were all dealt with in isolation. There was, as it were, no joining of the dots. The assumption was made that there were always recognised reasons for the use of HIG, which in effect precluded broader evaluation.

INI 346:

5.42 On 16th November 2011 the GMC wrote to Dr Stevens, the then Medical Director of the Trust, enclosing a letter to Dr Watt and pointing out that a request by the GMC to provide a medical report on INI 346 had not been answered, despite three earlier written reminders and four telephone messages. Dr Stevens wrote to Dr Watt on 23rd November asking him to *"respond to the GMC please"*. On 13th December, Mr Steve Cooke, the Clinical Director emailed Dr Stevens to inform him that: "*Michael Watt signed off the GMC report on Friday, so hopefully that's finished with now*". At no point was the fact that Dr Watt was still within the timescale of a 5-year GMC warning for not providing medico-legal reports identified or acted upon by Trust management or the GMC.

5.43 The failure to make a link between the extant 5-year warning and the request by GMC themselves for a medical report that had been outstanding was commented on by Una Lane of the GMC during oral evidence on 13th March 2019:

> We were looking at this one doctor: INI 346. Dr Watt happened to be the treating physician. He wasn't providing us with a report in a timely fashion. My instinct is that we didn't think about his — Dr Watt's fitness to practise.

The GMC chapter provides further commentary on this matter and the GMC's engagement with the Trust with regards to Dr Watt.

5.44 The significance of this issue is highlighted by the following observation from Ms Clare Lundy, the Assistant Service Manager, in her evidence of 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 …

INI 45 Received from the GMC:

5.45 Just two months after the GMC contacted the Trust about the INI 346 issues with Dr Watt, on 19th January 2012, the GMC again contacted Dr Stevens, this time regarding the INI 45 complaint against Dr Watt. The GMC sought:

> Any further information about this particular complaint or any other concerns about Dr Watt's practice. In particular please provide:
>
> - details of any other concerns or previous complaints (if any) about Dr Watt;
> - any audit findings (or other quality assurance measures) which might indicate problems with Dr Watt's practice;
> - any data (e.g. in relation to prescribing patterns) which might indicate poor practice, any other information which you think may be relevant to our enquiries;
> - confirmation of the capacity in which Dr Watt is employed by you.
>
> If you are already carrying out your own enquiries, could you please provide details?

5.46 INI 45 raised his complaint with the GMC on 15th December 2011. His complaint related to a private consultation at Hillsborough Private Clinic with Dr Watt on 17th October 2011 and was summarised by INI 45 as follows: *"Dr Watt performed no examination of any kind and briskly diagnosed "exercise-induced migraine. He recommended that my condition be managed with "cold showers after exercise"*. He arranged no follow up. He arranged no further investigations or test. He claimed that he could not opine on my MRI scans as he had no computer." Two letters of complaint from INI 45 dated 18th October 2011 and 14th December 2011 were sent to the Belfast Trust by the GMC, which further outlined the complainant's concerns.

5.47 The email from the GMC and attachment containing the INI 45 complaint materials was forwarded to the then Clinical Director, Mr Steve Cooke, under cover of an email from the Belfast Trust Medical Director's Office dated 20th January 2012 asking about *"any concerns etc. which we will need to advise the GMC about"*. A handwritten annotation, believed to be from Dr Stevens, on the email notes: *"(1) check complaints; (2) IRIs; (3) Previous GMC referral (4) [INI 5]"*.

5.48 On the same day, the Belfast Trust's Medical Director's Office also wrote to the Complaints Department, asking for any complaints on record in relation to Dr Watt. On 24th January 2012, the Complaints Department provided a document entitled *'Employee Report: Dr Watt complaints from RVH Legacy'*. This contained limited information, consisting of no more than a couple of sentences, regarding four complaints from 2004–2008, namely INI 409, INI 405, INI 430 and a complaint from 2008, for which records have been destroyed by the Trust in accordance with the destruction policies of Belfast Trust in force at that time.

5.49 Ms Gillian Moore, the System Manager of the Datix[2] system within the Belfast Trust explained, in her evidence of 4th June 2019, some of the limitations in searching against specific named individuals:

> The search, I would imagine – I don't work operationally on the day-to-day management of complaints – but the search again, would have been done on Dr Watt's name in the contacts module, and if he wasn't explicitly typed in as being a contact against the complaint, complaints won't have come up in the search.
>
> If they'd been maybe reviewed at the time and there was a procedure in place whereby any names that came up in documentation against – whether an investigation into a complaint or the written response or whatever, then, at that point, that person, the doctor, or whatever, should have been named as a contact and their information input into the contacts module. Thereby you would have got the closure of that loop.

5.50 There is no criticism of the actions of Ms Moore or staff within the Complaints Department. They simply worked within the limitations of the system in place at that time.

5.51 The printout also had a handwritten note of Dr Stevens stating: *"what do you have on record for [INI 5] Complaint?"* A further note, presumed to be in the handwriting of Dr Stevens' secretary, stated as follows: *"spoke to … complaints, on 27/2 who advised there are 5 complaints in total. In addition to the 4 outlined above, also [INI 5] complaint*

2 Datix is an on-line risk management and incident reporting software system used by the Trust for reporting incidents, claims, complaints, risk registers, safety alerts, requests for information and inquests. The Inquiry was informed that Datix was a system utilised by NHS Trusts across the UK and that the method of inputting information into Datix has changed in the Belfast Trust. The Trust has stated that this has led to a significant improvement in the accuracy of the system.

attached". The INI 5 complaint response was forwarded to the Medical Director's Office on 27th January 2012 with a note that: *"unfortunately employee screen was not complete and therefore overlooked"*. The Inquiry understands this to be a reference to the INI 5 complaint not being clearly linked to Dr Watt.

5.52 On 25th January 2012, the Medical Director's Office queried whether there were any IR1s (Incident Report Forms) regarding Dr Watt. The Belfast Trust Risk & Governance Department replied that there were no incidents logged against Dr Michael Watt, but: *"there are complaints logged for 2 contacts which appear to be the same person – Dr Michael Watts, Neurology (4 complaints logged) and Michael Watt, Consultant Neurology (2 complaints logged)"*. Ms Claire Cairns, then Senior Manager Risk & Governance, inquired if the Medical Director required copies of these on the same date. The Inquiry has seen no response to this email.

5.53 On 23rd January 2012, Mr Cooke, the then Clinical Director, responded to Dr Stevens' request for information regarding any concerns about Dr Watt. Mr Cooke responded to say: *"nothing formal, although I am aware of the recent delay in him responding to a GMC request for information, and a previous event a number of years ago when the GMC got involved in relation to another delayed report, I think from solicitors. He was due to complete his appraisal last week, so I'll check this has happened"*. The Inquiry understands that Mr Cooke was referring to Dr Watt's 5-year warning from the GMC in 2007 and the INI 346 complaint. Following Mr Cooke's response, Dr Stevens indicated he would hold off responding to the GMC until he had an update regarding the appraisal position.

5.54 An update was received from Ms Janine McArdle, Medical Workforce Manager, on 2nd February 2012. She informed the Medical Director's Office that Dr Stanley Hawkins met with Dr Watt on 19th January 2012 to complete the appraisal. However, Dr Watt's paperwork *"did not satisfy"* Dr Hawkins, who showed Dr Watt how to complete the appraisal form and told Dr Watt to re-submit. This had not been done as of 2nd February. Ms McArdle indicated that Mr Cooke was to speak directly with Dr Hawkins in relation to any concerns highlighted or discussed at the appraisal meeting and relay any information to the Medical Director's Office.

5.55 On 20th February 2012 Mr Cooke replied in an email to the PA of the Medical Director's Office:

> I spoke to Stanley [Hawkins] last week
>
> The appraisal meeting has taken place, but Stanley is awaiting the completed documentation. His concern was about the presentation of [Continued Professional Development] documentation.

> He has assured me that there are no clinical issues, nor probity issues
>
> I am not aware of any recent clinical issues either.

5.56 The formal reply of the Belfast Trust to the GMC was dated 27th February 2012. This correspondence outlined that the INI 45 complaint concerned a private patient and that the Trust would not routinely investigate such matters. The response went on to state as follows:

> With regard to any other concerns, I can advise that I am aware of a previous warning that Dr Watt received from the GMC, which was based on Dr Watt's record on 22 February 2007. This related to delays in preparing a report.
>
> With regards to previous complaints, I can advise you of five complaints. This included one complaint respectively from 2004, 2003, 2007, 2008 and 2010. The underlying theme appears to be concern about Dr Watt's attitude and relationship/communication with patients. You are also aware of correspondence between the Trust and GMC regarding Dr Watt in reference to [INI 346], your ref ND/2002/0950/01/CR.
>
> From a clinical perspective the Trust does not have any concerns at this time. There are no audit or other quality assurance measures that would raise concern or evidence of poor practice. I can confirm that Dr Watt is employed as a full-time consultant neurologist by the Belfast Trust.
>
> Given that this is the third time that the GMC have been in contact with the Trust about Dr Watt we now intend to review the situation with respect to his performance and will be in touch.

5.57 The letter omitted a range of other complaints which were not included in the Datix system and including in particular the recent complaints by INI 417, INI 419, INI 418, INI 431, earlier complaints including INI 403, INI 404, INI 406, INI 407, INI 408, INI 411, INI 222, INI 87, a number of complaints relating to waiting times at Dr Watt's clinics in 2007 and reference to any of the 14 complaints subsequently destroyed by the Trust in line with their disposal policies and which the Inquiry has not therefore had the opportunity to review.

5.58 Immediately thereafter, Dr Stevens emailed Mr Cooke, the then Clinical Director, Mr Ray Hannon, the Associate Medical Director for Acute Services, Mr Peter Watson, Senior Manager in the Medical Director's Office, and Mr Mervyn Barkley, Human Resources Co-Director, stating:

> Please see below my response to the GMC re Dr M Watt. I am getting increasingly concerned about Michael Watt. While I am generally satisfied that there are no

> substantial clinical issues or probity issues. I think the level of complaints and correspondence from the GMC now requires a further review by ourselves. I think he should be included in the doctors and dentist review meeting. I would also be grateful if we could confirm that he has now satisfactorily completed his appraisal and provided detail on his CPD activities. I note from the file there was previous concern about his registration with the Royal College of Physicians for CPD. I would be grateful if Steve [Cooke] and Ray [Hannon] could meet with him in the first instance to alert him to the situation and ask him to again [sic] on the issues that are causing complaint and concern.

5.59 Mr Hannon responded later that day and indicated that he *"wasn't aware that Michael was a problem"* and requested a relevant summary. The Medical Director's Office then forwarded Mr Hannon the print-off from Datix along with brief information regarding the GMC warning in February 2007 and the failure to provide a medical report from the GMC in 2011.

5.60 Dr Watt's 2011 appraisal carried out by Dr Hawkins was finally signed off on 23rd March 2012. The level of detail in the appraisal form completed by Dr Watt and supporting documentation was sparse and there was no reference to any complaints or probity issues. The lack of evidenced reflection in the appraisal forms is not a criticism of Dr Hawkins as appraiser. It rather illustrates the weakness of appraisal being carried out by a doctor who has not embraced the process. Further detailed commentary on Dr Watt's appraisals is contained in the chapter on Appraisal and Revalidation.

5.61 Dr Stevens, in his reflections to the Inquiry Panel on 3rd September 2019, was quite clear in his view of the INI 45 case:

> That was a significant case, not least because, again, it suggested an individual who was taking shortcuts with diagnosis, not being holistic in his approach, not examining people and then actually, I think, being a little disingenuous in his responses.

5.62 The Inquiry Panel regards the INI 45 complaint as one of the most important that the Inquiry considered. Both the Belfast Trust and the GMC must bear a degree of responsibility for what transpired. When asked by the GMC about other relevant complaints, the Trust forwarded a letter, which was unintentionally misleading and which failed to properly collate the relevant evidence, which would undoubtedly have been highly relevant to any GMC investigation.

Doctors and Dentist Case Review Meetings ("DDCRM") and First Finding of the Facts Exercise:

5.63 On 24th March 2012, Mr Hannon emailed Mr Cooke asking: *"have you spoken to Michael re recent complaint to GMC or are we still to do this together"."*Mr Cooke responded indicating that he had spoken with Dr Watt and *"will update you if you can give me a call"*.

5.64 On 30th March 2012, the DDCRM[3] discussed Dr Watt for the first time. The totality of notes in existence with reference to Dr Watt at the meeting record as follows:

> Current Position
> Mr [Peter] Watson noted that the GMC were continuing their investigations regarding a concern that had been raised in MW's private practice. It was noted that this was the latest in a number of issues regarding MW.
>
> Actions
> Mr [Ray] Hannon to initiate informal stage of MHPS. Maintain under review at DDCRM.

5.65 Dr Watt's involvement with the Belfast Trust DDCRM is set out in more detail in the chapter on Doctors and Dentists Care Review Meetings. The reference to "MHPS" refers to the Department of Health, Social Services & Public Safety framework entitled "Maintaining High Professional Standards in the Modern HPSS" dated November 2005.

5.66 On 13th April 2012, the GMC wrote to Dr Stevens and indicated that having conducted their investigations into the INI 45 complaint, and made other enquiries, it was decided to conclude the matter without further action. Dr Watt's consultation with INI 45 was found to be *"less than desirable"*. It was also noted that no physical examination, consideration of other possibilities for the patient's symptoms or management options had been discussed with the patient. The GMC Case Examiners considered, however, that a warning would be disproportionate given their conclusion that Dr Watt's reflections in his response to the complaint were constructive and that he had attended a UK Stroke Forum session. Dr Watt was *"strongly reminded"* by the GMC to review various paragraphs of the GMC Guide on 'Good Medical Practice' on the importance of good clinical care.

5.67 This investigation was the subject of a subsequent review by the GMC (known as a "Rule 12 review") in 2019, which concluded that the earlier decision in 2012 was potentially flawed, but that it was not in the public interest to reopen the

3 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).

investigation because of the much larger investigation being mounted by the GMC that was going on into Dr Watt's practice. The Inquiry Panel has further considered the GMC's handling of INI 45 and the Rule 12 investigation in the chapter on the General Medical Council. The Inquiry Panel accepts that those in the Trust who were tasked with managing Dr Watt were not aware of the potentially flawed nature of the GMC investigation in 2012. These issues highlighted a broader concern.

5.68 The failures of the GMC investigation are set out much more clearly in the GMC chapter. The internal review carried out in 2019 by the GMC revealed how the decision taken was "potentially flawed". In the view of the Inquiry Panel, if accurate information had been communicated to the GMC by the Belfast Trust and if the GMC had carried out a more thorough investigation, then it is possible that the INI45 complaint would have had a significant impact on the Finding of the Facts investigation being carried out by the Belfast Trust. In the event, however, it caused the opposite reaction and ended up providing false reassurance to both organisations.

5.69 The Inquiry wanted to understand the approach taken by the DDCRM and Dr Stevens to the Finding of the Facts exercise carried out within the context of the MHPS procedure. Dr Stevens told the Inquiry Panel on 3rd September 2019:

> … the informal stage of Maintaining High Profession Standards is finding the facts or "establishing the facts", to use the exact language … Ray Hannon would've been tasked then with that knowledge and with the knowledge that should've been available to him – was available to him – to go and, if you like, start triangulating the data, talk to people. I would've expected him to go and talk to clinicians – at least the Clinical Director, Clinical Lead. I would have expected him and Bernie Owens to think about their own experience and the information they had coming up through complaints; to look at litigation … to look at any serious adverse incidents that might relate to him … and also potentially to go and look at things like the national training survey, where the trainees have the opportunity to comment on their experiences … 'I would've expected Ray to go away and basically look and trawl and see was there an issue. Now what happened is he talked to Steve Cooke'.

5.70 Mr Hannon had a different understanding of what he had been asked to do when he told the Inquiry Panel on 3rd February 2020:

> I take it to mean you clarify the concerns and investigate the factual basis on which the concerns are based, more or less…I thought my role was to go and talk to Steve to see if there are any more recent concerns or anything worrying Steve, and if nothing else came of it I was to go to Michael Watt and say, 'Michael,

> get your act together and get this all written down in your appraisal', more or less…it wasn't an investigation. If you look at the flowchart it says finding the facts, but you can't find the facts until you establish the concerns. I was trying to establish where are the concerns, are there recent concerns?
>
> I didn't think I was asked to go out and trawl around and look for more.

5.71 On 13th April 2012, Mr Ray Hannon, having been tasked by the DDCRM to initiate a Finding of the Facts exercise under MHPS, emailed Mr Steve Cooke as follows:

> Need to talk to you about Michael
>
> Tony (Stevens] wants a fact finding under MHPS so that if the GMC get serious we can say we have looked. He is also worried that Michael's name has come up a couple of times in past year or two so he wants him to waken up.

5.72 The inference from Mr Hannon's email is that, in his view, management of a doctor's clinical practice was primarily a matter for the GMC as regulator and the Trust's role was to facilitate that responsibility. This view ignored the role of the Trust as employer and its own separate and prime responsibility for patient safety. For the avoidance of doubt, the Inquiry Panel accepts that the Trust should have been able to rely on the outcome of GMC investigations into a particular doctor as a material factor in their own assessment of an issue. Further relevant commentary on the role of the GMC is set out in the GMC chapter.

5.73 Mr Cooke replied on 16th April 2012:

> OK
>
> This is a big step and fraught with difficulties as my previous experiences with MHPS will testify.
>
> Can we discuss please

5.74 With regards to his statement that this was "a big step and fraught with difficulties", Mr Cooke provided the following explanation to the Inquiry Panel on 4th March 2019:

> This is a general comment based on my own experience – dealing with a colleague who does have performance issues – and, often, there's not good insight into that or acceptance – colleagues become extremely defensive. They kick back. Things become bogged down in lawyers, and there is a lot of procedural argument about the process. Sometimes, I felt that doing the right thing was lost in the process, because it becomes so adversarial … that email of mine was "Look, if we're going to be getting formal with Michael, we need to have" – my intent was a bit of a word of caution – "we need to have our ducks in a row." We have to have, if you like, a prosecution case that's ready to go.

5.75 Mr Hannon explained his approach to the issues raised following a discussion with Mr Cooke:

> When I met with Steve, and there's an email there which I know you picked up on I said, 'the GMC might get serious'. That one. I will explain about that email later on. But I met with Steve, and I said, 'right, now the concerns are these four concerns. There is the GMC thing, there's [INI 5] and the [INI 346] report. And Steve, my memory of it was, said, these aren't terribly serious, the complaints are very old, they're closed. The [INI 5] thing was complicated because it was Lyme Disease, which is a nightmare to deal with. The [INI 432] thing, Michael has filled in the report, he has sent it back to the GMC. He said, 'what's the fuss? I don't really want to go and meet him and create a whole stink'. More or less. Now I can't remember it's eight years ago, and that's more or less where we were at that point. Then at some point the GMC say 'right, we're not going to do anything more'. All of a sudden it appeared, from my point of view, to diffuse in as much as the impetus to get anything done, these were all old things and the GMC thing was the new thing and then they said they're not going to do anything more. So the heat, as it were, went out of it a bit.

5.76 Mr Hannon could not recall meeting Dr Watt at this time. In written evidence dated 15th March 2019 Mr Cooke referred to an earlier discussion he had had with Dr Watt in either March or April 2012:

> I recall discussing the [INI 346] issue with Dr Watt … on 12th or 13th December 2011 … This was a brief discussion as Dr Watt confirmed that he had already completed the report on [INI 346] the previous Friday.
>
> I then had a further discussion with him in relation to the complaint from case [INI 45] to the GMC subsequent to the email trails involving Dr Stevens, the GMC, Sharon Conway, Ray Hannon and Janine McArdle. This conversation would have taken place at the end of March/beginning of April 2012. I recall discussing the clinical aspects of the case with him in order to 'sense check' as a non-neurologist and discuss his response to the patient's complaint. I would also have reinforced the requirement for appraisals to be undertaken and also I recall discussing the fact that Dr Stevens was becoming concerned that there had been a number of issues identified to him and that he was considering a formal process. Dr Watt told me that he was concerned that this would be an unwarranted escalation, and by that, I understood that he would therefore be wishing to robustly defend himself should such a process commence. I recall then discussing this with Ray Hannon towards the end of March.

5.77 Mr Hannon conceded in his evidence that he did not do a detailed analysis because he was not given the details of the complaints indicating that: *"I was never given the details of the complaints. So, to these – these were – write down about these six cases until*

we sort them out type of thing. Tony was vexed but I had no idea what was winding Tony up".

5.78 The Inquiry Panel asked Mr Hannon as to whether Mr Cooke's previous experience of the Industrial Tribunal coloured his view. Mr Hannon, in his evidence of 3rd February 2020 responded to the Inquiry Chairman as follows:

> **Mr Lockhart QC:** Again, obviously one of the concerns we would have is that Steve's experience at a tribunal, or whatever, and his reticence to confront his earlier comments that really he can only persuade is actually causing blockage in the system?
>
> **Mr Hannon:** That's possible. Equally I think if I had had a bit more information or a steer I would have pushed harder on my side. I mean I don't think anybody, any one person could have known about all of those complaints, but there are some of these complaints which I would have thought would have been burning in your brain and could have been brought to the table.

5.79 The Inquiry Panel asked Mr Hannon about his approach to the investigation. He stated in his evidence of 3rd February 2020:

> **Mr Lockhart QC:** Why do you think Steve Cooke said it is a step fraught with difficulties? It looks to me that Steve is going, 'MHPS, that's a nightmare. I really don't want to have to go down that route because it's formal, it's finding the facts, it's investigation, and as my previous experience of MHPS will testify'?
>
> **Mr Hannon:** I knew there had been two particular neurosurgical things, one that had gone on for years and the surgeon was out of the country and another staff grade was going through a process, so I knew he'd had a bit of a torrid time. But when he said that to me he also said, 'Michael is a good guy, there's nothing going on here'. I suppose he didn't feel it was worth the candle.[4]

5.80 Mr Hannon believed that one of the fundamental problems was institutional memory. He told the Inquiry Chairman:

> **Mr Lockhart QC:** How is it, when you look at it from a system's point of view, that the key information doesn't get to the key decision makers? How can we, if you're looking at it now saying what can we do to ensure in the future this is fully understood by everyone what MHPS means, what finding the facts means, what a Clinical Director's role is, what an AMD's role is? That's what we are focused on.

4 In fairness to Mr Cooke, who was Clinical Director at this time, he had already shown that he was willing to escalate concerns about a doctor following a Grand Round meeting, even when that escalation was criticised by his colleagues. This is set out in some detail in the Medical Culture chapter. The Inquiry Panel does accept that Mr Cooke was not attempting to protect or cover up for Dr Watt, even while expressing caution about the MHPS process. Mr Cooke has pointed out that he rejects the suggestion by Mr Hannon that he viewed the fact-finding investigation as not "worth the candle".

> **Mr Hannon:** You have to have some sort of organisational memory which is not reliant on individuals because I mean I was sitting in a room one year managing the service never having met Michael Watt. Apart from Michael, here's a patient blah blah, and yet Tony has been ten years[5] there or whatever, Bernie Owens has run that service for years, and Peter, although Peter is a medical manager at that point, he'd run neurosciences at some point, so those people in the room didn't say, 'actually although we can't show it to you today, there's something at the back of our brain nagging here'.
>
> **Mr Lockhart QC:** Is that not what Tony Stevens' was saying in his email, 'I am unhappy, his name is coming up too much, I want something done about this'?
>
> **Mr Hannon:** But his name coming up too much, where do I go and look? There was no guidance. There was nothing to sort of, I have met this guy with Damien McAllister four years ago, that's not in the file. There was [INI 222] was a big problem. That's not in this file. And we all go, 'where the hell is it? Let's go and have a look'.

5.81 The informal nature of the Finding of the Facts exercise seems to have encouraged an approach which eschewed the taking of notes and recording of conversations. The lack of notes from meetings and conversations was a fundamental problem and also made any retrospective analysis of the decision-making framework much more difficult. The fact that an investigation was informal should not have precluded the taking of notes or made it more difficult to analyse how the decision-maker had approached the matter.

5.82 On 24th April 2012, Dr Stevens emailed Mr Cooke and Mr Hannon, and copied in Mr Peter Watson, after confirmation that the GMC were taking no further action:

> Ray/Steve
> I think it is important that there is a recorded conversation with Michael. While I accept he is an experienced and respected clinician his name is being flagged up too often.
>
> Peter – we must ensure follow through a DDCRM

5.83 The next meeting of the DDCRM on 14th May 2012 recorded:

> CURRENT POSITION
> It was noted that Mr Cooke had spoken with Dr [Watt] and considered that this was sufficient action at this time
>
> It was considered however that Mrs Owens and Mr Hannon should review the recent history of issues, meet with Dr [Watt] to discuss the various concerns and then for a formal letter to be provided to Dr [Watt] highlighting these concerns.

5 Dr Stevens had, in fact, been in place for 5 years, not 10 years.

ACTION

Mrs Owens to arrange meeting.

5.84 The meeting, as envisaged with Mrs Bernie Owens and Mr Ray Hannon, did not take place. Commenting on the need for a recorded meeting, Mr Hannon informed the Inquiry Panel on 3rd February 2020:

> **Mr Hannon:** The recorded conversation I thought it was just a conversation but anyway. It's down here that Bernie Owens was to get a summary and arrange a meeting. This isn't written down anywhere, but a few days later I said to Bernie -- and this is my recollection and I haven't spoken to her about it at all. I said, 'right, Bernie, we've to get a summary'. My recollection is she said, 'but Tony has already got a summary, what's the point of me doing that again?' So there was no further summary generated. I said, 'what about meeting with him?' I think she said to me, 'I'm not sure that's appropriate'. That's my recollection. So that meeting never happened and she didn't produce a sort of independent management summary of concerns.
>
> **Mr Lockhart QC:** Are you aware if Bernie went back to Tony Stevens and said, 'we have actually looked. We don't actually think we need to meet with him'?
>
> **Mr Hannon:** I don't think so because at the next meeting in June Bernie wasn't there …

5.85 Mrs Owens did not accept that the conversation occurred, or if it did occur, it did not take place in the manner described by Mr Hannon. Mrs Owens further emphasised that she played "a peripheral role" in the investigation. While it was the case that Mr Hannon was the person designated by the Medical Director to carry out the informal stage of the MHPS investigation, Mrs Owens was specifically asked by Dr Stevens to have alongside Mr Hannon, a recorded conversation with Dr Watt.

5.86 Mrs Owens, the then Co-Director, was asked in her evidence of 3rd February 2020 as to why the recorded conversation directed by Dr Stevens had not taken place. She told the Inquiry Panel:

> **Mrs Owens:** Obviously I can't say why this didn't happen in terms of this fundamentally. Just looking at the thing here in terms of again the doctors speaking, you know, Mr Hannon and Mr Cooke, and then they are dealing with the issue. Obviously, I recognise when I read this that had that meeting taken place on a formal footing it would have put it on to a more formal footing as opposed to this isn't just an ad hoc casual conversation. So that is probably an opportunity that was missed in terms of, and I can't be certain why the meeting didn't take place.

> **Mr Lockhart QC:** The next page. In June it was noted that the meeting was to have taken place and a formal letter. Mr Hannon was then to follow up on the letter.
>
> **Mrs Owens:** Mm-hmm.
>
> **Mr Lockhart QC:** Page 36: "I think the problem is Steve has had this meeting but meantime our minutes" – this is from Ray Hannon and he copies you in -- "at the meeting suggests a formal meeting with the Co-Director. "Steve's concerns are that if we have another meeting we are (from Michael Watt's perspective) 'escalating' things. Maybe just a note from me acknowledging meeting has taken place, advising him about his behaviour and asking that he discuss complaints with appraiser". Then Peter [Watson] says that's fine, that's how we are going to deal with it. What we're concerned about is Michael Watt says you wouldn't want to be escalating things, and everybody goes 'oh, yes, you're quite right, we wouldn't want to be doing that'. It is not really a courageous conversation, it is like 'Michael Watt doesn't want to have it escalated. Right then, maybe we'll not escalate it then'. I just wanted to give you an opportunity to comment on that when you saw it?
>
> **Mrs Owens:** It's just what I said before there's missed opportunities here about the courageous conversations and actually putting it on a formal footing, and that is what was absent in relation to that, and again back to we tolerated that. I, with others, tolerated it and it should have been more formal.

5.87 On 25th June 2012, there was a further DDCRM meeting, at which Mrs Owens was not present, which recorded that *"it was noted that a meeting was to have taken place with Dr W with a formal letter thereafter … Mr Hannon to follow up on this letter"*. On 30th June 2012, Mr Cooke emailed the Medical Director's Office and Mr Hannon as follows: *"have spoken to Michael & updated Ray"*.

5.88 On 2nd July 2012, Mr Watson from the Medical Directors Office, who was tasked to track and encourage progress on the actions directed at the DDCRM, emailed both Mr Cooke and Mr Hannon as follows:

> Steve/Ray
> My recall I (I can check the file if required) is that we had agreed that there would actually be correspondence to Michael from yourselves, noting the discussion
>
> Can you please copy the letter to me for our files?

5.89 Later that day Mr Hannon replied as follows:

> I think the problem is that Steve [Cooke] has had this meeting but meantime our minutes suggest a formal meeting with Co-Director+/CD or AMD.

> Steve's concerns are that if we have another meeting we are (from MW perspective) "escalating" things...
>
> Maybe a note from me acknowledging meeting has taken place, advising him about his behaviour and asking that he discuss complaints etc. with appraiser?

5.90 Mr Watson later confirmed by email that Mr Hannon's approach was *"the best idea"*.

5.91 The impression given in the email from Mr Hannon is that it is better to avoid escalation as this causes problems. The difficulty with such an approach is that it is inimical to the purpose of management and communicates to those, who are being managed that compliance is optional.

5.92 On 19th July 2012, Mr Hannon wrote to Dr Watt as follows:

> The Medical Director's office have become aware of a small number of complaints about you or the services offered by yourself over the last few years. I am aware that Mr Cooke has already discussed some of these issues with you earlier this year.
>
> A number of these have noted "a bad attitude"
>
> - 04.G.53
> - 03.G.255
> - 367.G.07
> - 050.G.08
>
> These reference numbers refer to the indexing of the Datix system.
>
> I have also been given the names of 3 other complainants: -
>
> - [INI 5]
> - [INI 346]
> - [The 2005 GMC complaint which led to the warning issued in 2007]
>
> I don't have any other details, but Complaints Department may be able to help or you may have already discussed these with Steve Cooke.
>
> I would be grateful if you would gather these complaints and reflect on them. When your next appraisal becomes due I would like you to discuss them as a group with your appraiser. This would be an important element of reflection and considering this as a whole may reveal something that requires attention.
>
> I will copy this to Mr Cooke so that your appraiser can be made aware of this.[6]

6 This section should be read in conjunction with paragraphs 111-112.

5.93 On 3rd August 2012, the correspondence was noted by DDCRM and the case was to be reviewed at the DDCRM meeting in December. No further details or discussions are recorded in the notes of the meeting and no meeting of the DDCRM took place in December (see paragraph 112 onwards for subsequent DDCRM involvement with Dr Watt).

5.94 In his oral evidence of 3rd September 2019, Dr Stevens reflected on Mr Hannon's letter:

> I accept that the letter is light and doesn't really address the issues. My only explanation for that, really, is that I had kind of accepted that we hadn't crossed a threshold, and, having not crossed a threshold, I probably let that go.

5.95 Mr Hannon, in his oral evidence on 3rd February 2020, conceded that it was not a great letter and explained to the Inquiry Panel:

> There was insufficient concern to produce immediate action, or the threshold of concern was not so high as to make other action appropriate, so therefore, "Michael, please would you have a think about this"?

5.96 The Inquiry Panel also explored with Mrs Bernie Owens, who in 2012 was a Co-Director in the Neurosciences Division, what appeared to be a reluctance to initiate management action:

> **Professor Mascie-Taylor:** You simply have to manage it like you'd manage anything else. I'm not certain about this, but I think interwoven with this Dr Watt story is a perception amongst a number of Clinical Directors and other medical managers and general managers that somehow it was very, very difficult to deal with these issues as opposed to relatively straightforward really. You simply sit down and say 'this is what you are required to do and I will write to you and tell you that, and then you must do it'. Am I being fair?
>
> **Mrs Owens:** Yes, I absolutely agree. When I look at this in terms of, and hindsight is a wonderful thing.
>
> **Professor Mascie-Taylor:** It is indeed. We are all privileged to have that on this.
>
> **Mrs Owens:** We all knew there were certain things happening here in terms of his admin, his delayed reports and all the rest of it, and we have tolerated it and have not chosen to deal with it properly, and I can see that.

5.97 When giving evidence to the Inquiry Panel about events during a later period (2016), Mrs Owens highlighted the perception that Dr Watt was not just a good doctor, but a busy doctor and that some leeway should be allowed for his administrative difficulties. In a sense this encapsulates the overall reticence to manage Dr Watt and

the desire to circumvent what were perceived as his difficulties:

> **Mrs Owens:** Yes. I personally think that here we have, because I remember having a conversation with John Craig at a point in time about the admin and his delays in getting the admin, and obviously the issue for him was he was very busy. He had a very busy clinic and whatever, so that, you know, admin was obviously the last thing he got to and whatever. So what I am saying is in terms of because of the view held by a lot of people he was a good doctor. He was a busy doctor...
>
> **Professor Mascie-Taylor:** Sure.
>
> **Mrs Owens:** ... that we had to give some tolerance or some level of bye-ball to the situation.

5.98 The Inquiry Panel was impressed at the straightforward and candid manner in which Mrs Owens, Mr Cooke and Mr Hannon approached the evaluation of relevant events in 2012-2013 in their oral evidence.

5.99 Dr Stevens reviewed in detail the previous complaints before attending the Inquiry. On his second appearance on 3rd September 2019, he stated in relation to the period just prior to 2012-2013:

> [Dr Watt] went out of my orbit at that stage. He came back in in 2010-11, and, obviously, at that time, I believe, there were three obvious cases — three obvious issues: the [INI 5] case …; 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…it was clear that other people saw him as an outlier in the use of immunoglobulin … but that was not something that, while I knew about the issue of the overuse of immunoglobulin, it was not known corporately that he might be an outlier.

5.100 Reflecting on the first Finding of the Facts exercise carried out by Mr Hannon in conjunction with the then Clinical Director, Mr Steve Cooke, Dr Stevens stated to the Inquiry Panel:

> The first, carried out by Ray Hannon I think is really interesting, and I think, of all the testimonies I've read, Steve Cooke's is one of the most powerful and interesting. Steve was pretty honest, and pretty honest that he really didn't want — thought the consequences of going in here were going to be very significant without much evidence. I think he was genuinely reflecting the trauma that he and some of his colleagues had experienced on at least two occasions in

> supporting me in a Maintaining High Professional Standards exercise, one of which resulted in he and several of his colleagues in two industrial tribunals accused of [*allegation redacted by the Inquiry as not relevant*] which seriously, seriously traumatised them and I didn't find much fun either, because that was potentially a career-ending decision at the hands of an industrial tribunal. The complainant lost both those cases. And so, I think — I think the Ray Hannon/ Steve Cooke Maintaining High Professional Standards was influenced by previous experience …
>
> Interestingly, the individuals involved were referred to the GMC, and I think some of Steve Cooke's experience is reflected in the fact that the GMC didn't issue warnings or take any action and the Trust was left dealing with very difficult situations.

5.101 Referring to the degree of push back from Mr Hannon and Mr Cooke, Dr Stevens stated:

> Looking back now, well, really, but I suppose the wind had been taken out of us a little bit by the GMC, and the other things that we might have thought about at that stage, which, you know, might've been Dr Paul Conn[7], for example, wasn't available for us. So, I still feel that we didn't push that as hard as we should or I probably didn't push it as hard as I should, and it's very interesting that I was getting this level of pushback.

5.102 Commenting on the Trust's response to the GMC outcome regarding the INI 45 complaint, Dr Stevens in his evidence to the Inquiry Panel on 3rd September 2019 stated:

> But, you know, could we have put more weight on that case ourselves? We were probably influenced by the outcome of the GMC.

5.103 Dr Stevens candidly reflected, as he had done throughout his testimony of 3rd September 2019, on the first Finding of the Facts investigation:

> My fault in this, to the extent that I am at fault, is that I didn't maybe stick to my instincts and I allowed myself to be talked down. For that, I'll have to accept responsibility. I may say in mitigation that, when your [Associate Medical Director] and your experienced Clinical Director are both telling you, "You're pushing this too hard, Tony. There's nothing here", it's a little difficult, but that's an excuse, that's not a reason.

5.104 In reflecting back on events in 2012, Dr Stevens considered to what extent matters could have been escalated:

7 The Inquiry understood this to be a reference to concerns held by Dr Paul Conn, a General Practitioner and now sadly deceased, relating to Dr Michael Watt. These concerns are detailed and commented on further within the Concerns chapter.

> Again, I suppose the issue for me is, in 2012, we have Ray Hannon and Steve Cooke pushing back, presumably, and I'm fairly sure, because the message from the neurologists is, "There's not an issue here". And then we're back in this territory again in 2013 where we really are looking for the reasons to escalate, looking for an assurance before we go to revalidation. And it's increasingly looking like the evidence was there. So, the question for me is: did our systems and processes let us down or was this down to individual decisions? It's probably a bit of both.

5.105 Mr Hannon felt that there was a lot of information and other complaints that he had not known about. In his oral evidence on 3rd February 2020, he told the Inquiry Panel:

> If I had had a bit more information or a steer I would have pushed harder on my side. I mean, I don't think anybody, any one person could have known about all those complaints, but there are some of these complaints which I would have thought would have been burning in your brain and could have been brought to the table.

5.106 Mr Peter Watson, whose job it had been to track and encourage progress on the actions directed at DDCRM, also reflected in his evidence of 9th October 2019 to the Inquiry Panel:

> Do I see evidence in the [Medical Director's Office] file of the rigorous completion of the actions agreed? Looking back on it, I don't see the full evidence that I would probably look for now.

5.107 Dr Stevens recognised that he was responsible to oversee the process, but he believed he had delegated the matter and he told the Inquiry Panel that Mr Hannon should have triangulated the data and attempted to glean information from all available sources:

> I would've expected him to go and talk to clinicians – at least the Clinical Director, Clinical Lead. I would have expected him and Bernie Owens to think about their own experience and the information they had coming up through complaints; to look at litigation … to look at any serious adverse incidents that might relate to him … and also potentially to go and look at things like the national training survey, where the trainees have the opportunity to comment on their experiences.

5.108 In retrospect, Dr Stevens looked back at the matter and felt that the issue had been missed:

> There was very significant pushback. I was pushing one way and I was getting a very significant pushback from Ray [Hannon] and Steve [Cooke] … I would

> not have been intimidated by Michael Watt saying he would defend himself robustly. I've spent most of my life dealing with people who are going to defend themselves robustly, but I was getting very significant pushback, and, in the end, the decision was made. I don't actually think I was there when the final decision was made. Peter [Watson] made a decision that we will de-escalate this. It is a letter to him – Steve's conversation with him and Ray's letter to him … I felt there was a bit of a rising tide. And what I had come back to me, from two experienced medical managers, was, "Tony, there's nothing to see here", and they were wriggling on that, and eventually I let them off the hook.'

5.109 The first Finding of the Facts exercise suffered from numerous impediments. There was clearly confusion as to what Mr Hannon believed he was required to assess and where he needed to look. Mr Hannon's approach was to speak to the Clinical Director. While Mr Cooke, the Clinical Director[8] may well have had difficult earlier experiences, where he had had to give evidence in two contentious Industrial Tribunals and was also aware of Dr Watt's perceived defensiveness at this time, the Inquiry Panel is of the view that he also sincerely believed that there was no clinical issue with Dr Watt. This view would have simply been confirmed by the GMC's decision in respect of the INI 45 complaint and the interaction between Mr Cooke and Mr Hannon suggests that an early view had been taken that there was no clinical issue of concern. In their minds, the issue was, therefore, reduced to one of administrative failings and it was subsequently agreed at the DDCRM that Mrs Owens and Mr Hannon were to collate various issues and have a formal meeting with Dr Watt. That meeting never occurred and ultimately a gentle reminder to ensure that complaints were reflected upon at the next appraisal was sent to Dr Watt in July 2012.

5.110 Commenting on the Maintaining High Professional Standards approach, and the view taken of Dr Watt, Dr Stevens noted:

> 'Maintaining High Professional Standards' is a complex and tricky document. And again, I said in my evidence to you before, managing doctors in difficulty or managing doctors who are challenging employees -Because there are two aspects to this: they can be a very good clinician and a very, very challenging employee who — and the two aren't necessarily the same. And, in a way, this is where — I think Michael Watt's case is more complex than this, but I think we probably fell into the trap that he wasn't a very good employee but was a very good clinician.

5.111 The problems were compounded by the absence of a clear process or system to ensure that relevant material about Dr Watt could be easily collated and assessed

8 Mr Cooke ceased to be the Neurosciences Clinical Director on 31st March 2013 and was replaced by Dr John Craig who had been the Clinical Lead for Neurology since 2011 (having replaced Dr Jim Morrow in that role).

and the absence of contemporaneous notes of meetings held. Mr Hannon's view was formed with only a limited amount of information. The absence of a process, therefore, engendered a greater likelihood that investigation would be cursory or focused only on events which were in the memory of the person involved in the management of the process. Clinical Managers tend to be in place for a limited time and are then replaced by one of their peers. If information is not collated, then identification of any trend or pattern is impossible and there is no real possibility that a concern in one area can be compared with a complaint in another.

5.112 The medical profession understands that careful attention to medical notes is a critical component of patient safety. In contrast, the systems in place to assess concerns, complaints and related circumstances in 2012-2013 were ineffective, poorly collated and overly reliant on the GMC. This ignored the reality that it was the Trust who as employer had a corresponding obligation to manage the doctor and maintain patient safety.

DDCRM and Second Finding of the Facts Exercise:

5.113 No DDCRM took place in December 2012. Mr Watson provided oral evidence to the Inquiry Panel on 15th January 2020 with regards to the sequence of events as follows:

> There wasn't a DDCRM in December 2012, but there was a discussion; 'discussed with Ray Hannon on 21st December'… RH will seek update further to the letter of 19th July 2012''. Just to be clear, that's where we get to the email of 3rd January, and then, in turn, to the email that I sent on 9th January '13.

5.114 On 3rd January 2013, Mr Hannon noted in an email sent to Mr Watson that the appraisal completed in March 2012 with Dr Hawkins as the appraiser, made no mention of previous complaints during his appraisal. Mr Hannon asked Mr Watson to *"remind me where we go to now"*.

5.115 In responding to Mr Hannon on 9th January 2013, and copying in Mr Cooke and Mervyn Barkley, Mr Watson pointed out that the appraisal related to the period ending March 2011, but at the time the appraisal was being completed Dr Watt was under investigation by the GMC and there had been previous issues in the Autumn of 2011. Mr Watson's email outlined as follows:

> While technically the appraisal was for the year ending March 2011 and the two issues referenced above were during 2011/12, I find it somewhat difficult to understand how Michael [Watt] made no reference to these issues when

> appraised in March 2012. I know that Steve Cooke had adjudged at that time that a conversation with Michael was sufficient but that we had considered that correspondence needed to go to him (that went from you dated 19 July 2012). In that July 2012 correspondence you had indicated that all these issues should be considered at the next appraisal; can I suggest that it would be prudent at this appraisal for there to be some discussion with Michael as to why he was not explicit in relation to the issues during 2011/12 when engaging in Appraisal in March 2012.

5.116 The Inquiry Panel notes with some concern that what potentially was a probity issue was designated as a matter for the next appraisal. If a doctor fails to mention complaints of which he is aware at an appraisal, then this needs to be promptly investigated by management as a matter of trust and confidence. Appraisal, which is a reflective process should not have been the primary forum for such a discussion. In this instance, the evidence suggests that the timing and ambit of appraisal was such that it may have permitted Dr Watt to have argued that the relevant complaints were outside the specific appraisal period.

5.117 The issue of appraisal was discussed at a DDCRM held on 21st January 2013. At the meeting the position was summarised as follows:

> CURRENT POSITION
> Mr Watson referenced his email to R Hannon of 9 January 2013 in which there were concerns in relation to [Dr Watt]'s appraisal.
>
> Dr Stevens indicated that he had received verbal concerns from INI 348 which concerns were to be followed up by correspondence from INI 348.
>
> ACTION
> Mr Hannon to follow up on the 9 January 2013 email issues. Dr Stevens and Mr Watson to discuss further upon receipt of correspondence from INI 348, it being considered that further investigation within MHPS may be required at this time.

5.118 At the same time Dr Watt's appraisal up to March 2012 was due and Dr Hawkins, who had now retired, was finding difficulty in getting Dr Watt to engage with the latest appraisal. On 9th January 2013, Mr Cooke requested an update with Dr Hawkins providing the same on 15th January 2013. He indicated that no appraisal had been performed. A date had been agreed for 22nd November. However, the meeting was cancelled at short notice as Dr Watt *"said he was not ready"*. Dr Hawkins indicated that he had *"spoken to him several times and tried to impress on him how important it is for him to engage with these processes"*.

5.119 Dr Hawkins was the appraiser and did not have a management role. Nevertheless, the failure of Dr Watt to engage was indicative of a prevailing attitude, at least with Dr Watt, that such obligations were either optional or could be deferred until the consultant felt was a convenient time. This approach was not appropriate in a managed system.

5.120 In an email of 7th February 2013 Dr Hawkins stated to Mr Cooke:

> Dear Steve
>
> Further to me email of last month detailing my attempts to engage Michael in the appraisal process, I understand from Ray Hannon that you are about to stand down as CD.
>
> I have spoken to Mary McCormick who advised me that the matter may be taken out of my hands.
>
> Please advise me of the position. Should I continue to try to get Michael to engage with me to submit his paperwork…

5.121 At the same time as Dr Hawkins was trying to arrange with Dr Watt an appraisal for 2011-2012, a complaint was received from INI 334 dated 7th February 2013. This complaint succinctly outlined that Dr Watt had misdiagnosed INI 334 with epilepsy and prescribed Tegretol.

5.122 A letter prepared by the Assistant Services Manager, Ms Clare Lundy, and reviewed by Dr John Craig, the incoming Clinical Director for Neurosciences, and by Mr Gerry Atkinson in response to the complaint was signed by Mrs Bernie Owens on 31st May 2013. The letter followed a familiar pattern of describing the nature of appointments, which dated from between 2002-2004 and treatment received but did not comment on the alleged misdiagnosis, beyond noting that INI 334 had recently attended the late Dr Tom Esmonde, then a Consultant Neurologist at Antrim Area Hospital.

5.123 On 22nd February 2013, a complaint was received from INI 347, who complained that she had been incorrectly diagnosed with a TIA by Dr Magorrian in discussion with Dr Watt in 2007. At a patient review appointment in February 2012 Dr Watt refused to alter the earlier diagnosis. An initial response dated 30th April 2013 was drafted by Ms Lundy, *'sense checked'*[9] or reviewed by Dr Craig and signed by Mrs Owens. This response recorded that Dr Watt was still of the view that INI 347 has suffered a TIA. At Dr Watt's suggestion INI 347 was offered the option of a second opinion from another consultant neurologist, which was accepted.

9 Dr Craig outlined in oral evidence dated 18th December 2019 that he understood his role in reviewing complaints as follows: *"you were just being asked to sense-check that there was nothing there that was completely inaccurate or contradicted itself rather than is there a trigger here? Is there an alarm bell ringing? Do we need to have a more carefully look at this"?* See the Complaints Chapter for further details.

5.124 In proposing a second opinion from Dr Ailsa Fulton, Dr Watt specifically requested that she was not made aware of his opinion before giving her own view. INI 347 attended Dr Ailsa Fulton, who disagreed with Dr Watt's diagnosis, but noted that the history appeared to be different from the earlier presentation. Dr Fulton opined as follows in correspondence dated 6th June and 24th June 2013:

> 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 appoint 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 …
>
> 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.

5.125 Dr Fulton pointed out that she had elicited a slightly different history from that taken by Dr Watt, but there is no evidence that anyone in the Trust took any steps to investigate the difference between the two opinions.

5.126 Dr Watt was discussed at the DDCRM again on 11th March 2013 with the position noted as follows:

> CURRENT POSITION
> It was noted that INI 348 had written to Tony [Stevens] indicating further details would follow. It was noted that there remained concerns that the appraisal had not taken place, including issues from the previous appraisal having not been resolved.
>
> ACTION
> Dr Stevens indicated he would be flagging concerns re this doctor with Joanne Donnelly [GMC Employer Liaison Adviser] in the context of year 1 revalidation. Mr Hannon to ensure attempts continued to be made re appraisal. Letter from INI 348 to be awaited.

5.127 The Inquiry Panel again notes that the action proposed regarding the failure by Dr Watt to be appraised was to speak to the GMC representative. That would

have been appropriate, but it did not obviate the responsibility of the managers in the Trust to confront Dr Watt directly. Dr Watt had a contractual obligation to be appraised annually. A failure to do so could have been the subject of actual sanction or disciplinary action by the Trust. This does not seem to have been considered in lieu of persuasion, encouragement and the threat of referral to the Regulator.

5.128 On 11th March 2013, Mr Hannon emailed Dr Watt noting that *"Stanley Hawkins has told me he has been having difficulties scheduling an appraisal for you. I am concerned that your revalidation date is September 2013. If it is judged that you aren't engaging with the appraisal process, the ROS*[10] *(Dr Stevens) may not be in a position to recommend revalidation"* and urged him to make an appointment with Dr Hawkins. Dr Watt responded to indicate that he was awaiting disclosure of relevant complaints from the Complaints Department. On 8th April 2013, Dr Watt indicated to Mr Hannon that he was *"making progress"* and should be ready for his appraisal meeting by the end of that month.

5.129 This matter came before the DDCRM again on 22nd April 2013 where it was noted as follows:

> CURRENT POSITION
> Dr Stevens was minded to flag concerns to [Joanne] Donnelly [GMC Employer Liaison Adviser] in the context of revalidation.
>
> Mr Hannon noted ongoing issues with finalising appraisal date.
>
> It was noted that a letter from INI 348 was still awaited.
>
> ACTION
> Mr Hannon to ensure appraisal date arranged.
>
> Mr Watson to check with Dr Stevens re letter from INI 348.
>
> Maintain under review at DCCRM.

5.130 On 31st May 2013, Peter Watson sought *"urgent advice"* from Dr Hawkins with regards to the progress of Dr Watt's appraisal. Dr Hawkins indicated on the same date that *"he has been making progress. John Craig and I have told him that he must engage with the processes laid out by the Trust,"* that 360-degree feedback[11] was being completed and that an initial review of paperwork was to take place on 6th June.

10 This is a reference to the Responsible Officer role within the Revalidation process. It is explained and commented upon in the Chapter on Appraisal and Revalidation but for most NHS Consultants their Responsible Officer was the Medical Director in their employing Trust.

11 "360-degree feedback" refers to a component of the revalidation process which is commented on and explained further in the Appraisal and Revalidation chapter.

5.131 On 1st June 2013, Dr Ken Fullerton, a former Medical Director prior to the establishment of the Belfast Trust, took over from Mr Ray Hannon as the Associate Medical Director with responsibility for neurology. Both were present at a DDCRM on 3rd June 2013. The notes of this meeting state as follows:

> CURRENT POSITION
> Mr Watson indicated that he had followed up with [Dr Stanley Hawkins] in relation to proposals for [Dr Watt]'s appraisal. [Dr Hawkins] had confirmed that there had been some progress with a review of paperwork planned for 6th June.
>
> It was noted that M Watt had a September 2013 revalidation date.
>
> Dr Stevens indicated that he had not yet received follow-up information from INI 348 further to the conversation that he had had with him.
>
> Mrs Owens indicated that she had recently signed two complaints in relation to Dr Watt.
>
> It was considered that the level of concern was such that it was important that Dr Fullerton should establish the facts within the informal stage of MHPS and that Dr Watt be advised by Dr Fullerton that he was doing this.
>
> ACTION
> As above.

5.132 The Inquiry Panel notes the reference to two complaints signed by Mrs Owens at the meeting. Based on the timeframe and the evidence received by the Inquiry, these complaints must have been that of INI 334 and INI 347. In his oral evidence dated 9th October 2019, Mr Watson outlined that although these complaints were referred to at the meeting in question, they were not disclosed to the Medical Director or included in the Medical Director's file during the period being considered by the Inquiry. Mr Watson stated that he believed the reason was because Dr Fullerton was tasked with conducting an exercise under the informal stage of MHPS, in which it was envisaged the complaints would be considered. Mr Watson also indicated that no other attendee at the meeting asked for disclosure of the complaints.

5.133 Dr Fullerton, in his evidence to the Inquiry Panel on 5th November 2019, stated that there had been a handover with Mr Hannon, the previous Associate Medical Director in or about June 2013 and that the issues with Dr Watt had been one of the first matters raised. He told the Inquiry Panel that: *"Michael Watt on the first day in post was well up my list of priorities"*.

5.134 On being tasked to investigate under the informal stage of MHPS, Dr Fullerton immediately inquired as to the status of Dr Watt's appraisal which was being carried out by Dr Hawkins. He was informed by the Medical Workforce Administrator in an email of 5th June 2013 that the appraisal with Dr Hawkins was due to take place the following day.

5.135 On 13th June 2013, Dr Stevens, then Medical Director, received the written complaint from INI 348, whose focus was on the failure by Dr Watt to furnish a report to her insurance company in respect of a critical illness policy. In January 2009, INI 348 attended the Belfast Trust Emergency Department at the Royal Victoria Hospital with left arm weakness, numbness and eyesight disturbance. A couple of days later she was reviewed by Dr Watt who diagnosed her with a stroke and subsequently arranged for an MRI. Several months later a claim under a critical illness insurance policy was made. The insurers requested a report from Dr Watt who, after a delay, submitted a report in February 2010 which stated that INI 348 had suffered a *"presumed infarct as no evidence of haemorrhage on imaging"*. The insurers disputed that this was evidence of stroke but would review the situation if Dr Watt clarified matters. Dr Watt failed to respond to requests for an updated report and at subsequent attendances maintained INI 348 had suffered a stroke. Having also sought help from the Ombudsman, INI 348 complained to the Trust formally on 12th June 2013.

5.136 On 14th June 2013, Dr Stevens forwarded the INI 348 complaint on to Dr Fullerton and Dr Craig, copying in Bernie Owens, Margaret McKee and Peter Watson, stating as follows:

> 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 Margaret McKee in complaints Dept). In parallel I would be grateful if you would consider any professional issues, taking account of previous concerns.
>
> Regards
>
> Tony

5.137 Dr Craig responded that day stating that he had informed Dr Watt that Dr Fullerton would be contacting him *"in the near future"* and explained the concerns that had been raised.

5.138 Dr Fullerton also responded on the same date to Dr Stevens. He indicated that he was already aware of a complaint in the service group and that the meeting with regards to Dr Watt's appraisal had been adjourned for him to collect further documentation. Dr Fullerton outlined that it was his intention to meet with Dr Watt in roughly two weeks to allow him to complete his appraisal.

5.139 On 17th June, in response to the INI 348 letter of complaint, Dr Watt apologised to Ms Clare Lundy "for his failure to provide the report for INI 348's insurers" and acknowledged that he had problems with providing such reports over the years. In explanation Dr Watt stated:

> 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 all my 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 enquiries. 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.

5.140 On reflection, the commentary from Dr Watt in his letter to Ms Lundy is a significant and candid observation. Given that there had previously been a concern about the clinic template and the number of patients that Dr Watt was seeing, his admission that he was struggling *"to keep on top of the workload"* should have alerted managers to a potential problem. The comment, however, does not seem to have been picked up on or highlighted.

5.141 In addition, the suggestion that patients were being diagnosed with stroke, despite normal imaging, is a comment which should have merited further discussion and/or investigation. The Inquiry Panel recognises that there are some cases where a stroke can occur even with normal imaging, but if it was the case that Dr Watt was an outlier in this regard then this is a matter which merited further consideration. Again, this does not seem to have been picked up at the time and the Inquiry undoubtedly has the benefit of hindsight in this instance in light of the events that subsequently transpired.

5.142 Ms Lundy used this information and INI 348's notes and records to prepare a draft response on 30th June 2013 which was reviewed by Dr Craig and Mr Atkinson. This response referred to INI 348's attendance in January 2009 which recorded a probable diagnosis of a *"minor stroke"*. Reference was also made to an attendance in February 2012 after which Dr Watt recorded that the probable diagnosis *"once more lies between migraine and a further stroke with migraine appearing the more likely"*. A

further review in October 2012, did not record evidence of a stroke nor did an MRI scan record anything of significance.

5.143 This response was forwarded to Dr Fullerton for review on 3rd July 2013. The following day Dr Fullerton responded to indicate that: *"I would be inclined not to put in so much clinical detail as this is not material to the case"*. To her credit, Ms Lundy rejected this suggestion and stated that: *"I think we need the clinical details as there is information there that suggests that maybe the symptoms were in relation to migraines"*. A 'tracked changes' version of the draft response was then shared with the Medical Director's Office with the information struck out but still visible. Dr Stevens accepted Dr Fullerton's changes and made some additional minor amendments before the final response was issued on 19th July 2013.

5.144 This final response to INI 348's complaint noted that: *"Dr Watt has offered his sincere apologies"* and outlined that: *"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 you verbally."* No reference is made to any of the previous notes or the correctness of the stroke diagnosis. Dr Watt was to make an apology and to reflect on this matter. It does appear that Dr Watt did apologise, but the Inquiry has not seen any document which details the apology.

5.145 The DDCRM of 22nd July 2013 noted that as follows:

> CURRENT POSITION:
> It was noted that MW's appraisal was not yet completed and that KF would be meeting MW to impress on him the importance of satisfactory completion.
>
> It was noted that Dr Stevens had responded to a particular complaint received from another doctor.
>
> It was noted that in relation to Finding the Facts, Dr Fullerton's exercise continued.
>
> ACTION:
> Await update re appraisal.
>
> Await confirmation from complaint closure.
>
> Await final FTF report from Dr Fullerton.

5.146 On 25th July 2013, Dr Fullerton emailed Mr Atkinson noting the existence of *"at least one complaint (not "INI 348") over the past few months involving Michael Watt,"* and asked for copies of the same in advance of a meeting due to take place with Dr Watt the following day. On 26th July 2013, Mr Atkinson sent Dr Fullerton two

emails, the first contained an unknown attachment which Mr Atkinson *"assume[s] is the complaint you refer to"* and the second contains attachments relating to the INI 418, INI 347 INI 419, INI 334, INI 417 and INI 5 complaints. Ms Lundy also gathered complaints within the Service Division and forwarded these on to the Service Manager, Mr Atkinson, who, in turn, furnished them to Dr Fullerton. In an email at the time, Ms Lundy stated:

> I have read through these. These are references to attitude or communication related issues.

5.147 On 29th August 2013 Mr Watson emailed Dr Fullerton in advance of an upcoming DDCRM and asked: *"can you be in a position to update on each of the referenced actions at Monday afternoon's meeting?!? we would need a copy of MWa letter to complainant, update on audit and report on FTF from yourself"*. Dr Fullerton responded to state that: *"verbal report on FTF will be provided. Documentation on apology and appraisal (audit) not in my possession – has now been requested"*.

5.148 Dr Watt's appraisal documentation for the year January to December 2012 was signed on 18th July 2013 and marked as complete by Dr Hawkins on 2nd September 2013. With regards to Domain 4 – Maintaining Trust, the discussion records that: *"Issues in previous years discussed. No issues in year 2012"*.

5.149 Dr Watt also signed a Probity Declaration which recorded:

> Since my last appraisal/revalidation I have not, in the UK or outside: - been convicted of a criminal offence or have proceedings pending against me, - had any cases considered by the GMC, other professional regulatory body, or other licensing body or have any cases pending against me, - had any disciplinary actions taken against me by an employer or contractor or have had any contract terminated or suspended on grounds relating to my fitness to practice **OR** if I have been subject to any of the above, I have discussed this with my appraiser.

5.150 The issue presented by the wording of the probity declaration and its ambiguity is considered in further detail in the chapter on Appraisal and Revalidation.

5.151 At the DDCRM meeting on 2nd September, Dr Fullerton provided a verbal report on Dr Watt to conclude his exercise under the informal stage of MHPS. Dr Fullerton was clear in oral evidence that, so far as he was concerned: *"I wasn't ever asked, nor did I believe there was an expectation that I would produce a written report"*. The position was recorded as follows:

> CURRENT POSITION
> Dr Fullerton noted that appraisal was due to be completed on 2 September.

> It was noted that Dr Fullerton was to follow up on the letter which [Michael Watt] was to have sent to the complainant.
>
> Dr Fullerton indicated that in relation to Finding the Facts he had not found a lot of information since the GMC issues. Dr Fullerton indicated that appraisal would be used as the forum to reinforce the importance of these issues, with Dr Fullerton personally to review appraisal documentation to ensure that all issues are adequately addressed.
>
> ACTION
> As above.

5.152 The Inquiry has seen a contemporaneous handwritten note of the meeting prepared by Mr Peter Watson which states as follows:

> File review at 2nd September '13.
>
> 1. Appraisal to be completed today.
> 2. Response to complaint has according to M Watt gone -> K Fullerton following up.
> 3. [Finding of the Facts]. Ken Fullerton said 'not a lot' since GMC has withdrawn, only two cases, via directorate, via MDO. Both re insurance report, in appraisal. KF {Ken Fullerton] has impressed import of seriousness of these issues.
>
> Agreed KF [Ken Fullerton] to review the appraisal to ensure all issues adequately addressed.

5.153 The Inquiry has further seen a contemporaneous handwritten note of the meeting prepared by Mrs Bernie Owens which outlined as follows:

> MW
>
> – Apologised to [patient] by MW – Ken Fullerton
> – KF met with MW.
> Since GMC withdrew communication – delay in reports.
> Largely in independent sector.
> – Both cases
> – Revalidation this month.

5.154 Dr Fullerton stated to the Inquiry that: *"although the notes from DDCRM meetings are very succinct they don't actually outline the conversation"* that occurred on each occasion. Mr Watson, with reference to 2nd September meeting was clear in his evidence of

9th October 2019 that *"the verbal report is as reflected in the note of the meeting"*. The notes of Mr Watson and Mrs Owens above refer to only two complaints regarding report writing. Dr Fullerton was adamant in his oral evidence to the Inquiry that he assessed numerous other complaints, but the lack of any detailed written report from Dr Fullerton makes it difficult to analyse what actual level of investigation was carried out by Dr Fullerton and the Inquiry Panel remain unconvinced that there was a proper investigation of the relevant complaints.

5.155 No one within the DDCRM seems to have enquired with Dr Fullerton at any time as to his methodology, analysis and findings in relation to the relevant complaints or conduct of the Finding of the Facts exercise. Dr Fullerton makes the not unreasonable point that he was not given any guidance on how the informal investigation was to be carried out, and that having approached the exercise in the manner he did, he was not in any way queried. The Inquiry Panel considers that, given the level of concern which necessitated that the Finding of the Facts exercise be conducted, such enquiries or scrutiny would have been crucial before the DDCRM accepted the conclusions of the verbal report from Dr Fullerton. He told the Inquiry Panel that he was not required to provide a written report to the DDCRM. He also pointed out that the MHPS guidance refers to involving NCAS. This was not suggested to him, nor was he aware of its existence, and Dr Fullerton believes that, in retrospect, this may have helped bring structure to the informal stage of MHPS.

5.156 Mr Watson, when asked as to what he believed Dr Fullerton had been required to do, stated to the Inquiry Panel in his evidence of 15th January 2020:

> Well, what was he asked to do? Well, let's look and see what he was asked to do. He was asked to establish the facts within the informal stage of MHPS. That's what he was asked to do. No more, no less. So, it's for him to explain what he understood it should entail … if there is something that needs to be investigated, if there's a matter of concern that needs to be investigated. It should be investigated. At the risk of sounding very obvious, it should be investigated by way of investigation.

5.157 Dr Fullerton, however, emphasised that his focus was not on clinical issues in his oral evidence of 5th November 2019:

> At none of those meetings did anyone, including Dr Stevens, raise any concerns about clinical practice. So the context for what I was doing …was investigating concerns about delays in reports, not doing appraisals, those things. So, it's not that my eyes would've been closed to a clinical matter because I'm well aware that an issue in one domain may indicate there's issues in other domains as well, but that wasn't actually the focus of what I was asked to do …

> It was said to me that Dr Watt had previously been referred to the GMC and there was an issue about timeliness of things. So I was aware of that at this meeting but not that there had been any previous investigation …
>
> Finding the facts, as you can see, is very vaguely defined, and, as I've said, I am very well aware that a doctor who has issues in one domain – let's say, attitude to patients – can also have issues in another domain: the clinical one, let's say …
>
> that was never conveyed to me. Now, as I've said, I would have been alert to clinical issues anyway but that was never conveyed to me as a primary concern.

5.158 In his evidence of 5th November 2019, Dr Fullerton commented on the outcome of the INI 45 complaint:

> My expectation at the time was that if a case, which had clinical aspects, was sent to the GMC, then the GMC would have applied appropriate expertise to reach a conclusion on the clinical case. And the GMC, I think, used the words "reasonable", although they were critical of some aspects.

5.159 The Inquiry Panel accepts that the view of the GMC would have influenced Dr Fullerton but a GMC decision of itself is not determinative. The Trust had its own responsibility to manage Dr Watt and could not delegate that responsibility to the Regulator. In this instance, it was not sufficient to conclude that as the GMC did not take the INI 45 complaint further the Trust could be reassured regarding Dr Watt's clinical abilities.

5.160 Unbeknown to the clinical managers carrying out the Finding of the Fact exercise, the GMC, whose evaluation of complaints such as INI 45 were being relied upon heavily by the Trust, had problems in their own process as highlighted in the Rule 12 review in 2019. Mr Hannon and Dr Fullerton were not aware of the inadequacies of the GMC investigation. The effect of this was cumulative and led to the GMC decision in INI 45 being given a weight and an influence that was inappropriate, given as we now know it was potentially flawed. For the avoidance of doubt, the Inquiry Panel accepts that the Belfast Trust is entitled to take into account as a material factor the outcome of a GMC investigation. They were not to know that that investigation was potentially flawed, but nor did they ensure that the GMC had all of the accurate information about previous complaints regarding Dr Watt.

5.161 Following his first appearance at the Inquiry in October 2018, Dr Stevens returned to give evidence in September 2019. He stated in an opening reflection to the Panel:

> He [Michael Watt] then came back into orbit in 2012-13, and I think that's probably the most crucial period and, if I'm honest, I think, the time when we may have missed the opportunity to pull him in.

5.162 Later in his evidence, Dr Stevens states in relation to Dr Watt's administrative failings as opposed to his clinical skills:

> I mean, I accept that. I accept that there's a pack of us going out of our way to support this guy and keep him out of difficulty, and I'll come back again to the point I made earlier that we believed him to be a good clinician and worth the effort.

5.163 It is a part of the role of the Trust to support one of its employees, but its prime responsibility was (and remains) the safety of patients. The indulgence of Dr Watt because of his perceived clinical abilities served no one's interests including that of Dr Watt himself.

5.164 Dr Stevens referred to the two Finding of the Facts exercises under MHPS which took place in 2012 and 2013:

> I think we carried out two informal exercises under Maintaining High 8 Professional Standards at that stage, in '12 and '13 — two different Associate Medical Directors, who both came back and said they did not feel there were any clinical issues.

5.165 Dr Stevens in his evidence highlighted the link between a revalidation exercise and a performance concern. Dr Watt could not have been recommended for revalidation by Dr Fullerton if an investigation was continuing under Maintaining High Professional Standards. Given the deadline for revalidation in September 2013, there was a concern that ongoing issues with appraisal and outstanding complaints may have prevented Dr Watt being revalidated or placing him in a deferral category. As late as July/August 2013, Dr Fullerton had written to Dr Watt indicating that at that juncture he was unlikely to be recommended for revalidation.

5.166 Dr Stevens gave evidence to the Panel that when the issue of performance was raised again in June 2013, he was anxious to exclude any clinical question in relation to Dr Watt:

> So, in June, the conversation at Maintaining High Professional Standards, when both Ray and Ken were there together, along with Bernie Owens — so the three main protagonists who would've had the best sight to tell about his practice were there — and the conversation was about, "Oh, this guy's date is coming up. We want to be absolutely certain that there are no clinical issues that mean that we should be handling this in a different way". So, Ken had three months before he came back and said, "There are no clinical issues here, Tony", and we switched gear at that point. So, there is a question, I think, a legitimate question, as to whether or not the establishing the facts stage, the informal stage

> of Maintaining High Professional Standards was robust enough. I think Ken will have to answer to that.

5.167 Dr Fullerton when he came to give evidence to the Inquiry Panel stated:

> However, I can tell you that what I had done by that stage is I had reviewed the following complaints: INI 418; INI 347; INI 419; INI 334; [INI 417]; [INI 5]; INI 348; and INI 349, although that was still quite a recent one at that stage. And I had also looked at the GMC findings in both 2007 and in 2012; the 2012 being the INI 45 case. I had spoken to two neurologists, both in positions of authority: John Craig, who was the Clinical Director and a fellow neurologist; and Stanley Hawkins, who was the appraiser and a fellow neurologist and indeed working in some of the same areas as Dr Watt. And my intentions at that stage, which is roughly referred to here, was, when Dr Watt's appraisal documents came through, to review those and then to personally meet with him, which is what I subsequently did.

5.168 Dr Fullerton also gave evidence about an interaction he had with Dr Craig in which he recalled Dr Craig expressing frustration at Dr Watt being "very slow at doing stuff". Dr Craig could not however recall a meeting as expressed in oral evidence to the Inquiry on 18th December 2019 as follows:

> My memory of the meeting that I had with Ken was very much around the very detailed email that he had sent out in September 2013, which was around him trying to be revalidated. So my memory of that meeting was that it was primarily about "how do we achieve the steps that we need to achieve to see if we can come up with a positive recommendation? ...
>
> I went and looked in my diary. I can't find anything. That doesn't mean that there wasn't a meeting, but I don't remember a meeting where we sat down and we talked about DDCRM or finding the facts. No I do not remember.

5.169 Dr Fullerton's failure to record the meeting with Dr Craig, then Clinical Director made it likely that the recall of such events many years later would be difficult. The Inquiry panel is not surprised that Dr Craig has no recollection of discussing Dr Watt within the context of the informal stage of MHPS informal stage at a meeting with Dr Fullerton in 2013.

5.170 Dr Fullerton gave evidence that he had personally reviewed the complaints using his own experience as a physician with experience in strokes and gave an analysis of each of the cases and why he had not been concerned when he had reviewed them. The problem however was that such an approach conflated management of a process with exercising one's own judgment and expertise.

5.171 Dr Fullerton, during his oral evidence to the Inquiry Panel on 5th November 2019, reviewed the documentation with regards to INI 334 and noted that the complaint letter was submitted in 2013 but had referred back to events in 2002. He felt that a therapeutic trial of medication and review was *"a perfectly reasonable course of action"*.

5.172 In relation to INI 347, which concerned the diagnosis of a TIA, Dr Fullerton commented in November 2019 that:

> 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.

5.173 Commenting on INI 348 in November 2019 which concerned a stroke diagnosis, Dr Fullerton, exercising his own clinical judgment stated

> I would agree there's a clinical component in that, 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.

5.174 Dr Fullerton rejected any suggestion of a discernible clinical pattern although accepted that there was a clear trend in relation to complaints of maladministration:

> And now having had a Royal College of Physicians review and all of that you can see a pattern, but in 2013 there was no discernible pattern that I could see relating to clinical practice. There was a discernible pattern in how he related to patients. There was a discernible pattern in things being delayed. And there was also a discernible pattern of him being relative – well, having clinicians that were exceedingly busy, despite having had several conversations before as to how steeps would need to be taken to reduce that.

5.175 The issue of the extent to which Dr Fullerton considered the INI 347, INI 348 and INI 334 complaints with full access to the notes was explored in Dr Fullerton's evidence:

> **Mr Lockhart QC:** Would you have had access to the notes at that stage?
>
> **Dr Fullerton:** No.
>
> **Mr Lockhart QC:** So how would you have come to that conclusion without access to the notes?
>
> **Dr Fullerton:** I asked myself —. Well, what I had was the correspondence, 2 and the notes from 2002 I eventually, probably, did see. I have no recollection, at this point, when I would have seen them, if ever. I know that I received the letters, and I looked at all the letters, but the narrative —

> **Mr Lockhart QC:** You thought was sufficient?
>
> **Dr Fullerton:** — _was sufficient. I can't actually tell you that I didn't review the notes. I know that you asked me that. I don't know

5.176 At a later point in his evidence when the question of accessing the notes via the integrated electronic care record[12] was raised Dr Fullerton then stated:

> **Mr Lockhart QC:** Could you have used it? Could you have accessed it at the time you were looking at this?
>
> **Dr Fullerton:** Um, yes, but, if the case was an old one, the records might not necessarily have been there, because there was only a certain amount of retrospective stuff, and it certainly did not contain anything about complaints.
>
> **Mr Lockhart QC:** Sure.
>
> **Dr Fullerton:** It did contain clinical records, and I certainly would have, in 2013, accessed it in respect of some of the clinical aspects of some of these cases, but I don't recall which ones.
>
> **Mr Lockhart QC:** So, you're quite clear: you would've accessed it
>
> **Dr Fullerton:** Oh, yes, definitely.
>
> **Mr Lockhart QC:** — in relation to, say, the more contemporaneous complaints?
>
> **Dr Fullerton:** Yes, absolutely.

5.177 Dr Fullerton also gave evidence that he was made aware of the INI 222 complaint.[13] Dr Fullerton indicated that he *"went looking for it"* after somebody, who he could not recall, mentioned it in passing. He recalled that he had sight of the complaint letter and response. In oral evidence of 5th November 2019 Dr Fullerton stated that the INI 222 complaint *"was the nearest to raising a concern with me clinically"* however he noted *"it was some time in the past, in 2006, and the evidence at the time was that a number of other people, including the Medical Director of the time, Dr Stevens, had been through this case with a fine toothcomb"*.

5.178 Dr Fullerton was clear that his view in 2013 would have remained his opinion in 2019. When he had the opportunity to again review the complaints prior to giving evidence, he stated:

> I have obviously been through these complaints again not least in preparation for today and in the light of hindsight I cannot honestly say on the evidence that I had at the time I would have acted any differently.

12 The electronic care record ("ECR") is an online record of each patients' NHS medical notes in Northern Ireland, which can be accessed by all medical practitioners with appropriate safeguards. Northern Ireland is the only part of the UK with such a facility.

13 For further information on this complaint see the 2006/07 Chapter.

5.179 As outlined above, Dr Stevens in oral evidence in September 2019 stated that 2013 was *"the most crucial period"*. Dr Stevens indicated that "rightly or wrongly, I relied on" Dr Fullerton's assessment and that *"maybe we didn't push harder to see a documentary report, but the informal stage for establishing the facts is what it is. It's quite informal"*.

5.180 The significance of this moment cannot be overstated and is correctly identified by Dr Stevens as: "the pivot point in this." *Dr Stevens in his oral evidence encapsulated the change in the Trust's approach upon receiving Dr Fullerton's report as follows: "[Dr Fullerton] came back at the beginning of September to say there were no concerns, and we flipped into a different mode then, which was, 'Let's go get this recalcitrant – administratively recalcitrant consultant through revalidation.'"* Reflecting further, Dr Stevens stated:

> But that's where we found ourselves in June or September 2013, when we decided this was an impossible employee who was a clinical asset to the organisation … best get him thought revalidation. That's my reflection now and I would also accept there was albeit in a disjointed way, evidence to support that … But we didn't put it together. And the overwhelming weight of peer support he got blinded us to that.

The problem identified by the Inquiry Panel is that it appears as if the method of managing Dr Watt was to assist him in securing revalidation rather than properly evaluating the many problems and complaints which had arisen.

5.181 The observations made in relation to the first Finding of the Facts exercise apply equally to the second. Dr Fullerton was an experienced manager with previous Medical Director experience. He also adopted the approach of talking to Dr Craig, the then Clinical Director within Neurosciences, and Dr Hawkins, who had regularly carried out Dr Watt's appraisal, to look for evidence of broader problems. The Inquiry Panel accepts that he was reassured by those conversations. There were no notes, however, taken of these discussions and it is difficult to assess the methods utilised by Dr Fullerton. It appears likely that Dr Fullerton also adopted the early view in his investigation that Dr Watt was a clinical asset and that the real problem here was his difficulties in getting appraisal completed in light of the impending revalidation.

5.182 The lack of a written report to the DDCRM, even in an informal process, in both of the Finding of the Facts exercises was problematic. A written report would have ensured clarity and provided a better opportunity for the DDCRM to review and scrutinise Dr Fullerton's findings. A verbal report cannot easily be recalled years later and the brief notes taken by attendees actually point to a view being taken

that there was little to worry about apart from a failure to be appraised and general administrative tardiness.

5.183 Although Dr Fullerton attempted to justify the view that he had taken in respect of those complaints, which had a clinical dimension, the Inquiry is not satisfied that this was done properly at the time. The medical notes and records were not sought, nor was an independent view obtained. Dr Fullerton, who was the manager of the process, adopted a retrospective perspective, which he believed justified the approach that he had taken in 2013. The Inquiry has concluded that the method of investigation in 2013 was inadequate because of the combination of poor records and the absence of the coherent system of storage and collation. In this regard, Dr Fullerton would have faced the same difficulties as Mr Hannon. Nevertheless, the early adoption by Dr Fullerton of the view that the problem was essentially administrative, ensured that the focus stayed on that issue. Whether Dr Watt was practising appropriately and safely was a different question which was not properly investigated at this time. The opportunities afforded, therefore, by the additional information that is set out in this chapter were not grasped.

5.184 Dr Fullerton was influenced by the views of Dr Hawkins and Dr Craig regarding Dr Watt's administrative shortcomings and focused at an early stage on ensuring appraisal was completed and revalidation achieved. The Inquiry Panel does not believe there was a sufficient briefing given to Dr Fullerton on the nature of the investigation. Further, the failure of the DDCRM to require that Dr Fullerton provide a written report prevented any effective scrutiny of Dr Fullerton's findings.

5.185 The Inquiry Panel believes that it was a mistake for Dr Fullerton to rely on his own judgement in assessing clinical complaints. To do so conflated the role of a manager of the process, charged with collating the relevant evidence and that of an independent assessor required to come to a specific view based on the medical facts of the case. Dr Fullerton took the view that he was qualified to personally assess the complaints. Although Dr Fullerton could not recall whether he had viewed the relevant medical records, the Inquiry Panel has concluded that, on balance, it is more likely that he did not review the records. In those circumstances, any assessment is likely to be partial and even cursory. The Inquiry Panel is, therefore, not satisfied that a proper assessment of any of the most relevant complaints was carried out by Dr Fullerton in his Finding of the Facts exercise.

5.186 The Inquiry Panel is not satisfied that the cases of INI 348, INI 347 and INI 334 together with INI 45 and INI 5 if properly and rigorously analysed would have led to the conclusion reached by Dr Fullerton that there were no clinical concerns. While the

Inquiry Panel is not in a position to offer a fully informed judgment, the absence of medical records or contemporaneous note of Dr Fullerton's conclusions undermine Dr Fullerton's review carried out shortly prior to giving evidence. Further, as Dr Fullerton was managing the exercise, he would have been better served obtaining a view from another specialist or neurologist on the clinical issues, (if any) arising. The Inquiry Panel accepts that Dr Fullerton spoke to Dr Craig and Dr Hawkins in general terms and that neither would appear to have raised any clinical concerns. This approach remained sub-optimal. The specific cases should have been reviewed by a neurologist or other relevant specialist.

5.187 Even though important information was not properly brought to the attention of the Medical Director or those deputed to carry out the Finding of the Facts exercise within Maintaining High Professional Standards (MHPS), in the view of the Inquiry Panel there was sufficient clinical, as well as administrative concerns, which should have given rise to greater inquiry. The threshold for escalation[14] was often reached and yet, time after time, a doctor with responsibility, using his own judgement of Dr Watt, decided that nothing further needed to be done.

Dr Fullerton's Review of Appraisal Folder and Removal from DDCRM:

5.188 On 5th September 2013 a complaint was received from the Patient Client Council on behalf of INI 349, an MS patient who had been waiting, in one instance for 14 months, for reports to be completed by Dr Watt for two insurance companies in respect of critical illness cover. This was despite monthly reminders. The following exchange took place on 6th September between Mr Atkinson the Service Manager and Dr Craig the Clinical Director:

> I will speak with Michael. Is this a new complaint or one that has been known about?
> John
>
> John
> This particular case has not been brought to my attention before now
> Gerry
>
> Not good for Michael potentially
> [John Craig]
>
> No not good at all. These issues keep arising
> Gerry

14 Section 25 of the GMC Guide on Good Medical Practise.

5.189 On 5th September, Mr Atkinson emailed Dr Watt and asked if he could *"please provide the requested reports as soon as possible?"* Dr Watt indicated that the required reports were "actually sitting next to do on desk!"

5.190 On 9th September, Dr Fullerton went through Dr Watt's appraisal documentation and emailed Dr Craig pointing out that *"there are still a few deficiencies, although with some focused attention I think it should be possible to address these before the revalidation date of 27 September"*. Dr Fullerton noted the following deficiencies:

(i) No evidence of reflection on CPD which is *"important in light of deficiencies in previous years"*.

(ii) *"No indication in the appraisal of the activity figures associated with his HSC work"*.

(iii) Inadequate attention to *"quality improvement activity"*.

(iv) *"Undertakes significant amounts of private practice, equivalent to 28 patients per working week, but has given no information of outcomes and insufficient information on the patients seen."*

(v) *"There is a prospective PDP but no signed off previous PDP"*.

(vi) *"I am aware that this doctor has recently been involved in some significant complaints. These are not mentioned and not reflected upon."*

(vii) No indication of certificate from Trust in respect of research governance.

5.191 Dr Fullerton indicated that these matters would need addressed and *"as a minimum he needs to reflect on his CPD record (or lack of it), his patient and colleague feedback, his recent complaints and his responses to them, his contributions to private practice and research and his workload"*. Finally, Dr Fullerton asked if Dr Craig could *"please use your good offices to see if we can get Michael on track for revalidation?"*

5.192 On 24th September, Dr Fullerton wrote to Dr Watt indicating that he was *"cutting this very fine"* in view of the impending date for revalidation on 27th September 2013. Dr Watt responded indicating that it was *"bizarre"* that this matter had only just been raised directly with him. Dr Fullerton then indicated that Dr Watt was in danger of *"having something other than a positive recommendation"* and offered to meet with him to go through his appraisal folder. He had indicated on 23rd September to the Revalidation Administrator, Andria Gormley, that the only recommendation he could make at this stage would be a deferral as he had *"not yet received the information I would need to make a positive recommendation"*.

5.193 The meeting between Dr Watt and Dr Fullerton took place on 26th September. In an email from Dr Fullerton that same morning, Dr Fullerton noted: *"your 2012*

(Calendar year) appraisal folder did in fact contain most of the evidence required to support your revalidation, but this had not been fully reflected in the appraisal documentation". Dr Fullerton also noted that Dr Watt had provided additional evidence of quality improvement activity and updates "on two complaints received by you since December 2012, both of which have now been satisfactorily resolved."

5.194 The email went on to summarise the discussion that had taken place. Some of the areas noted are as follows:

> **Job Plan** You are on an old style 10/11 contract. Your job plan was in the appraisal folder and consisted of a weekly timetable only. This had not been reviewed for a number of years. I advised you of the need for a job plan review using the standard Trust documentation, even for those on the old contract. I have copies this email to your CD so he can arrange a Job Plan meeting with you.
>
> **Activity Figures** Activity figures for both your Trust work and your private work are in your appraisal folder. We discussed your intensive workload and agreed that this should be a matter of discussion at your next Job Planning meeting…
>
> **Complaints and Significant** Incidents Your folder contained reflections on both. We agreed that you would immediately reflect in written form on the two complaints mentioned above and include this in your next appraisal.

5.195 Directing reflection on a significant incident or a complaint in next year's appraisal was not satisfactory. Dr Watt was subsequently appraised by Dr Hawkins on 21 November 2014 for Jan – Dec 2013. The Appraisal Folder contained a print out from Datix including reference to INI 334, INI 347 and INI 348. There is, however, no evidence of reflection in the appraisal folder, which appears to undermine effectiveness of the instruction from Dr Fullerton and highlights the importance of ensuring that written reflection is carried out contemporaneously. Dr Watt was subsequently not appraised again until 2017 and the written reflection required never materialised.

5.196 On the evening of 26th September Dr Stevens, having received the email from Dr Fullerton directed Andria Gormley *"to trigger a positive recommendation"*. On 26th September 2013 Dr Fullerton signed the revalidation record and Dr Stevens signed the same on 1st October 2013 noting: *"positive recommendation. See email trail with an agreement & met requirement. No outstanding issues re complaints"*. The revalidation record also notes under 'evidence from the Doctor and Dentist Review Committee' that *"recent issues re correspondence now satisfactorily resolved"*.

5.197 At the next DDCRM on 14th October 2013, the position was noted as follows:

> CURRENT POSITION
> Mr Watson noted the update from Dr Fullerton that he had seen a copy of the personal letter of apology sent by [Dr Watt] to the complainant, that another similar issue had been dealt with by [Dr Watt] and was not closed, that he had personally reviewed the Appraisal folder with a positive recommendation for revalidation, and that he had met [Dr Watt] and agreed a number of actions.
>
> ACTION
> Remove from DDCRM

5.198 Dr Fullerton did discover on 15th October that the response to the INI 349 complaint was outstanding. He emailed Dr Watt that afternoon:

> Michael,
>
> When we met I was assured that there was 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.
>
> Regards
>
> Ken

5.199 Dr Watt responded on 17th October:

> 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.

5.200 A further complaint had, in fact, been received by the Trust from a patient INI 350 on 12th September. It is unclear if anyone, including Dr Watt, was aware of this prior to 26th September discussion with Dr Fullerton. This complaint again centred on delay. On 14th October 2013 Dr Watt was removed from the DDCRM. Mrs Bernie Owens responded to the complaint in December 2013.

Maintaining High Professional Standards (MHPS):

5.201 A significant problem was that the focus on informality which is a feature of the first stage of the MHPS procedure, tended to also induce a lack of rigour. The procedure describes the first informal stage as follows:

> Paragraph 15 of Section 1 of MHPS (DHSSPS November 2005)
>
> The first task of the clinical manager is to identify the nature of the problem

> or concern and to assess the seriousness of the issue on the information available. As a first step, preliminary enquiries are essential to verify or refute the substance and accuracy of any concerns or complaints. In addition, it is necessary to decide whether an informal approach can address the problem, or whether a formal investigation is needed. This is a difficult decision and should not be taken alone but in consultation with the Medical Director and Director of HR, taking advice from NCAS or Occupational Health Service (OHS) where necessary.
>
> Page 43 provides an outline of the Informal Procedure and simply states in this regard "Clinical Manager (usually the MD) establish the facts"

5.202 How the facts are determined is left entirely to the discretion of the clinical manager. As the guidance is silent on the point there is, therefore, a wide margin of appreciation on the part of those who are tasked with investigation. In this instance, Dr Stevens had a different expectation of what steps should have been taken than Mr Hannon. This highlights the importance of clarity and effective management.

5.203 The Inquiry Panel is concerned that Dr Watt was never managed in or before this period in a fair but assertive manner. The informal process of MHPS is simply defined as not being the formal process. As stated above it rightly allows flexibility in the approach but does not justify overly relying on the regulator to avoid enforcing the Trust's own policies or developing clear terms of reference for any initial investigation. The manner in which the informal process was carried out at this time was characterised by a lack of robust interrogation, a failure to take expert advice, when necessary, keep file-notes of meetings, put findings in writing, collate relevant information, and set clear standards which hold employees to account against clear timescales. Conflation with the process of medical appraisal, designed to be developmental and not managerial further compounds the situation.

Triangulation of Data:

5.204 Any analysis of missed opportunities also needs to consider some of the communication between the Complaints Department and those looking at the actual complaints within the Service Department, with a view to triangulating the data. On numerous occasions the Trust systems, which utilised the Datix system did not identify accurately the number of complaints held in the system, an indicative example being the response of the Trust to the GMC in February 2012. Further, the Service Manager in the Neurology Department was involved in the complaints process and would have known about the complaints, but there seems to have

been minimal triangulation of data or identification within the Neurology Service Department or the Neurosciences Division. The effect of not accurately identifying all relevant complaints was to undermine the opportunity to discover any discernible pattern of aberrant practice.

5.205 A continuing problem that the Inquiry Panel identified in many of the investigations that were carried out was the failure of the person managing the process to ensure that all of the relevant information could be brought together. Accessing information from the Complaints Department or the Neurology Service was difficult and on a number of occasions, incomplete information was communicated to the investigator or the appraiser. The arrangements in place to assist an Associate Medical Director or other senior manager tasked with a Finding of the Facts investigation under the MHPS procedure were essentially *ad hoc*. There was no effective or reliable system to ensure that the Medical Director was properly sighted on all aspects of a doctor's practice. Information on Dr Watt was held in a range of locations, and it was never the case that all of the relevant information could be viewed by the person charged with analysing the problems that had arisen. The Belfast Trust has now drawn up a professional governance report to address some of these problems, although the detail in respect of this has not yet been viewed by the Inquiry.

Labelling of issues as being 'Administrative' in nature:

5.206 The Inquiry Panel was struck by the repeated references in the documents and in the evidence to Dr Watt's problems being of an administrative nature, as if administrative deficiencies were irrelevant to a doctor's clinical abilities. In some instances, one can understand why one could take that view, but the failure to carry out an appraisal, provide a report to an insurance company where peoples' livelihoods are dependent on the outcome of such a report, goes well beyond an administrative deficiency. The Inquiry Panel takes the view that consistent failure in this regard betrayed an attitude towards both scrutiny and oversight, which should have been of major concern to the Trust as Dr Watt's employer.

5.207 Underlying the missed opportunities during this period was the perception among both colleagues and other medical practitioners that Dr Watt was a hard-working and good clinician and that any problems were essentially administrative. This assessment was the view of Mr Cooke and Mr Hannon who liaised together during the first Finding of the Facts exercise. As Mr Hannon put it: *"He [Mr Cooke] said, 'what's the fuss? I don't really want to go and meet him and create a whole stink'. More or less … we were at that point. Then at some point the GMC say 'right, we're not going to do*

anything more'. As Dr Stevens put it 'we believed him to be a good clinician and worth the effort."

5.208 The fact that the focus of concern at that time was on Dr Watt's administrative inadequacies, may well explain what was, in the Inquiry Panel's view, a 'light touch' approach to the clinical aspect of complaints. When some of the complaints, including INI 334, INI 347 and INI 348, are reviewed in retrospect, it is possible to discern a pattern of practice, which should have given rise to a train of inquiry. The pattern would have included traits such as inadequate examination of the patient, coming to a definitive view on diagnosis before all tests had been carried out, prescribing significant drugs at the first consultation and a rigidity in changing his opinion when further evidence is presented. The Inquiry Panel believes that complaints with a clear clinical dimension should be examined by another clinician with appropriate expertise in the area and, where appropriate, by an independent external expert.

Evidence that did not come to the Attention of the Medical Director:

5.209 Any analysis of this period must also consider evidence, which did not make its way to the Medical Director or to the Trust, principally a relevant complaint received by the Ulster Independent Clinic, concerns held by registrars in Neurology and by GP's as discussed below.

Ulster Independent Clinic Complaint:

5.210 On 9th January 2012, INI 325's mother wrote to the Ulster Independent Clinic regarding the treatment of her daughter in February 2011. Dr Watt had stated in a letter to INI 325's GP that *"examination was unremarkable"*. It was pointed out by INI 325's mother:

> Dr Watt did not clinically examine [INI 325], he did not look into her eyes or carry out any neurological tests … [INI 325] had an MRI carried out on 5th June 2011 at the Ulster Independent Clinic and was diagnosed with a tumour.

5.211 Miss Diane Graham, Matron/Chief Executive of the Ulster Independent Clinic, asked Dr Watt to respond to the complaint. In a letter of 31st January, Dr Watt stated: *"I did not perform a full clinical examination because there was nothing on history to suggest that it would influence my decisions regarding diagnosis and management"*. On 7th February 2012, Miss Graham wrote to INI 325 enclosing Dr Watt's statement and offering to facilitate a meeting with him. She also stated: *"For information each*

consultant using facilities at the Ulster Independent Clinic does so in the capacity of a self-employed practitioner". This approach is commented upon further in the chapter on the Independent Sector.

5.212 On 9th February 2012, Miss Graham responded to a query from the GMC in relation to the INI 45 complaint. The original letter from the GMC could not be located but Ms Graham confirmed that they had no information about the INI 45 complaint and stated that the internal audit system *"does not highlight any concern regarding Dr Watt"*. Miss Graham added *"I am currently dealing with a complaint by a mother regarding her daughter's consultation with Dr Watt."* The Inquiry received no evidence that this reference was ever explained or expanded upon, further queried by the GMC, or brought to the attention of the Belfast Trust. This matter is further explored in the chapter on the Independent Sector.

5.213 Dr Stevens noted that he was not aware of the INI 325 complaint, which had arisen in the Ulster Clinic and commented specifically on the separate Finding of the Facts exercise carried out in 2011 and 2013:

> We now also, in retrospect, know about the INI 325 case in the independent sector, which, I think, was very interesting and I was not aware of. I think we carried out two informal exercises under Maintaining High Professional Standards at that stage, in '12 and '13 — two different Associate Medical Directors, who both came back and said they did not feel there were any clinical issues. I've read their testimonies, and there's not a lot of detail in there about the depth they went to in their investigation, but, in retrospect, I probably left with the conclusion that it wasn't as thorough as it should've been, and I have to take my responsibility for that as well.

5.214 Dr Stevens outlined that if he had knowledge of the INI 325 complaint contemporaneously when Dr Watt was under consideration at the DDCRM then *"I think that would have triggered something"*. Dr Fullerton expressed similar sentiments, outlining in oral evidence of 5th November 2019 that: *"had that been in my possession at the time, I might've taken a very different view"*.

5.215 2012-2013 highlighted significant problems in communication between the independent sector and the Responsible Officer. The independent sector cannot avoid its own responsibilities in seeking to operate a private hospital. The standard of care must be analogous to that in the NHS and by definition, this will entail having a proper governance framework that can manage and oversee the system generally. Patients have the same right to expect that their safety is paramount, whether they are being treated privately or in the NHS.

5.216 The failure by the Ulster Independent Clinic to bring to the attention of the Responsible Officer the INI 325 is not justified by the independent provider taking the view that they have spoken to the relevant doctor and reassured themselves. There needs to be a recognition that a clinician whose main practice extends to not just the National Health Service, but to other private clinics, may have similar complaints in other parts of the system. That was the reality of the situation in Dr Watt's case.

5.217 It can legitimately be argued that the chances of further inquiry would have increased if the INI 325 complaint had been forwarded to the Medical Director's Office by the Ulster Independent Clinic. It quite clearly should have been brought to Dr Stevens' attention. Secondly, the pre-existing narrative that Dr Watt's problems were administrative and did not in any way involve his clinical acumen was strengthened considerably by the decision of the GMC not to take any further action on the INI 45 complaint. A subsequent review has found that the earlier decision of the GMC was potentially 'materially flawed' and the Inquiry Panel believes that if a GMC sanction had been given at that time this would have caused a much greater clinical focus on the Finding of the Facts exercises carried out in 2012 and 2013.

5.218 The development of new systems and oversight of the independent sector is commented on in the chapter dealing with that sector, but for the purposes of the period in question, the Inquiry Panel takes the view that the failure to escalate to the Responsible Officer in the INI 325 case was a serious omission and could have changed the direction of the investigation, which unbeknownst to the Ulster Independent Clinic was then taking place.

Registrar Concerns:

5.219 In or about the summer of 2013, then neurology registrar Dr Ingrid Hoeritzauer met with Dr John Craig, the then Clinical Director. Dr Hoeritzauer stated to the Inquiry Panel that she had raised four cases of concern in relation to Dr Watt with Dr Craig. Dr Hoeritzauer, in her evidence, believed that Dr Craig was going to look into this himself. It is common case that Dr Craig did not get back to Dr Hoeritzauer, nor did he take a note of the conversation. Dr Craig took the view that Dr Hoeritzauer did not wish the concerns raised to be taken further when the formality of investigation was explained. Dr Hoeritzauer in her evidence was clear that her understanding was different. The Inquiry accept that Dr Craig genuinely believed that Dr Hoeritzauer did not wish to take the matter further. However, that was not or should not have been the end of the matter. It was a significant and courageous step for any registrar

to raise such concerns about a senior colleague and the Inquiry Panel wishes to commend Dr Hoeritzauer's actions. As the Clinical Director, Dr Craig could not 'unknow what he knew' and was obliged to record the concern and to escalate the issues raised.

5.220 Shortly after Dr Hoeritzauer had spoken to Dr Craig, she raised the matter with Dr Jamie Campbell, a fellow registrar, in the registrar's room. Dr Hoeritzauer's evidence is that Dr Craig had mentioned that another registrar had raised similar concerns with him. Dr Craig does not recall stating this and Dr Campbell confirmed to the Inquiry Panel that, while he discussed cases on an individual basis with Dr Craig, he did not go to see him specifically in the same manner as Dr Hoeritzauer. Dr Campbell does however recall Dr Hoeritzauer raising her concerns with him at that time.

5.221 In or around June 2013, Dr Ellen Campbell, at that stage a registrar within the Belfast Trust, had concerns following the prescription of medication to pregnant women during pregnancy. Dr Ellen Campbell believed one patient did not meet the criteria for a diagnosis of epilepsy. A number of cases were raised with Dr Jim Morrow, the former Clinical Lead & Clinical Director, who had undertaken to speak to Dr Watt about the particular cases. Dr Morrow did not discuss the matter with Dr Ellen Campbell again and to the best of the Inquiry's knowledge and belief, concerns were not raised with the Medical Director at this time. Dr Morrow was unable to give evidence to the Inquiry regarding Dr Ellen Campbell's concern because of his medical condition. These matters are explained and expanded upon further in the Concerns chapter.

5.222 The Inquiry Panel is satisfied that neither Dr Hoeritzauer nor Dr Ellen Campbell's concerns were brought to the attention of the Medical Director, Dr Stevens. These issues are explained and expanded upon in greater detail in the Concerns chapter.

5.223 Dr Watt's reputation as a hard-working and up to date neurologist was the consensus view of his own colleagues. Although Registrars had on occasions raised concerns at or about this time (2012/2013) regarding Dr Watt's approach these were not escalated further or investigated. It appears to the Inquiry Panel that Dr Watt's reputation was such that when concerns were raised, the default position of colleagues was to look for reasons as to why there was no need for concern or adopt an incurious approach on the basis that they genuinely believed Dr Watt to be a good clinician. It is not for the Inquiry Panel to come to a view on Dr Watt's abilities in this regard, but what should be highlighted is that the medical professionals, both working alongside Dr Watt and those in medical administration operated from

a background narrative that effectively inhibited or undermined inquiry. Too often those charged with medical management failed to escalate legitimate concerns. This raises a question of the extant medical culture, which is specifically commented on in a separate chapter.

GP Concerns:

5.224 Dr Paul Conn was a General Practitioner at the Ballygomartin Practice in North Belfast. He was tragically killed in a motorsport accident on 27th July 2019. He gave oral evidence to the Inquiry Panel on 30th October 2018 that those in his practice *"did have concerns … it seemed that [Dr Watt] was over-diagnosing and overtreating"*. At that time Dr Donagh MacDonagh had been appointed as Associate Medical Director for Primary Care Liaison in the Belfast Trust. Dr Conn rang Dr MacDonagh in his role as the out-of-hours Clinical Lead for Belfast Trust. At the end of a conversation about operational issues, Dr Conn referred to Dr Watt and that he *"really wanted to find out where there any other concerns because it was really…you know, he quite rightly said "if you have concerns you need to put them in writing to me." That just was, you know, it was a step at that time I didn't want to take"*. Dr Conn was candid in stating that he *"mentioned it almost off the record in a way to Dr MacDonagh to see were there any other concerns"*. In his oral evidence to the Inquiry, Dr MacDonagh recalled Dr Conn outlining a specific case and referring to two or three further cases, although Dr Conn did not inform Dr MacDonagh about other partners in his practice having concerns. Dr MacDonagh recalled emphasising that Dr Conn had to give him the names or speak to the consultant involved, a step Dr Conn was unwilling to take. Dr MacDonagh recalled this incident happening sometime in 2012/13. Dr MacDonagh also pointed out to the Inquiry that at the time of his discussion with Dr Conn he was not aware of any other concerns in respect of Dr Watt's practice. The interaction between Dr Conn and Dr MacDonagh is set out more fully in the Concerns chapter.

5.225 Unfortunately, Dr MacDonagh was incorrect in assuming that, because the concerns were not put in writing, or the patient numbers disclosed, he was unable to take it further. He should have reported the matter to the Medical Director although the Inquiry Panel accept that he mistakenly believed that he was constrained.

5.226 In his oral evidence of September 2019, Dr Stevens commented as follows on this issue:

> There were the GP concerns — the Paul Conn concerns — which, I guess, must've been around 2012, because Donagh MacDonagh took up post at the end of 2011, so it had to have been in 2012.

> I have looked — you asked me the last time I was here did I know about those concerns, and I have racked both my memory and my records, including my notes, and can find no evidence that I knew.

5.227 Dr Peter MacSorley was INI 5's GP who, in his 2013 appraisal, raised 3 cases concerning Dr Watt with his appraiser, Dr George O'Neill. In oral evidence to the Inquiry on 2nd October 2018, Dr MacSorley outlined as follows:

> I think it was a year or two afterwards, I presented three cases to my appraiser in relation to Dr Watt and they were in relation to the prescription of steroids, one of which was to a patient with MS and the other two were in relation to - - and in both cases the CT scan or the MRI scans, did not show inflammatory - -… his line as far as I can see was that he considered that we were dealing with an inflammatory condition, which may be MS, that does not show up on a MRI scan and that to me was very challenging.

5.228 Dr O'Neill's commentary on the appraisal reads as follows:

> His Form 3 was open to criticism as it contained a polemic related to justifiable concerns he has surrounding the prescribing budget, and also praises and is critical of individual clinicians. These issues are for other venues and are not appropriate material for the Form 3.

5.229 The Inquiry Panel does not accept Dr O'Neill's analysis that concerns about a consultant should not be raised in an appraisal. It was the case that Dr MacSorley should have ensured that his concerns were effectively escalated and if he felt that Dr O'Neill would not do this to take them elsewhere. Dr O'Neill also had a responsibility to escalate the matter. As an appraiser he also could not 'unknow' what he knew.

5.230 The Inquiry Panel has received no evidence, nor was it suggested by Dr MacSorley or Dr O'Neill, that this matter had been raised or brought to the attention of anyone within the Trust.

INI 45 Reconsideration by the GMC:

5.231 In his evidence, Dr Stevens addressed the point that, in 2012 *"the wind had been taken out of us a little bit by the GMC"* not taking action with regards to the INI 45 complaint. It is noted that the GMC decided to conduct a review of the INI 45 decision pursuant to Rule 12 (2) (a) of the General Medical Council (Fitness to Practice) Rules 2014 after the suspension of Dr Watt in 2018. Rule 12 (2) (a) and 12 (3) states as follows:

> (2) The Registrar may review all or part of a decision specified in paragraph (1) on his own initiative or on the application of the practitioner, the maker of the

allegation (if any) or any other person who, in the opinion of the Registrar, has an interest in the decision when the Registrar has reason to believe that—

(a) the decision may be materially flawed (for any reason) wholly or partly; or

(b) there is new information which may have led, wholly or partly, to a different decision,
but only if one or more of the grounds specified in paragraph (3) are also satisfied.

(3) Those grounds are that, in the opinion of the Registrar, a review is–

(a) necessary for the protection of the public;

(b) necessary for the prevention of injustice to the practitioner; or (c) otherwise necessary in the public interest.

5.232 In the decision, which was forwarded to the Inquiry in March 2019 the Assistant Registrar in the GMC concluded that the original decision taken in relation to Dr Watt following the complaint in 2011 may have been materially flawed. It was noted that Dr Watt had not given reasons for his diagnosis of exercise-induced migraine and the original case examiners, despite criticising aspects of the care given to the patient had no substantial evidence of remediation to address the deficiencies in care. Given the subsequent performance concerns raised and the comprehensive investigation initiated by the GMC, the Assistant Registrar concluded that a further review was not in the public interest.

5.233 A separate chapter deals with the role of the GMC as the Regulator. The Inquiry Panel accepts, however, that in the context of considering 2012/2013 as a missed opportunity, the inadequate investigation by the GMC did have a significant influence on subsequent investigations by the Belfast Trust. It is, of course, the case that the Trust had a responsibility, regardless of steps taken or not taken by the GMC, but the effective dismissal of a complaint by the doctor's Regulator makes it more difficult for the employer to adopt an entirely different view. That said, it is not sufficient for an employer charged with ensuring patient safety to rely solely on the judgment of a GMC investigation, without looking at the issues raised independently. The Finding of the Facts reviews, by Mr Hannon, in particular, but also the review by Dr Fullerton, the Associate Medical Directors, were both influenced by the outcome of the GMC investigation into INI 45. The difficulty in such an approach is that any flaws identified in the GMC analysis were not identified by the Trust, who were overly reliant on the GMC, whereas both had a separate and distinct responsibility for patient safety.

Conclusions and Findings:

5.234 The Inquiry was asked to determine whether there are any complaints, concerns or related circumstances, which should have alerted the Belfast Trust to instigate earlier and more thorough investigations. The focus of this chapter were the years 2012/2013 because of the number of events that occurred during that period.

5.235 It was instructive for the Inquiry to have analysed the complaints relevant to the period in question. The list below repeats events which are detailed earlier in this chapter, but separates them into those issues which were brought to the attention of the Medical Director or those with senior management responsibility and those that were brought to the attention of other medical professionals but were not escalated to the Medical Director/Responsible Officer or those with senior management responsibility:

(i) A 5-year GMC warning in 2007 was unexpired.

(ii) The GMC had contacted the Belfast Trust because of a failure by Dr Watt to complete a report for the GMC (INI 346). No link was made by either the Trust or the GMC with the earlier warning, despite the fact that it related to a similar type of transgression.

(iii) Dr Watt's failure to complete appraisals was an ongoing problem, which was insufficiently and inadequately managed.

(iv) The failure to mention certain complaints in the appraisal was picked up by the then Associate Medical Director Mr Hannon and the Senior Manager in the Medical Directors office, Mr Watson. This was a factor at the DDRCM but does not seem to have been a focus at a subsequent appraisal nor directly confronted by management.

(v) Appraisal was at times being relied on for performance management purposes despite being designed as a reflective process.

(vi) Numerous complaints with a clinical dimension were extant or made at this time including INI 45, INI 347, INI 334 and INI 348.

(vii) There were additionally earlier complaints in 2010 and 2011 including INI 5, INI 417, INI 419, INI 418 and INI 431.

(viii) Two separate Finding of the Facts exercises, pursuant to the MHPS procedure were carried out by Associate Medical Directors during this time under the oversight of the DDCRM and the Medical Director. In April 2012 Mr Hannon was tasked to consider various matters, having regard to the GMC investigation into INI 45 and other matters. The outcome was that there was to be a recorded conversation with Dr

Watt. This was eventually replaced simply by a letter of 19th July, which referred to a small number of complaints noting a "bad attitude" and 3 other complaints including INI 5 and INI 346 about which Dr Hannon did not have any other details. The correspondence requested that Dr Watt reflect on these matters at his next appraisal.

(ix) In June 2013 after earlier referral to the DDCRM Dr Fullerton was tasked by the Medical Director to carry out a further Finding of the Facts exercise. At this time initial concerns about the failure to carry out appraisal and impending revalidation were reinforced by several new complaints including INI 348, INI 334 and INI 347. Dr Fullerton reviewed all the complaints and exercised his own clinical judgement that there was nothing of clinical concern. The focus therefore quickly shifted to Dr Watt's impending revalidation and Dr Watt was approved for revalidation after significant input from Dr Fullerton.

5.236 In addition to those issues, which were within the knowledge of the Medical Directors office other relevant complaints and concerns were made during this period which were not brought to the attention of the Medical Director or senior management. These included:

(i) A complaint made to the Ulster Independent Clinic by INI 325 relating to the alleged misdiagnosis by Dr Watt which was not passed on to the Responsible Officer.

(ii) The UIC response on 7th February 2012 to the GMC, having been contacted regarding INI 45 stating 'the internal system of Ulster Clinic does not highlight any concerns regarding Dr Watt … I have no further information regarding the complaint which you have highlighted. I am currently dealing with a complaint by a mother regarding her daughter's consultation with Dr Watt.' This referred to the INI 325 complaint but was not followed up by GMC.

(iii) A call for a review of the prescribing of HIG on grounds of cost was made by the Director of Commissioning at the HSCB, which was not linked to the fact that Dr Watt was the outlier[15] in respect of the prescription of HIG.

(iv) In June 2013, Dr Ellen Campbell was concerned about the diagnosis of epilepsy by Dr Watt in several cases involving pregnant women, which caused her to speak to her the former Clinical Lead, Dr Morrow. There is no evidence that this was reported to the Medical Director although we have been unable to put the question to Dr Morrow.

15 The fact that a doctor is an outlier is not per se a problem as there will often be a wider margin of approach between different doctors. Being an outlier, however, does give rise to the possibility of investigation in relevant circumstances and HIG would have been a relevant circumstance, particularly when questions were being asked by the Health & Social Care Board about its use.

(v) In or about the summer of 2013, Dr Ingrid Hoeritzauer went to Dr John Craig, her Clinical Director with concerns about Dr Watt's clinical practice. These were not reported to the Medical Director or senior management.

(vi) The Inquiry notes that in or about 2013, Dr Peter MacSorley raised with his appraiser three cases in relation to Dr Watt, where, in his view, steroids had not been properly prescribed. It was the responsibility of Dr MacSorley to ensure that the matter was effectively escalated, but it was also something, which could have been escalated by his appraiser Dr O'Neill.

(vii) In or about 2013, Dr Paul Conn (now tragically deceased) raised with Dr Donagh MacDonagh, the Trust Associate Medical Director for Primary Care, concerns about Dr Watt's practice. These were not passed on to the Medical Director even though the patients' details were not given to Dr MacDonagh, as Dr Conn wished to reassure himself others had also complained.

5.237 Dr Stevens, former Medical Director of the Belfast Trust, attended the Inquiry to give evidence on two occasions. In his last appearance on 3rd September 2019, Dr Stevens, having reflected in some depth on the material received, gave an opening statement to the Inquiry. In relation to the period 2012/2013 he stated:

> He [Michael Watt] then came back into orbit in 2012-13, and I think that's probably the most crucial period and, if I'm honest, I think, the time when we may have missed the opportunity to pull him in.

5.238 It was clear from the contemporaneous written material that the Medical Director, Dr Stevens was uneasy about the number of times Dr Watt was being mentioned. He gave several directions that the concerns should be further investigated, but despite several investigations, nothing emerged which caused a clinical concern. Dr Stevens had many of the right instincts and the Panel is aware of other instances where he did take action, where there was evidence of competence issues involving a clinician. Following his first appearance at the Inquiry, he returned and had perhaps reflected more than any other witness on what he believed the failings were at the relevant time. For that, he deserves credit, and he provided an example of how to confront the difficulties of the past.

5.239 He did so against a backdrop where no flags were being raised by Dr Watt's colleagues, which corroborates the Medical Director's own view that while *"he would acknowledge Michael's clinical skills and commitment"* there was *"an issue about administration and communication that has previously caused him difficulty"*.

5.240 The Inquiry Panel is satisfied that 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. The Inquiry Panel agrees with Dr Stevens that the period between 2012 and 2013 was a missed opportunity.

CHAPTER 6 – FEBRUARY-NOVEMBER 2016 MISSED OPPORTUNITIES

Introduction

6.1 As was the case in both 2006-2007 and 2012-2013, the Inquiry identified several key periods where it believes there were related concerns or circumstances, which should have alerted the Belfast Trust to instigate an earlier and more thorough investigation. 2016 was a further period, which was examined by the Inquiry as a possible missed opportunity.

6.2 Some of the 2016 material that was analysed by the Inquiry Panel was proximate to the index concerns raised by Dr Fitzpatrick with the Medical Director's Office in November 2016. Given that action was taken at that time, the question arises as to whether it would have affected the timing of the patient recall or amounted to concerns or circumstance which should have alerted the Belfast Trust to instigate an earlier and more thorough investigation.

6.3 The Inquiry Panel believes that there are significant lessons to be learned from a governance perspective on the manner in which information was assessed, collated and acted upon in the period February to September 2016.

6.4 From February 2016 onwards, the Belfast Trust was dealing with a number of concerns with regards to Dr Michael Watt at various levels within the clinical governance structure. Further, there were additional concerns outside of the Trust, which were not brought to the attention of Dr Cathy Jack, as Dr Watt's Responsible Officer. As a number of these concerns ran concurrently, it is not possible to set all the concerns out in chronological order. This chapter will, therefore, examine concerns in the following order:

(i) INI 286 Concern received from the NHSCT.

(ii) Matters discussed at the DDCRM in March 2016.

(iii) Matters discussed at a meeting in August 2016.

(iv) Further Concerns within the BHSCT not discussed at either the DDCRM or August 2016 meetings.

(v) Further Concerns outside of the BHSCT.

Evidence:

INI 286 Concern

6.5 At the core of concerns about a missed opportunity in 2016 was the events surrounding issues raised by Dr Lowry[1], the Medical Director of the Northern Trust, with Dr Jack, the then Medical Director of the Belfast Trust, on 1st February 2016. The Concerns chapter sets out in some detail the actions taken by Dr Jack and the advice of Mr Peter Watson, the senior Manager in the Medical Director's Office, and commends the decision to obtain an independent expert report at a time when there was disagreement between three doctors in the Northern Trust and Dr Watt and Dr Mark Magorrian in the Belfast Trust on the diagnosis of stroke by Dr Watt.

6.6 On 25th January 2016, INI 286's mother complained to the Northern Trust regarding the treatment of her son by various doctors in the Northern Trust. The patient went to see Dr Watt privately at the Ulster Clinic and Dr Watt disagreed with the diagnosis of the Northern Trust doctors. All three doctors in the Northern Trust, Dr Tom Esmonde, Dr Joy Cuthbertson and Dr Djamil Vahidassr were sufficiently concerned regarding the difference in treatment and potential harm to the patient that they approached the Medical Director in the Northern Trust, Dr Ken Lowry.

6.7 Dr Lowry passed the concerns to Dr Jack on 1st February 2016. Following an earlier telephone conversation, Dr Lowry emailed Dr Jack as follows: *"the patient has significant neurological symptoms but normal CT x6 and MRI x2. All of the clinicians who have seen him in Antrim believe there is no physical explanation for his symptoms and are concerned that he is being harmed by unnecessary treatment and by not having his symptomology challenged"*. Dr Jack was clear in her evidence of 12th December 2019 that this was a clinical concern: *"I'm dealing with the concern. The concern is mine. They are dealing with the complaint"*.

6.8 Dr Jack immediately forwarded this email to Mr Watson, Senior Managers in the Medical Director's Office. He responded to Dr Jack on the same date, copying in representatives from NCAS, with whom Mr Watson had already engaged. In his email, Mr Watson advised as follows:

> In this case there are three separate institutions involved, NHSCT as the NHS provider of care, BHSCT as the employer of Dr Watt, and the Ulster Independent Clinic as the host provider of the private care.
>
> I would expect that NHSCT in managing this complaint will seek to engage with Dr Watt, and I would suggest that as his Responsible Officer it would be

1 Dr Lowry sadly passed away in April 2022 prior to the publication of this report.

> prudent for you to write to Dr Watt to confirm your expectation that he would cooperate with NHSCT in a timely way. We would need of course to disclose the complaint and email from Ken to Dr Watt.
>
> In relation to us as the employer of Dr Watt and our concerns regarding patient safety for patients at BHSCT, it would seem prudent for us to share the details with Dr John Craig, for him to discuss with Dr Watt and to confirm to us whether consequent upon this or other cases he has any concerns regarding the clinical practice of Dr Watt. Finally, I would suggest that we require Dr Watt to share details of the complaint and the email with his colleagues at the Ulster Independent Clinic in order that they can determine for themselves if any action is indicated; obviously if we decide that action is indicated ourselves then we would need to ensure that UIC were aware of this.
>
> I have spoken with Colin Fitzpatrick of NCAS this afternoon and he is in agreement with the strategy outlined above.

6.9 NCAS responded to Mr Watson formally by way of letter on 2nd February 2016 as follows:

> We discussed options open to you. You intend to write to the Consultant pointing out that he is expected to co-operate fully with the investigation being commenced by the Northern Trust. You have no other significant concerns about the Consultant, so there does not appear to be an immediate patient safety issue. You will however disclose the information received from the Northern Trust to the Clinical Lead for Neurology and check whether he has any concerns about the Consultant's practice. You will also seek an assurance from the Consultant that he will inform the Medical Director of the independent clinic in which he was practising of the issue.

6.10 It is instructive to note that the Northern Trust concern had been raised in February 2016 by the Medical Director's Office directly and appropriately with Dr Colin Fitzpatrick, who at that stage was an NCAS adviser in Northern Ireland. It was Dr Fitzpatrick who subsequently brought the index cases to the Medical Director's Office in November 2016. Dr Fitzpatrick's evidence was that the NCAS' file on this matter had been opened and closed on the same day. On being asked why this was the case, Dr Fitzpatrick told the Inquiry Panel on 13th May 2019:

> **Mr Lockhart QC:** Yes, because you were the NCAS adviser, and you opened the file, closed the file the same day.
>
> **Dr Fitzpatrick:** yes, yes, because it was a pretty – it was a single episode, and the picture I got when I was – I'm going back to the NCAS thing now – the picture I got when I was talking to Peter Watson at the time was that this was one episode. He didn't say, "this is a guy we've got real concerns about" because I wouldn't have closed the file otherwise.

6.11 In line with the plan of actions proposed by Mr Watson, approved by NCAS, Dr Jack wrote to Dr Watt on 3rd February 2016. Relevant extracts from the correspondence are set out below:

> In relation to the BHSCT as your employer and our concerns regarding patient safety for patients at BHSCT, I have shared these details with your Clinical Director Dr John Craig, for him to discuss them with you, and to confirm to me whether consequent upon this or other cases he has any concerns regarding your clinical practice …
>
> Maintaining High Professional Standards (MHPS) … is the framework for the management of concerns about the conduct, health or clinical performance of a doctor and I will therefore consider these concerns within that framework.

6.12 Dr Craig emailed Dr Watt on 8th February 2016, copying in Mr Watson and Dr Jack. This email was further to a discussion the two had had and noted the following:

> 1) The patient is now under the care of the BHSCT.
>
> 2) That your clinical diagnosis is still that he has had a stroke. I did record that you had stated that you have reviewed this on a number of occasions.
>
> 3) That another consultant Dr Magorrian, from the BHSCT, has seen the patient and agreed that the patient has likely had a stroke.
>
> Please be aware that I will be contacting Dr Magorrian in regards to his involvement in the case.

6.13 Dr Craig then discussed this matter with Dr Magorrian and confirmed by way of email on 11th February 2016 that Dr Magorrian had seen INI 286 in a clinic at the BHSCT, that *"on the balance of probabilities and having considered the information available, that you were also of the opinion that he could have had a brainstem stroke"* and that he subsequently discussed this case with Dr Watt.

6.14 On receipt of the views of Dr Watt and Dr Magorrian, Mr Watson advised Dr Jack and Dr Craig on 11th February 2016 that:

> In the context of disputed opinion from colleagues at NHSCT and at BHSCT, it may seem appropriate to seek an independent review of the care of the patient who is now a BHSCT patient it would presumably be for us to lead on securing this opinion, sharing with the patient / family the details regarding the differing views (which they are already aware of) and our wish to ensure that they can be assured regarding current diagnosis, care and treatment. We could of course also with the patient's permission advise NHSCT of the approach we would be taking.

6.15 Mr Watson is to be commended for appreciating the significance of the issue and identifying the importance of having this matter independently reviewed and advising Dr Jack accordingly. Equally, Dr Jack acted promptly and appropriately.

6.16 Steps were then taken to establish such an independent review. Dr Craig initially suggested Dr McVerry or Dr McCarron, two neurologists in Altnagelvin with an interest in stroke noting that: *"for advice on complex neurological matters, especially relating to diagnostic matters, generally only flows in one direction, i.e. it is neurologists who are asked for their opinion not the other way around"*.

6.17 On 18th February 2016, Mr Watson spoke with Dr Lowry who confirmed that the NHSCT would release the medical notes. In response to this, Dr Craig indicated that: *"I would have thought that it is only proper to have informed Dr Lowry that another consultant in the BHSCT backs up Dr Watt's clinical opinion. The implication is therefore that there may equally be potential concerns in regards to the agents of the NHSCT who have brought their concerns forward"*. Mr Watson confirmed that Dr Lowry was advised of this.

6.18 On 24th February 2016, Dr Jack wrote to INI 286 and informed him that: *"colleagues at the Northern Health and Social Care Trust believe that the diagnosis you have received from our Consultant Dr Watt is not correct. Dr Watt and Dr Magorrian at the Belfast Trust both believe that on balance the diagnosis that they have made is correct"*. The letter outlined that Dr Jack's *"first concern is to ensure that we can all be confident that your diagnosis and treatment is correct and appropriate"*. The plan to pursue an independent review based on the records from the NHSCT, BHSCT and private sector was outlined and INI 286 was asked to confirm that they were content.

6.19 On 14th March 2016, INI 286's wife confirmed that they consented to the review. Steps were then taken to obtain the relevant notes.

6.20 On 3rd May 2016, Dr Craig emailed Dr Raeburn Forbes, the ABN[2] representative for Northern Ireland, to see if a neurologist with an expertise in stroke could be identified to conduct the independent review. On 17th May 2016, Dr Forbes enquired with the ABN about an independent expert to conduct the review. Professor Adrian Wills, a consultant neurologist from Nottingham University Hospital confirmed his availability.

6.21 On 6th June 2016, Mr Watson wrote to Professor Wills, subsequent to an earlier telephone conversation. The notes from the BHSCT, NHSCT and private sector were enclosed along with the letter of complaint to the NHSCT and the BHSCT's correspondence of 4th March 2016. With regards to the question of issues to be

2 Association of British Neurologists.

addressed, Professor Wills was asked to *"advise the Belfast and Northern Trusts as to the appropriateness of the diagnosis, care and treatment provided to the patient"*.

6.22 In his report of 7th June 2016, Professor Wills came to the view, on the basis of the medical records and letter of complaint, that INI 286's symptoms were non-organic and that he was suffering from a functional neurological condition. He, therefore, agreed with the Northern Trust doctors and not with Dr Watt and Dr Magorrian, who had also reached the conclusion that the patient had suffered a stroke. In the opinion section of the report, Professor Wills stated as follows:

> [INI 286] has presented with a bewildering array of symptoms. Management of his case must have been challenging for the various Healthcare Professionals involved in his care. I have carefully considered whether [INI 286] is suffering from an organic neurological illness. Most Neurologists are aware that no investigation is 100% sensitive, and it is possible for patients with stroke or epilepsy to have normal investigations. However, in this case, given the severity of [INI 286's] disabilities, in the face of recurrently normal investigations, I am of the view that his symptoms are non-organic and that he is suffering from a "functional" neurological syndrome e.g. a psychologically mediated disorder.
>
> In these disorders, symptoms in the body, which appear to be caused by problems in the nervous system, are not caused by a physical neurological disease. Health professionals sometimes call these disorders 'medically unexplained' or psychosomatic. These disorders are quite common, occurring in about one quarter of patients seen in neurology clinics. For some people these symptoms are persistent and very disabling. Symptoms tend to change with time, and as a result patients may often repeatedly consult different doctors for advice or investigation. Many doctors also find these conditions puzzling, and patients may become frustrated by the shortage of information about why these symptoms occur and what to do about them.
>
> My advice would be that this diagnosis is explained to [INI 286] on a face-to-face basis by a senior member of the team currently responsible for his clinical care. He should be directed to the 'functional disorders' website at http://www.neurosymtpoms.org. I do not know if there is a Neurologist in Northern Ireland with a particular interest in this field. If there isn't and there are still therapeutic difficulties, then [INI 286] could be referred further afield for ongoing management. There are appropriate specialist services in Sheffield, Glasgow and London (UCL).

6.23 Following receipt of Professor Wills' report, Mr Watson sent the report to both Dr Watt and Dr Magorrian. In an email of 28th June 2016, Mr Watson stated to both doctors:

> I enclose a copy of a report from Professor Adrian Willis [sic] and regarding INI 286.
>
> Prior to considering what actions should be taken on foot of this report, Dr Jack has asked that you provide your considerations to her as soon as possible, and no later than Thursday 7 July 2016.
>
> I should confirm that the report has not, nor will be, shared more widely at this time.

6.24 Dr Magorrian responded promptly on 30th June. In a balanced reflection on the matter, Dr Magorrian stated:

> Professor Wills acknowledges that the management of [INI 286's] case must have been challenging for the various healthcare professionals involved in his care. From reviewing the available information, it is clear that this has been the case. It has also clearly been a real challenge for [INI 286] and his family.
>
> I do not have all the answers. Perhaps [INI 286's] problems are all non-organic. It could be an organic problem with some psychological problems on top. Or it could be all organic.
>
> There are grey areas. I have been working long enough to know that I, like anyone else, can be wrong. My general impression at the time I assessed [INI 286] was that there was a reasonable chance he had had a stroke with various other problems secondary to this. I remain open minded about diagnosis.

6.25 Dr Ivan Wiggam, Clinical Lead for Stroke Services at Belfast Trust, had also been forwarded the report. In a brief response to Mr Watson, he stated:

> I note that John Craig has previously been copied in and I think that John should be kept in loop as this involves a patient at the neurology-based TIA clinic, with input from both Michael Watt and Mark Magorrian (who does sessions there).
>
> I note the independent review is in keeping with some of the opinions offered at NHSCT and I suspect the NHSCT will wish to make reference to that.
>
> Differences of opinion in medicine, especially in difficult cases, are inevitable. Moreover, functional illness and physical problems often coexist.

6.26 It is of note that there is no recorded view expressed from Dr Craig, Dr Watt's Clinical Director. In oral evidence of 16th January 2020 Mr Watson addressed this issue as follows; *"Do I see John Craig specifically being asked for a view? And providing the same? I don't…Do I see John Craig specifically asked the question, do you think there's a problem? I don't see that in the records that I've looked at."*

6.27 After several reminders from Mr Watson, Mr Young and Dr Craig, Dr Watt emailed Mr Watson on 26th July 2016 and indicated that he was *"happy to go with Professor Wills' recommendations"*.

6.28 The Inquiry Panel considered at some depth as to why further action was not taken on receipt of Professor Wills' report, given that he had essentially agreed with the diagnosis of the three Northern Trust physicians. The Inquiry Chairman enquired of Dr Jack as to why Professor Wills had not been specifically asked about whether Dr Watt's treatment had fallen below a standard. She stated:

> **Mr Lockhart QC:** Did you not need to ask him if it fell below a standard? You inferred that he hasn't. You said about "appropriate" treatment.
>
> **Dr Jack:** Yes … well rightly or wrongly, we didn't. I would have thought if you are saying, "is the diagnosis, care and treatment appropriate?" to say it's appropriate or not … but reading his opinion, my view was, "he didn't ping him." I remember that: he didn't ping him. And then we'd go to the CDs.

6.29 Dr Craig, in his evidence of 19th December 2019, agreed with Dr Jack that the report from Professor Wills did not suggest that Dr Watt had fallen below the threshold. Mr Watson was also of the opinion that Professor Wills had not stated that Dr Watt had acted inappropriately. In evidence of 16th January 2020, he stated:

> Nowhere in this document, as an independent expert, nowhere does he say the case provided by Dr Watt here is not of an acceptable standard. I would have expected that if a doctor asked in relation to a colleague that they would have identified that. I don't even know Professor Wills' view, and perhaps we will never know.
>
> My initial view of the Wills' report, there is no real concerns about Dr Watt in here … and our focus is dealing with how we are going to manage this patient and the complainant.

6.30 In his evidence of 16th January 2020, Mr Watson told the Inquiry Panel:

> … Did we get an absolutely clear answer to those questions? I am not sure that we did in the report that was received. Certainly I, reading that report, don't see Professor Wills having identified that Dr Watt was acting inappropriately … He comes down on functional. He also then talks about how "many doctors also find these conditions puzzling", in the paragraph below it. So, at the time, rightly or wrongly, -- I did not identify this, perhaps because I was not aware of any of the history and wasn't sensitised to it, but I did not read this report as providing an expert opinion, 'here you have a problem with Dr Watt' … I have said I regret that we didn't expressly repeat the question, because we had asked the question … What we get back is, it could almost be read as a case

> for the defence for Dr Watt in terms of the first paragraph … Nowhere in this document, as an independent expert nowhere does he say the care provided by Dr Watt here is not of an acceptable standard. I would have expected that if a doctor asked to provide an expert opinion had identified a concern in relation to a colleague that they would have identified that … if you want to find out if there's a concern about a doctor's performance in the context of care and treatment, you don't actually have to ask the expert the question. The expert has a duty to flag that … do I wish we had gone back and asked the question in as many words? Absolutely …

The Inquiry Panel accepts that Dr Jack acted in good faith in coming to the view that Professor Wills had not, in her words, *"pinged"* Dr Watt, in relation to his professional practice. In retrospect, it would have been better if Professor Wills had been asked more about the approach taken by Dr Watt and specifically whether it fell below an acceptable standard. That said, the Inquiry Panel can understand that, given the views of Dr Magorrian and Dr Wiggam, it was reasonable to conclude that this was a normal disagreement between physicians. In the absence of Professor Wills having been specifically asked if he had any concerns about Dr Watt's practice or whether the care and treatment fell below an acceptable standard, in the view of the Panel, Professor Wills should not be criticised for not addressing these issues in his report.

6.31 Matters are compounded by the fact that although the Northern Trust's concern was initially referenced by Mr Watson in the Medical Director's Office in December 2016, following the index cases of concern raised by Dr Fitzpatrick, the issue of what happened in the Northern Trust concern was not reviewed or referenced again.

6.32 Though not unreasonable, in view of Professor Wills' report to conclude that this was a disagreement amongst various neurologists, a main criticism of the Trust is that the matter was not reviewed when further concerns were raised by Dr Fitzpatrick in November 2016. A handwritten note on 1st December 2016 by Mr Watson does reference the INI 286 case, but the matter is not followed up on at any stage. The sense from the Belfast Trust is that once a decision has been taken to close a case, whether it be revalidation or, in this instance, the findings of an independent report, that is the end of the matter. The problem with such an approach is that every case must be considered without reference back to potentially similar incidents, which may suggest an aberrant pattern of practice.

Meeting with INI 286, and the Disclosure of the Wills Report:

6.33 Following Dr Watt's agreement to treat INI 286 in line with Professor Wills' recommendation, Mr Watson drew up an email to Dr Craig and Dr Jack on 28th July 2016 suggesting the approach to be taken as follows:

> I would suggest that we should seek to arrange a meeting chaired by Dr John Craig (as Clinical Director) with Dr Watt in attendance (as the current consultant in charge of the patient's care). At this meeting, the findings of Professor Wills and the comments of BHSCT colleagues can be shared with the patient and his wife. At the same meeting I would suggest that Dr Craig seeks the consent of the disclosure of the report to NHSCT. It would also be helpful if Dr Craig and Dr Watt would discuss with the family how the NHSCT complaint might be closed in a context where the approach of the NHSCT has at the very least been understood by Prof Wills to be not unreasonable.
>
> Only today, I have received a further voicemail from [the patient's mother] and I would wish to be clear on the approach which we will now take, prior to calling her back.
>
> Consequently, I would be grateful for your consideration of this approach asap.
>
> Finally, if the approach is agreed, I will relay this to NHSCT.

6.34 Dr Jack confirmed on 1st August that she was content with this approach and Mr Watson indicated that he had briefed Dr Lowry on the next steps. It was unfortunate that even the gist of what Professor Wills had stated in his report was not disclosed to Dr Lowry. It should have been. Of much greater import, however, was the fact that Dr Lowry did not take the opportunity to indicate to Mr Watson that Dr Tom Esmonde had approached him in May 2016 with a further concern about other patients under the care of Dr Watt. This was a serious failing by a Medical Director, who should have known what his responsibility was in the circumstances.

6.35 Significant information was, therefore, retained at this time by the Belfast Trust and not disclosed to the Northern Trust on grounds of patient confidentiality. The Inquiry Panel does understand that the disclosure of notes and records ordinarily requires consent. The context in this case was entirely different. Professor Wills was instructed by Mr Watson on the basis that he was to advise the Belfast **and** Northern Trusts. The patient had complained to the Northern Trust and had previously been under the care of the Northern Trust. The insistence on seeking the additional consent of the patient to disclose Dr Wills' report was unnecessary and impeded the paramount concern of ensuring patient safety. Even if it was perceived by the Belfast Trust that the patient did not wish the Northern Trust to see the report in the circumstances that pertained, that view was not decisive.

6.36 Dr Craig, the Clinical Director, who had been asked by Mr Watson to attend the meeting with INI 286, suggested in an email of 5th August that Mr Frank Young[3], also attend the meeting. Dr Craig told the Inquiry Panel that he wanted Mr Young to attend as he had not been involved in these types of meetings before. In an email of 30th August 2016, Dr Craig stated to Mr Watson:

> Frank Young will attend. He has also suggested that some [sic] from Complaints attend. This is an unusual situation and I want it to be done correctly.

Dr Craig also expressed a desire for Nicky Vincent, Clinical Risk and Governance Manager within the Directorate, to attend.

6.37 On 30th August, Mr Watson stated that the approach to the meeting was as outlined in his earlier email, which he attached again for convenience. Mr Watson stated:

> As per Professor Wills' advice the report will not be shared until the meeting, in order than [sic] you can set a context and support the family as they receive the details.

6.38 The meeting eventually took place on 13th September 2016 at the Royal Victoria Hospital and was attended by INI 286, his family, Dr Craig, Dr Watt and Mr Young. Dr Craig helpfully drew up a minute of the meeting, which, in light of subsequent developments, became an important document. The salient extracts are set out below:

> **2. Report.**
>
> INI 286 and his relatives were given the chance to review the report on their own. Having done so they were given the time to provide their thoughts on the contents of the report. Concerns were expressed that the report that [sic] been prepared by someone who had not seen INI 286 in person. Significant concerns were also provided in regards to the contents of the report. Family concerns were expressed that the contents of the report would influence how INI 286 would be treated if he attended the NHSCT in the future.
>
> Dr Watt provided his clinical opinion on INI 286's problems and gave his comments on the report. That INI 286 and his family had no concerns in regards to care offered by the BHSCT and Dr Watt, in particular, was clearly expressed.
>
> Further reference was made to the website detailed by Professor Wills.
>
> **3. Actions.**
>
> 1. On being asked did the BHSCT have consent to disclose the report with the NHSCT it was clearly stated that consent was not being given to do so.

3 Co-director of Unscheduled & Acute Care.

2. Since much of the meeting involved concerns, as detailed in the letter of complaint to the NHSCT, in regards to perceived attitudes of staff from the NHSCT, INI 286 and his family were asked about whether they wished to have meeting with representatives from NHSCT.

A clear answer was not offered.

3. INI 286 stated that he wishes to continue to be under the care of Dr Watt in the BHSCT.

6.39 Further to this meeting, correspondence was sent by Dr Jack to Dr Lowry on 16th September 2016. After outlining the background to the commissioning of the report from Professor Wills, the letter stated as follows:

> Subsequently we commissioned Professor Adrian Wills to prepare a report on the diagnosis, care and treatment of the patient. This report was received by the Trust on 20 June 2016 and as had been suggested by Professor Wills, a meeting was organised with the family for the report to be shared with them. This meeting took place on 13th September 2016. Dr Craig, Clinical Director, Dr Watt, Consultant Neurologist and Mr Young, Co-Director, met with INI 286 and members of his family.
>
> At that meeting, Dr Craig, Clinical Director for Neurosciences, shared the report with the family and sought to offer clarification on a number of aspects. Dr Craig sought permission from the family for the report to be disclosed to the NHSCT, but the family were clear that they would not provide such consent. The family raised a number of concerns in relation to the experience of INI 286 and indeed the experience of other family members at NHSCT and Dr Craig confirmed that such concerns would need to be addressed to NHSCT. The family were asked whether they wished to have a meeting with representatives of NHSCT but there was no confirmation of this.
>
> Finally, the family indicated that they wished INI 286 to remain under the care of Dr Watt. We are of course happy to continue to provide treatment to INI 286.

6.40 Mr Young was asked by the Inquiry Panel as to what he believed his role was at the meeting on 13th September 2016. He stated:

> I mean, in terms of the meeting, I'll be honest with you; I don't actually remember the meeting itself, but my role would've been there as a senior manager to say, "look-", as a witness, I suppose.

6.41 Dr Jack did not accept this view. In her evidence of 12th December 2019, she told the Inquiry Panel:

> I think Frank will need to talk for himself, but my impression is he's not there

> as a witness; my impression is he's there as a Co-Director, which is delegated responsibility for the Director, so he is responsible for this service and everything in it.

6.42 Mrs Owens, the Director of Acute Services, in her evidence of 3rd February 2020, was more specific in her view:

> Quite clearly, he's a senior officer in the Trust and I would have expected him to be there co-joined with John Craig in terms of meeting with the family. He had a role obviously while John was there from a clinical angle. Frank's role was to be there as what needs to happen from here, what's their understanding and being sensitive to how do we proceed from their perspective … I would have expected that Frank could take the lead in taking the family through what the report is saying, that John can then obviously supplement what that means in terms of the clinical perspective.

6.43 Mr Watson was also critical of Frank Young's assessment of his role in evidence of 16th January 2020 as follows:

> I would have expected that, Mr Young as a Co-Director in the service, at the time, in which there was a difficult patient complaint, would have been attending, in a role, certainly beyond that of a witness.
>
> I assumed that he'd be there to support and assist Dr Craig in the management of what was a … and Dr Watt in the management of what was a potentially very difficult conversation with a family…if I were there as the Administrator, I would probably be the one who would, subsequently, craft the note of the meeting.

6.44 Mr Young, in his response on 22nd April 2021, agreed that his choice of the word "witness" was a *"very poor choice of words"*. Nevertheless, he had believed that he was there to support Dr Craig and pointed to the fact that Professor Wills' report had stated that the chair of any meeting with the family would be a clinician indicating as follows:

> I wasn't involved. Having review all of the email correspondence and all of the letters leading up to this, I wasn't involved in this at all. So when it came to the meeting with the INI 286 family, John wanted me there to support him as Co-Director and also to try and reassure the family "look we are taking this seriously"…
>
> The Wills' report actually stated that the Chair should be a clinician. What I assume was going to happen was that John, he took a formal note of the meeting, and I assumed he was going to write to the family. I was very concerned and very disappointed to hear that Bernie Owens was suggesting that I should have

> been writing to the family directly. I think it was a serious governance breach - - I can't remember the exact words - - and I was really taken aback by that. Given that the Medical Directors in both the Northern Trust and the Belfast Trust were involved, I would have thought the Medical Director's Office would have led on that formal letter.

6.45 Having reflected on the matter, the Inquiry Panel has concluded that it was unrealistic in this case to expect Mr Young to take the lead as suggested by Mrs Owens. This was a difficult conversation, where the family were expecting a meeting with a consultant physician and were intensely focused on continuing under the care of Dr Watt.

6.46 The Inquiry Panel accepts that the Co-Director, Mr Young would have had a responsibility well beyond that of a witness to a clinical meeting with a family who were likely to be disturbed by the findings of an independent report. The confusion, however, reveals that roles were not clear. Part of Mr Young's role would have been to ensure that the specific actions to be implemented were, in fact, followed up and implemented.

6.47 On 19th December 2019, Dr Craig told the Inquiry Panel as to his expectations of the meeting with patient INI 286:

> Going into the meeting, there would've been a discussion in terms of did he agree with the diagnosis that had been given, and certainly it was my understanding that Dr Watt was now going to treat this person as having a functional neurological disorder rather than continuing to treat them with medications for stroke.

6.48 The Inquiry Panel met with INI 286 and his wife on 5th November 2019. INI 286 confirmed that he had only read Professor Wills' report on the day of the meeting, as highlighted by Dr Craig, but it became ever clearer that the situation remained both confusing and confused. What mattered above all to the patient was that treatment should continue under the care of Dr Watt. INI 286 had been treated at Antrim Area Hospital and believed that that was where the complaint was lodged. They had then had correspondence with the Northern Trust and liaison with the Belfast Trust at the Royal Victoria Hospital. The degree of confusion is illustrated by the following interaction between the Inquiry Chairman and INI 286's wife:

> **Mr Lockhart QC:** Did they tell you how it came about? That it was jointly by the Northern Trust and Belfast?
>
> No, we were told that it was Antrim, because we were there telling them that we didn't understand why it was them sharing it with us if it had nothing to

> do with them. The complaint – the problem – that we had was never with the Royal, so we didn't understand why we were there seeing them and why they were sharing the report. How did they get it? We never found an answer to that.

6.49 It was apparent, as Dr Craig had noted, that INI 286 was keen to stay under the care of Dr Watt and was critical of the fact that he had not been physically examined by Professor Wills. Both INI 286 and his wife recalled that the meeting with Dr Craig, Dr Watt and Mr Young had been short and not a great deal had been said to them. In particular, they could not recall Dr Watt giving them a clinical opinion, nor could they remember being referred to the website referred to by Professor Wills, (although they accepted that this could have taken place). The central confusion was that INI 286 and his wife could not understand why they were being asked about disclosing the report to the Northern Trust or Antrim Area Hospital. The transcript states:

> **Mr Lockhart QC:** … I'm just trying to gently understand this. Did you not say, "But, sure, the Northern Trust were the ones who got the report"?
>
> **[INI 286's wife]:** Yes. We were asked would we share it with Antrim Area, and I said, "But this is all about them, and it's them that has organised the report. Why are we here with you?"
>
> **[INI 286]:** You know, it was very confusing.

6.50 As far as INI 286 was concerned, Antrim Area Hospital should have known about the report, as it had been the subject of the complaint. INI 286 and his wife gave evidence of further confusion and delay, but INI 286's wife summarised the situation as follows:

> To be perfectly honest with you, at the time all that mattered was the Royal wasn't going to change his treatment.

6.51 At a later point, INI 286's wife explained that they thought they were being asked to meet with the Antrim Hospital physicians again and they didn't see the point of such a meeting. INI 286 also felt that the report from Professor Wills was not properly explained to him and his wife and the sense he had was that the report would not affect care at the Belfast Trust. INI 286 believed that the Belfast Trust agreed with Dr Watt.

6.52 Towards the end of the evidence of INI 286 and his wife, it became clear that INI 286 was still being prescribed anti-seizure medication, despite the fact that he was no longer being treated by Dr Watt.

6.53 This issue obviously raised questions as to how INI 286 and his family had come away with such a different understanding of what, in fact, was meant to occur.

This was raised with Dr Jack during her evidence of 12th December 2019. Professor Mascie-Taylor queried with Dr Jack how the recommendations of Professor Wills were to be explained:

> **Professor Mascie-Taylor:** - and however kindly it's put and however skilfully it's put, there are only two things, I think: one is, "That diagnosis was correct, and that one was incorrect".
>
> **Dr Jack:** "The diagnosis was incorrect. Here's the website for support".
>
> **Professor Mascie-Taylor:** Yes: "And, in terms of your medication, that will have to change in the following way".
>
> **Dr Jack:** "When we see you in clinic and – ", yes.
>
> **Professor Mascie-Taylor:** "And do all of that", yes. That would have been the essence, however long the meeting took.
>
> **Dr Jack:** That's my expectation, absolutely.

6.54 The Inquiry Panel cannot properly evaluate how it was that INI 286 continued to be prescribed the same medication that had originally been prescribed by Dr Watt, as this is outside its Terms of Reference. Nevertheless, Dr Jack was surprised by the fact that, for whatever reason, INI 286 was still on the same medication. As she put it: *"Nobody expected to find that the patient might still be on medication now"*.

6.55 The Inquiry Panel accepts that Dr Craig had, in good faith, made the assumption, following the meeting in September 2016 with INI 286 and his wife, that INI 286 did not wish the report to be disclosed and that he wished to continue under the care of Dr Watt. The Inquiry Panel further accepts that explaining to a patient a functional neurological disorder in the context of the case would have been both sensitive and difficult. What is clear, however, is that INI 286 and his family had a limited understanding of what, in fact, had transpired. They did not in any way appreciate the various nuances between the names of the Trusts and the hospitals. This is entirely understandable.

6.56 Unfortunately, despite Dr Watt agreeing to act in accordance with the recommendations of Professor Wills, he appears not to have done so and continued as before. Dr Craig had assumed that Dr Watt would have acted in accordance with what he had agreed, but the explanation given by Dr Craig to INI 286 did not achieve the intended aim. Mr Young's claim that he was simply there as a witness is not a proper description of his role. This was accepted by Mr Young in his subsequent evidence to the Inquiry Panel. As the Co-Director he should have ensured that the approach agreed with Mr Watson and agreed with Dr Jack was carried out.

Dr Esmonde's Further Concern:

6.57 Information at this stage seems to have been kept in silos. From a patient safety perspective, this can become a significant issue. The Inquiry Panel noted that the report from Professor Wills was received on 9th June 2016. Within the same period, the late Dr Tom Esmonde, who gave evidence to the Inquiry on 8th May 2019 (and who sadly passed away in August 2021) raised a further concern about Dr Watt and the pattern of his practice with the Medical Director of the Northern Trust.

6.58 On 5th May 2016, Dr Esmonde emailed Dr Ken Lowry stating as follows:

> You will recall I had a brief meeting with you in relation to the practice of a colleague in the BHSCT.
>
> Unfortunately, I have become aware of another instance of unusual practice (diagnosis and treatment) regarding the same colleague. The matter has come to light following the patient's request for copies of her NHSCT case notes (she had been under my care a few years ago). I would prefer to discuss this in person. Would you be free for approximately 15 minutes next Monday or Wednesday?

6.59 Dr Esmonde had the following interaction with Professor Mascie-Taylor during the course of his evidence on 8th May 2019:

> **Dr Esmonde:** … And I thought the correct channel then, because he works in a different Trust, would be to speak to a Medical Director about what – the next steps.
>
> **Professor Mascie-Taylor:** So, you went to see Ken Lowry. Was it Ken Lowry?
>
> **Dr Esmonde:** Yes.
>
> **Professor Mascie-Taylor:** Yes. And presumably you appraised him in slightly more detail, but, nevertheless, the principles [inaudible]. And what did he do? Do you know?
>
> **Dr Esmonde:** He said he would speak to Cathy Jack, the Medical Director in the Royal
>
> **Professor Mascie-Taylor:** Right.
>
> **Dr Esmonde:** -- and get back to me.
>
> **Professor Mascie-Taylor:** And he did or didn't?
>
> **Dr Esmonde:** Didn't. Well, didn't speak back to me.

6.60 Dr Lowry failed to pass on the concern raised by Dr Esmonde. He undoubtedly should have done so. When asked about this by the Inquiry Panel on 5th September 2020, Dr Lowry stated:

> **Mr Lockhart QC:** Obviously, we've had the evidence of Tom Esmonde, and he happens to have put an email. Do you recall that email, or do you recall seeing him?
>
> **Dr Lowry:** I don't recall the email. I recall meeting him briefly, before I went on leave when he came and said that there was a second patient that he had concerns about – a patient who had a diagnosis of stroke – and he didn't believe it and that he was going to go and find the records and look at it. The reason he came, as I recall, was because the lady herself had asked for her Northern Trust notes to be released to her, and that rang an alarm bell with him. As I recall, he didn't discuss with me the finer detail, and, when I read his statement, I was particularly concerned, because, certainly, if he'd mentioned methotrexate to me, I would've got very upset about a patient being given methotrexate inappropriately. So, I don't recall that bit of the conv – but I do recall him coming with concerns about a female patient …
>
> **Mr Lockhart QC:** Right. Do you recall, when you came back, if you had any other conversations with him?
>
> **Dr Lowry:** No, I don't recall.
>
> **Mr Lockhart QC:** You had been so – in one view, you had been very proactive when you had received the first complaint. It was a textbook example of how to deal with a complaint. I'm just wondering why you didn't immediately –
>
> **Dr Lowry:** To my recollection, Tom did not share the detail. He shared a concern and was going to go and get the detail. I don't recall him sharing the detail with me.
>
> **Mr Lockhart QC:** But, even if he didn't, was there not sufficient in that email of itself to say, "Hold on, there may be a pattern here"? I mean, unusual practice, diagnosis and treatment, same colleague, same TIA again. Apparently, he's obviously had a conversation with you about it. Does it not suggest that we may have a pattern of practice which is cutting corners?
>
> **Dr Lowry:** Yes, I think you could say that, but, again, before I would approach Cathy Jack, I would want fact rather than, you know -. At what point does raising concerns become harassment of the person you're concerned about or, you know, a personal issue between two individuals? I needed to have fact, and I don't recall ever getting those detailed facts …
>
> **Mr Lockhart QC:** But, at the very least, do you not then, when you come back, say, "Now did you get me those notes?", or did you, you know--?

> **Dr Lowry:** No, perhaps – I didn't follow up on it; I was kind of expecting him to come back to me…
>
> **Mr Lockhart QC:** But you can't – do you recall, if he would've talked to you about the fact that it was the same? What he says is "another instance of unusual practice", and then he has a further discussion with you. Presumably, that discussion – would that not have – kind of what he would have alluded to would have been to say, "Look here's another situation where we've got a functional patient who's been diagnosed with having a TIA and that there's a prescription of drugs in relation to that, when there's no underlying objective test which reveal the presence of this diagnosis." Is that--? You know, even if he didn't go into the actual drug, surely the discussion would – if you can recall at all, would he not have said, "I'm really concerned about this?"
>
> **Dr Lowry:** I suspect he did. I can't recall exactly, but I think – what I do recall is that he was to get me more information so that I could make a detailed --. It's a bit like, having the first kickback from the Belfast Trust, I wanted to make sure the second time, again, it was, you know, it was a proper structured concern …
>
> **Professor Mascie-Taylor:** So, the issue here is that Cathy didn't know, and your contention is you didn't feel you had enough information, and his contention is that you did.
>
> **Dr Lowry:** Yes.

6.61 The Inquiry Panel does not accept at all that Dr Lowry had insufficient evidence from Dr Esmonde in order to raise a further concern with Dr Jack. Whether he was anxious to ensure all the detail was included or not, the fact that Dr Esmonde had escalated the matter to him as Medical Director meant that it was Dr Lowry's responsibility to ensure that the matter was properly investigated and considered. It is in no way sufficient to conclude, as Dr Lowry seems to have done, that because Dr Esmonde did not revert to him again, the matter could then be ignored. Dr Esmonde was quite clear in his evidence that he, having raised the matter in an email, and discussed the detail with Dr Lowry, was sufficiently concerned that there was a pattern of practice, which needed to be reviewed.

Communication with the Northern Trust:

6.62 On 16th September 2016, Dr Jack wrote to Dr Ken Lowry at the Northern Trust. The correspondence summarises the steps that had been taken as follows:

> You will recall that I copied you into correspondence on 4 March 2016 (dated 24 February 2016) in relation to [INI 286].

> You will also note that subsequently I was advised by [INI 286's wife] that she and her husband were in agreement with the proposals made at that time.
>
> Subsequently, we commissioned Professor Adrian Wills to prepare a report on the diagnosis, care and treatment of [INI 286]. This report was received by the Trust on 20 June 2016 and as had been suggested by Professor Wills, a meeting was organised with the family for the report to be shared with them. This meeting took place on 13 September 2016. Dr Craig, Clinical Director, Dr Watt, Consultant Neurologist and Mr Young, Co-director, met with [INI 286] and members of his family.
>
> At that meeting, Dr Craig, Clinical Director for Neurosciences, shared the report with the family and sought to offer clarification on a number of aspects. Dr Craig sought permission from the family for the report to be disclosed to the NHSCT, but the family were clear that they would not provide such consent. The family raised a number of concerns in relation to the experience of [INI 286] and indeed the experience of other family members at NHSCT and Dr Craig confirmed that such concerns would need to be addressed to NHSCT. The family were asked whether they wished to have a meeting with representatives of NHSCT but there was no confirmation of this.
>
> Finally, the family indicated that they wished [INI 286] to remain under the care of Dr Watt. We are of course happy to continue to provide treatment to [INI 286].
>
> I am conscious that the complaint made by the mother of [INI 286's wife] to NHSCT remains unresolved and in this context wished to ensure that you were aware of this update. I am also copying this correspondence to [INI 286 and his wife] for their information at this time.

6.63 The irony is that just as Dr Lowry felt he did not have sufficient information to pass on to Dr Jack the further concern raised by Dr Esmonde, the Belfast Trust did not feel it incumbent upon them to share the independent report of Professor Wills with the Northern Trust and Dr Lowry, its Medical Director. Consequently, significant information, which if shared with the other Trust, could have made a difference, remained within the knowledge of the relevant Trust. The Inquiry Panel is of the view that had Dr Lowry passed on the second concern raised by Dr Esmonde in May 2016, it would have reinforced the existing concerns of Dr Jack to the point where action would have been taken. Similarly, if Professor Wills report had been shared with the Northern Trust, it could have confirmed not just the concerns of Dr Esmonde, but of Dr Lowry.

6.64 The Inquiry Panel explored with both Mr Watson and Dr Jack the reasons for not sharing Professor Wills' report, or the gist of it, and why reassurance was not given

to the three doctors who were the subject of complaint within the Northern Trust. In his evidence of 16th January 2020, Mr Watson stated:

> **Mr Watson:** Then Cathy signs that letter ... it doesn't say in it, 'and we don't have any concerns [about] your doctors'. I think Cathy and I, having looked at this, we both agree it would have been even better if we had said expressly …
>
> **Mr Lockhart QC:** I think 'even better' is kind. I mean I have queries for Dr Lowry in particular. I also have queries as to why on earth somebody didn't say, 'the doctors who are the subject of this complaint can rest easy' …
>
> **Mr Watson:** Yes, we should have done so.

6.65 Dr Jack, in her evidence of 12th December 2019, also accepted that in retrospect, it would have been better if the information had been shared with all relevant parties:

> Look, I accept it would've been even better. Can I tell you? … we did want to share it. If I was doing this differently, I would seek consent straight up, and we can argue about was it a patient safety. As far as I'm concerned, the three doctors in the Northern Trust, there were no worries about them, and, actually, because I didn't go back, you knew I wasn't worried about them. But actually… if I was doing … whatever I do now, I will make sure that the consent is that [sic] [what] I intend … "I want to get this opinion, and we intend to share it with all the parties … ", because if we'd done that, it wouldn't be a problem.

6.66 The meeting with the patient's family compounded the original error of not disclosing to the Northern Trust and Dr Lowry, the report from Professor Wills as soon as it was received. The Belfast Trust believed that they did not have the explicit consent of the patient and his family to disclose Professor Wills' report. The upshot of this is that the opportunity for the Belfast Trust to receive further information about the practice of Dr Watt in similar circumstances was lost. In large part, Dr Lowry is responsible for that failure. As the Medical Director, he had a duty to pass on the information. The fact is, however, that the Belfast Trust also bears some responsibility in failing to ensure that the family properly understood the effect of Professor Wills' recommendations and that Dr Watt would continue his treatment in line with those recommendations.

6.67 The Inquiry Panel accepts that the Belfast Trust and Dr Jack and Mr Watson believed in good faith that the lack of consent from INI 286 at the meeting in September 2016, prevented the Trust from sharing the Wills report or reassuring the three doctors in the Northern Trust who had been the subject of the original complaint by INI 286, that Professor Wills agreed with their diagnoses. It was only shortly prior to Dr Esmonde giving evidence on 8th May 2019 that Dr Esmonde saw a copy of Professor

Wills' report. In the view of the Inquiry Panel, Professor Wills was giving a report for both the Northern Trust and the Belfast Trust and explicit consent had been obtained for that process. It would, therefore, make no sense that the conclusions of Professor Wills would not be shared with both Trusts, especially given that it was the Northern Trust who was the subject of complaint. Consequently, it was unnecessary to seek explicit consent at the meeting in September 2016 with INI 286 and his wife. As it turned out, it is apparent that the family of INI 286 were confused in any event about what they were being asked to consent to.

6.68 The INI 286 concern and the manner it was handled between the Trusts highlights the danger of bodies operating in silos. If patient safety is to be the paramount concern, governance systems must ensure that critical information, which potentially bears on patient safety, is appropriately shared between relevant decision-makers and is not impeded or subordinate to patient confidentiality concerns.

Referral to the Doctors and Dentist Case Review Meeting ("DDCRM"):

6.69 Dr Watt was referred to the DDCRM as a result of the concern from INI 286. It is clear that the Medical Director had a limited insight into issues that had arisen between revalidation in 2013 and the complaint from INI 286. Commenting on this, Dr Jack told the Inquiry Panel on 29th October 2018:

> If you look at the Doctors and Dentists Case Review in October '13, which was after he was revalidated, I was at that because Tony [Stevens] didn't come and Ken Fullerton said there are no issues, so that is when they closed that … then [Dr Watt] didn't come back on my radar at all until February '16. There was a complaint that came in, but it had already come into the system and the service group were dealing with it, so we sent it through to them.

6.70 Dr Jack indicated to the Inquiry Panel on 29th October 2018 that the reappearance of Dr Watt at the DDCRM did not cause her to review the history in relation to Dr Watt. She told the Inquiry Panel:

> This was 22nd March 2016. He had been revalidated in September '13 and that is just the information subsequent. I did not go back and review the historical file.

6.71 In a subsequent attendance on 12th December 2019, Dr Jack outlined what she knew about at the time of the index concerns raised by Dr Fitzpatrick in November 2016:

> I've got that anonymous complaint. I've got the coroner. I've got the appraisal, and I've got the Northern Trust, but I don't have the others. So, in other words,

> if it comes to the Medical Director's office, it's in here, but if it's managed in service, it's not.

6.72 Mr Watson, in his evidence of 16th January 2020, agreed with Dr Jack in stating that his view of Dr Watt as at start of February 2016 was as follows, *"This was somebody who had been revalidated in 2013. Not that that clears the slate. But the slate had been cleared to facilitate the revalidation in 2013. There was no other significant concerns, and therefore, there wasn't an immediate patient safety issue"*.

6.73 Dr Watt was discussed by the DDCRM on 22nd March 2016. Dr Jack, Mr Watson and Mrs Owens were present. Among the apologies were Dr Fullerton and Mr Young, whose attendance at the meeting would, no doubt, have been preferable. The notes of the meeting record as follows:

> CURRENT POSITION
> It was noted that a complaint received in NHSCT had resulted in concerns being expressed regarding [Dr Watt's] care in BHSCT and private sector; this was currently being addressed with it having been agreed with the complainant that an expert report would be sought.
>
> It was noted that a case of non-compliance with the Coroner had been raised in relation to MW and this was with Dr Craig to resolve.
>
> It was agreed that Mrs Owens would ensure that Dr Craig escalated any other concerns regarding MW.
>
> ACTION
> Maintain under review at DDCRM.

6.74 It does not appear as if Dr Watt was discussed subsequently at a DDCRM. This is elaborated upon in the DDCRM chapter. An "update" was attached to the note of the meeting when shared by Mr Watson. This update stated as follows:

> **Update at 3 May 2016**
>
> Copy of patient notes awaited from NHSCT and details of expert to be sourced by Dr Craig.
>
> Cooperation with the Coroner in this case now complete and MW asked to reflect with his appraiser.
>
> An anonymous compliant is currently being addressed, in which MW is named.
>
> Dr Fullerton wrote to MW on 20 April 2016 regarding non-engagement with Appraisal, asking him to arrange an appraisal date in the near future.

> The issue with regards to the Coroner relates to Dr Watt's delay in producing a statement for an inquest. On 29th October 2015, a statement was requested from Dr Watt and this was followed up on 18th November 2015, 4th December 2015, 21st December 2015, 23rd December 2015, 4th January 2016, 26th January 2016 and 8th March 2016 by Dr Johnston, Assistant Medical Director for Litigation Management with the Trust. On 15th March 2016, Dr Johnston escalated this matter to the Medical Director's Office, having previously copied in Dr Craig and Mr Atkinson to correspondence.
>
> On 16th March 2016, Mr Watson emailed Dr Craig, and copied in Dr Watt, Dr Jack, Dr Fullerton, Dr Johnston and Mr Atkinson, indicating that: *"it would be a sad waste of Medical Director time, if [Dr Jack] had to personally intervene to resolve this matter"*. Receipt of the statement was confirmed by the Coroner's Office on 14th April 2016.

6.75 Subsequently, Mr Watson sought an explanation from Dr Watt as to the delay in provision of the statement. Dr Watt responded on 25th April 2016 to state that he was *"at the AAN. As you are no doubt aware I am extremely busy, and it was difficult to find the time to go through the box of notes to complete the report"*. Dr Jack replied directly to Dr Watt the following day asking Dr Watt to reflect on this incident with his appraiser and afford such matters sufficient priority in the future.

6.76 The Inquiry Panel noted that the suggestion that Dr Watt reflect on his non-compliance with the coroner's direction at his next appraisal was a further example of the conflation of performance management and the reflective process at annual appraisal. It would have been more appropriate for management intervention to have been taken, rather than simply inviting reflection at Dr Watt's next appraisal, which, in any event, had not taken place for several years and as it transpired did not occur until November 2017 (some 18 months later).

6.77 Issues with Dr Watt's appraisal were also discussed by the DDCRM and flagged by Dr Fullerton in an email of 20th April 2016. Dr Fullerton noted that Dr Watt's appraisal for 2014 was incomplete and his appraisal for 2015 was now due. Dr Fullerton indicated that Dr Watt was *"given a deadline of 18 April 2016, but no date has been arranged"*. Dr Fullerton believed that Dr Watt was at risk of being deemed as failing to engage in revalidation and urged him to agree a date. Dr Fullerton raised this issue with Mr Watson on the same date, indicating that Dr Craig was *"extremely frustrated"* by the issue.

6.78 Subsequent emails revealed that Dr Watt had not agreed a date by June 2016. On 1st June 2016, Mr Watson drafted correspondence, which he sent to Dr Jack with regards to this matter. The salient part of this draft read as follows:

> I now consider that your continued non-compliance in this regard raises concerns in relation to your conduct. In the event that I do not receive assurance from your Clinical Director within 7 days of the date of this email, that you have now engaged with the Appraisal process, I will have little option to further consider what action is required within the framework of Maintaining High Professional Standards in the Modern HPSS.

6.79 On that date Dr Jack indicated that she thought this matter constituted *"non-engagement wrt [sic] revalidation as such discussed with GMC directly"*. Enquiries were made with the Revalidation and Appraisal Co-ordinator who confirmed that Dr Watt had been revalidated on 27th September 2013 with his next revalidation due on 26th September 2018. Consequently, the problem was, therefore, a failure to complete annual appraisal as opposed to revalidation. Dr Jack directed that a letter be drafted emphasising that annual appraisals were expected that being the policy of the Trust and therefore a management issue. The Inquiry Panel has not seen evidence that any letter in those terms was issued to Dr Watt at this time.

6.80 The appraisal issue was raised by Mr Young and Dr Craig in the context of a meeting held with Dr Watt on 30th August 2016. The outcome of that meeting was that an appraisal was *"to be completed on or before end of September"*. An update by Mr Young to Mr Watson on 29th September 2016 stated that work on the appraisal was *"well underway"*. No appraisal was, in fact, completed by Dr Watt until November 2017.

6.81 On 14th March 2016, the Belfast Trust received an anonymous letter of concern from a fellow inpatient in Ward 4E with regards to the treatment of another patient on the ward, INI 439. The anonymous complainant alleged that Dr Watt had been *"insensitive, cruel, unethical, spiteful and totally unprofessional"* in his dealings with INI 439.

6.82 On 16th March 2016, the complaint was emailed to the Service Department within Neurosciences and the Complaints Department had noted 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, the Service Manager, forwarded the same to Mr Young and Dr Craig, with Mr Young responding stating that: *"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"*.

6.83 Dr Craig, on the other hand, forwarded the complaint on to Dr Fullerton, the Associate Medical Director, asking for his thoughts. Dr Fullerton responded by forwarding the complaint on to Mr Watson and suggested that Dr Watt may need to be considered by the DDCRM, seemingly unaware of the meeting on 22nd March 2016.

6.84 Mr Watson sought advice from the Trust solicitors, who advised that there was a duty to investigate and asked Dr Craig to review the notes. Mr Watson also indicated that Dr Watt should be informed of the complaint and advised that preliminary enquiries would be conducted to see if the concern had any substance to warrant formal or informal action under MHPS. Dr Craig subsequently reviewed INI 439's notes and spoke to INI 439's wife. He concluded that there were no concerns in relation to the accusations contained in the letter of complaint.

6.85 On 22nd March 2016 it was noted at the DDCRM that Mrs Owens would ensure that Dr Craig escalated any other concerns regarding Dr Watt.

6.86 The Inquiry Panel investigated whether Mrs Owens had, in fact, spoken to Dr Craig regarding other concerns. Dr Craig would not have been in attendance at the DDCRM. In her evidence of 3rd February 2020, Mrs Owens stated in relation to contact with Dr Craig:

> I don't actually recall speaking to him, but I would have been speaking to him regularly by phone and I would have expected that's where the conversation came up, but I don't remember specifically saying.

6.87 Dr Craig, in his evidence of 19th December 2019, did not believe that he had had any conversation with Mrs Owens regarding other concerns about Dr Watt:

> I saw that in the minutes. I don't remember that happening, her coming specifically to tell me about the DDCRM and any additional concerns that I might have. I don't believe that did happen.

6.88 Mr Watson was also of the view that there did not appear to have been any discussion between Mrs Owens and Dr Craig about Dr Watt. He told the Inquiry on 16th January 2020:

> We know it didn't happen because there's no record of any other concerns in 2016. Other than that anonymous complaint, there is nothing else.

6.89 The Inquiry Panel believes that, on balance, it is unlikely that Mrs Owens discussed the need to escalate further concerns with Dr Craig at this time.

August 2016 Meeting:

6.90 On 9th August 2016, Mr Atkinson emailed Mr Young a *"summary of outstanding queries and complaints requiring Dr Watt's input"*. This summary appears to have been prepared subsequent to a discussion between Mr Atkinson and Mr Young and raised the following concerns:

- Immunoglobulin request queries
  - Query from Immunoglobulin Pharmacist to MW 9 October 2015
  - Request from Immunoglobulin Pharmacist to MW 12 January 2016 to complete IFRs for 11 patients as required by Assessment Panel.
  - Request from Immunoglobulin Pharmacist to MW 9 May 2016 to complete IFRs for patients (now up to 15) as required by Assessment Panel.
  - Request from Immunoglobulin Pharmacist to MW 13 June 2016 to complete IFRs for patients (now up to 16) as required by the Assessment Panel.
  - Request from Ray Hannon to MW 13 June 2016
  - Escalated to John Craig by Ray Hannon 8 August 2016

- Outstanding response to correspondence to MW in February 2016 from Mr O'Brien in Fracture Clinic re combined referral to Queens Square for patient INI 284 – **resolved today, 9 August 2016**
  - Complaint from patient received 24 May 2016
  - Email from G Atkinson to MW 21 June 2016 seeking update
  - Email from G Atkinson to MW 27 June 2016 seeking update
  - Email from G Atkinson to MW 27 July 2016 seeking update
  - Email to G Atkinson from MW 9 August confirming that he has dictated draft referral letter.

- Outstanding request for MW to attend meeting to discuss ongoing complaint from patient INI 130
  - Attempts to arrange a meeting in March / April 2016 with dates suggested by MW fell through
  - Numerous requests to MW from G Atkinson and Complaints Department since April 2016, most recent of which was 1 August 2016

- Outstanding comments on complaint from patient INI 440 – **initial response received today, 9 August**
  - Complaint received 25 May 2016
  - GA emailed MW asking for comments 26 May 2016
  - GA sent reminder to MW 6 June 2016
  - GA sent reminder to MW 27 July 2016
  - **Email to G Atkinson from MW 9 August with initial response and advising that he will get the notes to see what is documented**.

- Comments on independent report on INI 286
  - Requested from MW by Medical Directors Office 28 June 2016
  - Reminded from Medical Directors Office to MW 13 July 2016
  - Reminder from Frank Young to MW 19 July 2016
  - Escalated to John Craig by Medical Directors Office 24 July 2016

6.91 The prescription of Human Immunoglobulin ("HIG") is addressed more fully in the Prescribing chapter. The handling of the complaints relating to INI 284, INI 130 and INI 440 is evaluated in the Complaints chapter. The handling of the INI 286 concern is set out above.

6.92 On 10th August 2016, Mr Young emailed Dr Craig and copied in Mr Atkinson. Mr Young indicted that: *"I have spoken with Bernie, and she has advised that you and I need to meet with him in our capacity as Co-Director and Clinical Director."* Mr Young indicated that once a date was agreed Dr Watt would be emailed and allowed to bring a colleague for support. Finally, Mr Young confirmed that: *"a formal letter to confirm the reason for the meeting and expected outcomes and timeframes will be issued"*.

6.93 A meeting took place between Dr Watt, Dr Craig and Mr Young on 30th August 2016. In email correspondence to Mr Atkinson, Mr Young noted that the meeting was *"positive"* and that Dr Watt *"completely accepted the need to have the list of issues addressed and completed"*. Mr Young's email included a list of actions as follows:

> **Follow up actions:**
>
> **Immunoglobulin Request queries**
> MW confirmed he will complete IFRs for all new requests as agreed with R Hannon
>
> **INI 284 Complaint**
> MW to review his dictated referral letter when [ ] his secretary returns from leave on Wednesday.
>
> Can you please ensure that as [ ] is bound to have a backlog that this is prioritised?
>
> **INI 130**
> MW is seeking patient at UIC on Wednesday so hopefully closures after that and a meeting with patients (as per Complaints Dept) not required but still need to track.
>
> **INI 440**
> MW confirmed initial response forwarded but MW to review notes so need to track.
>
> **INI 286 Report**
> Meeting with family to take place, MW [Michael Watt] and JC [John Craig] will be present – have asked that Nicky Vincent also be present.
>
> Recommendations to be tracked to ensure they are complete (from a Belfast Trust perspective)

> **Appraisal**
> To be completed on or before end of September.
>
> For our part we now need to ensure the above are completed ASAP and also that any subsequent queries are escalated as early as possible.

6.94 The Inquiry Panel has seen an annotated note of Mr Young's follow up actions as disclosed by Mr Atkinson. The issues regarding HIG and the INI 284 and INI 286 complaints are marked *"complete"*. Despite Mr Young identifying the *"need to ensure the above are completed ASAP"*, several of the issues identified continued unaddressed, including Dr Watt's appraisal (which was not resolved until November 2017) and the INI 130 and INI 440 complaints, which both continued well into 2017.

6.95 Of the issues discussed at the meeting, the Medical Director's Office was only aware of the INI 286 concern and the failure of Dr Watt to undergo his appraisal, which had been brought to their attention in June 2016. The Inquiry Panel notes that Dr Jack was quite clear in her evidence of 12th December 2019 that she was unaware of any of the issues raised in the meeting with Dr Watt or of any discussions as between Mr Young and Mrs Owens. Mr Watson was also clear that he was not aware of the issues raised in the August 2016 meeting, or of the fact that it had taken place.

6.96 While the delay in responding to complaints was significant and should have been flagged with the Medical Director's Office, perhaps the most important issue concerned the prescription of HIG. As discussed in the Prescribing chapter, Dr Watt was a significant outlier when it came to the prescription of HIG, and the administrative process linked to same. This matter was raised by Dr Ray Hannon, who was not just the then Associate Medical Director, but also a member of the Immunoglobulin Panel Meeting. In an email of 8th August 2016 to Dr Craig, the Clinical Director, copied to Mr Atkinson, the Service Manager, Mr Hannon stated:

> Dr Watt is a regular user of HIG for a variety of conditions, many of which are not "routine" i.e. grey indications.
>
> Unfortunately, he and his team fail to follow up with retrospective justification of some prescriptions, progress reports and IFR so we can properly track funding of these drugs. At our last immunoglobulin panel meeting we decided that unless the paperwork for all of Dr Watt's patients were brought into line, his requests for immunoglobulin wouldn't be fulfilled unless discussed with Ms Tyrie. This could of course delay treatment for urgent or out of hours requests as Ms Tyrie isn't available 24/7. The Directorate would need to think through options for patients if this comes to pass.

> Niamh Tyrie will liaise with NIBTS who have agreed not to issue ig automatically if prescriptions that arrive from teams or individuals that have had this sanction applied.
>
> I will remind Michael of our decision.

6.97 In his response on the same day, Dr Craig thanked Dr Hannon and stated:

> I think that your approach is fair. I will remind Dr Watt of his responsibilities when I next see him.

6.98 The managerial position of the Clinical Director is something that has been frequently commented upon in other chapters. Dr Craig's response could arguably be described as appropriate, in that the manager will often, as one of his duties, remind people of their responsibilities. Dr Craig's response was also consistent, however, with his perception of the role of Clinical Director, which, like Mr Cooke before him, was to *"explain and persuade"*. When the question of HIG use is forwarded to the Co-Director, Mr Young, he responded to Dr Craig and Mr Atkinson on 8th August 2016 as follows:

> Yet again Michael is not doing himself any favours!
>
> Are we getting to a stage where he's at risk of failing to maintain high professional standards to an extent that a more formal approach needs to be brought to bear?

On that same date Dr Craig indicated: "we should discuss".

6.99 Whether a referral under MHPS was the correct course of action required, in the view of the Inquiry Panel, the matter to be brought to the attention of the Medical Director's Office. Notwithstanding that Mr Young and Dr Craig met with Dr Watt on 30th August, the issues raised should have been referred to the Medical Director's Office by Dr Craig, Mr Young and/or Mr Hannon.

6.100 Mrs Owens, in her evidence of 3rd February 2020, had no recollection of the discussion with Mr Young, although she accepted that it must have taken place. Mr Young was clear that Mrs Owens would have been aware of the various issues that were subsequently raised at the meeting and that: *"I would have expected that Bernie would have briefed [Dr Jack]"*. He reflected to the Inquiry Panel on 22nd April 2021:

> We didn't have a robust system in order to do that. There were a number of triggers and cumulatively, and when you look back on it, absolutely you think that this should have been followed up on. Starting with the INI 286 complaint with the Northern Trust, that was the first serious, in hindsight when I look back on this where there's two different Trusts saying: 'there's something wrong with this guy and his diagnosis.' We have given him instruction and he decides to

> ignore them. We should have been doing something at this stage and we failed to do so.

6.101 The Inquiry Panel agrees with Mr Young that more action should have been taken. Dr Jack, in her evidence of 12th December 2019, felt that even though an audit of HIG usage had not been carried out, those involved would have known that Dr Watt was a significant outlier, and, in her view, those cases should have been reviewed. Dr Jack was entirely unaware of any issue with HIG in August 2016.

6.102 The direction from Mrs Owens in August 2016 that Dr Craig and Mr Young should have a formal meeting with Dr Watt was clear evidence that there were, in fact, other concerns, some of which would have been known about in March 2016. The various interactions illustrate that a greater degree of formality and follow up is required whenever a query is raised about the previous performance of a doctor and any concerns that have been highlighted in the past. The present system, as operated, restricts the opportunity for recognising patterns of aberrant practice as information is stored in different places. At that point, there was no straightforward or systematic way of ensuring that all relevant information could be viewed by the Medical Director's Office.

Further Concerns within the BHSCT:

(i) Prescription of Alemtuzumab

6.103 At the end of Mr Young's and Dr Craig's meeting of 30th August 2016, the need to ensure that *"any subsequent queries are escalated as early as possible"* was identified. Similar views were expressed in the DDCRM of 22nd March 2016. There were, however, other concerns, which were not discussed at either the DDCRM or the meeting on 30th August, which also should have been brought to the attention of the Medical Director's Office.

6.104 An issue of note within the Neurosciences Department, at this time, was the requests by consultants specialising in multiple sclerosis for Alemtuzumab. The full circumstances surrounding issues with the prescription of Alemtuzumab is considered in the Prescribing chapter. On 16th February 2016, Mr Young had asked Mr Atkinson to flag to Dr Craig the fact that within the table provided, Dr Watt was a significant outlier in terms of the requests for such drugs. There was sensitivity around this drug because of its expense and impact on budgets. The drug also carried known patient safety risks. Dr Craig believed that Dr McDonnell, who was

both the Clinical Lead and a specialist in the area of multiple sclerosis, should be involved. The concern was that there was a significant budgetary shortfall. Demand for this drug had already exceeded the early estimates, in part due to Dr Watt's enthusiasm for prescribing this drug.

6.105 At the Neurosciences Clinical Leads meeting on 18th February 2016, attended by Dr Craig and Mr Atkinson, it was recorded under the Safety & Excellence category that a protocol for Alemtuzumab was required. It was also agreed that Dr Craig and Mr Atkinson would *"attend the next meeting of the multiple sclerosis consultants to discuss concerns re volume of referrals"*. Subsequently, Mr Atkinson emailed Dr McDonnell on 23rd February asking if both Dr Craig and Mr Atkinson could attend the next meeting of the MS consultants' team to look at revised projections for the drug for 2016/17 and to consider the impact of Alemtuzumab on the inpatient service.

6.106 The specialist MS meeting eventually took place on 12th April 2016. Both Dr Craig and Mr Atkinson were in attendance together with other MS consultants, including Dr McDonnell, Dr Gray, Dr Hughes, Dr Hawkins and Dr Droogan. Noticeably, however, Dr Watt was not in attendance, nor were his apologies recorded. The meeting had three substantive items on the agenda: *"DMT projections as of 31st March 2016 discussed by Gerry Atchinson [sic]"*, during which Alemtuzumab was discussed; the need for *"private patients to be referred and seen in the NHS prior to making request for any DMT"* and *"a possible panel to discuss funding requests."* The Inquiry Panel notes that issues relating to private patients and the setting up of a panel were especially relevant to Dr Watt. The concern regarding private patients was uncovered by Mr Atkinson after a search on the Northern Ireland Electronic Care Record revealed that Dr Watt may not have been following the appropriate processes.

6.107 At the Neurosciences Clinical Leads meeting on 21st April, it was noted that the meeting of the MS consultants attended by Dr Craig and Mr Atkinson had discussed the *"volume of Alemtuzumab referrals, projections for current year and IFRs*[4] *for private patients"*.

6.108 On 29th April 2016, Mr Atkinson emailed Dr Craig, Dr Watt, Dr McDonnell and Mr Young as follows:

> Dr Craig and I attended a meeting of the neurologists specialising in MS on 12 April. This was to discuss projections for DMTs, particularly Alemtuzumab, and private patient referrals for these therapies. Dr Watt was unable to attend the meeting on 12 April and the purpose of the proposed meeting is the same as the previous one. The projected costs for DMTs is an increase of around £4Million, principally due to increased prescribing of Alemtuzumab. We will need to meet

4 Individual Funding Requests.

> to formulate a response to the Commissioner who will undoubtedly ask us to explain the rationale for the increase.

6.109 A meeting appears to have been held with Dr Watt on 3rd May 2016. At the Neurosciences Clinical Leads meeting on 5th May, it was noted that *"projections for DMTs in 2016/17 have been costed"* and *"actions agreed"*. No notes or records appear to have been kept of the meeting. In evidence of 18th November 2020, Mr Atkinson recalled the meeting as follows:

> I think it was that meeting where Michael explained why he was prescribing alemtuzumab more than any of the other consultants, and that is where he used the expression early adopter, and he used some other words to describe himself as being quite progressive, describing the other consultants as more conservative … It was agreed that he wouldn't refer patients directly in from his private practice for alemtuzumab or any other purpose, and there was a process to be followed, and he agreed to abide by that process … I don't recall discussing the panel.

6.110 There is no clear evidence as to how these issues were to be monitored to ensure that all concerns were addressed.

6.111 On 4th August 2016, Dr McDonnell, who had been reviewing requests for Alemtuzumab, required clarification from Dr Watt in relation to an application submitted. Dr Watt responded in robust terms on 9th August 2016, which led to a discussion about the purpose of signing the forms as outlined in the Prescribing chapter. In response to a suggestion from Dr Craig that this matter be discussed at a Clinical Leads meeting, Mr Young stated as follows on 22nd August 2016:

> Gavin / John
>
> Given the cost of this drug it is essential that there's a very clear audit trail around the approval process and that the guideline is being consistently applied for every patient – especially as the Board views Michael to be an outlier compared to other Neurologists.
>
> If we were not to do so and the process were audited (which given the cost could very well happen) the Trust would be very vulnerable and open to criticism.
>
> Definitely need to discuss at the next clinical leads meeting.
>
> Frank.

6.112 Given the terms in which it is acknowledged that there are potential issues, including an acceptance that Dr Watt appeared to be an outlier, the Inquiry Panel considers that this matter should have been raised with the Medical Director.

6.113 On 25th September 2016, after the meeting of 30th August between Dr Craig, Dr Watt and Mr Young to discuss a number of issues, including requests for HIG, Dr McDonnell sent a long email to other MS consultants. The panel, which had been previously mooted, had not been set up and Dr McDonnell highlighted some of the difficulties:

> Over the last few months CPC requests have been passed on to me for approval, particularly those for MS DMT's. Until now I have been looking at these requests as far as possible before signature as I felt that my signature could be construed as being a guarantor that guidelines are being met.
>
> There are at least a few problems with this, and I don't feel that it is sustainable. Firstly, my requests are not submitted to the same scrutiny by another MS Neurologist. There is therefore an equity issue which could only be addressed by a panel considering all of these requests – there is no consensus among us regarding such an arrangement, however. The second problem is that there is insufficient information provided by the CPC process (and often on ECR) to allow me or anyone else to take a fully informed view on patient treatment. This can really only be done by the individual making the application under the present arrangements. Thirdly the term "Gatekeeper" does not appear anywhere in my job description.
>
> From now on I will approve all CPCs without any scrutiny on the basis that the applicant is fully satisfied that our local guidelines are being met, stating this clearly with supportive evidence. The CPC process is not a method for getting a second opinion. It goes without saying that applications should only be submitted for MS patients who are being managed within the NHS at the time of the application since this is an NHS process for treatment within the NHS.

6.114 Dr McDonnell's concern that there was no consensus on the introduction of a panel highlighted a fundamental problem. Consultants, including those in management operated on the principle that such initiatives required consent. They did not. The establishment of a panel could have been directed as a reasonable work instruction to an employee. Dr McDonnell noted that Alemtuzumab had already been approved on 80 occasions in that financial year, despite the fact that the system could only cope with 48 patients being treated. Dr McDonnell attached the local guidelines. The Inquiry Panel subsequently received from the Trust a summary of approvals for Alemtuzumab between 2014-2018. The drug was approved on 175 occasions. Of those 175, 93 approvals (53%) were in respect of applications made by Dr Watt. Six other neurologists had also made applications, four of whom had a speciality in multiple sclerosis. Although the table would also need to take into account the

volume of patients seen, the figures remain striking. The issues in relation to the prescription of Alemtuzumab are outlined in more detail in the Prescribing chapter.

6.115 At no point was there an analysis, which raised more fundamental questions about Dr Watt's practice or performance. The perception continued to be that Dr Watt's clinical competence was not in question and that his problems were largely administrative. This was the same analysis that had been highlighted by Dr Stevens in 2013. Despite ongoing and continuing evidence that Dr Watt was an outlier in respect of prescribing, and was attracting a much greater volume of complaints, there is no evidence of management viewing the picture holistically.

6.116 With regard to the prescription of Alemtuzumab, one can clearly sense the frustration of Dr McDonnell, but the matter is not effectively addressed with Dr Watt. While there is some suggestion in May 2016 that a meeting took place with Dr Watt that led to agreed outcomes, the problem remained and Dr McDonnell's email in September revealed that difficulties continued.

6.117 Mr Young candidly accepted that this issue should have been flagged up to the Medical Director's Office in his evidence of 22nd April 2021:

> In hindsight should I have escalated, should I have done something different about that, should I have been more aggressive in my approach? Yes. I suppose, wrongly, I was under the belief that his peers were looking at this. These kind of things were being audited. No-one was addressing the fact that while he was an over-prescriber people were coming to harm. It was never raised that there was a concern about patient safety because of what he was prescribing them. So, wrongly, in hindsight, I was more focused on keeping the budget side of it right.

6.118 Mr Atkinson, the Service Manager, agreed in his evidence of 18th November 2020:

> It was purely about the numbers. There was never any issue raised about the clinical appropriateness, or otherwise, of prescribing this therapy.

(ii) Blood Patching:

6.119 In addition to those issues, which were discussed at the meeting in August 2016 with Dr Craig, Mr Young and Dr Watt, 2016 also saw a continuation of the dramatic increase in the incidence of blood patch procedures for patients with a diagnosis of spontaneous intracranial hypotension ("SIH"). The Inquiry Panel queried with Dr Craig how this dramatic increase was not commented upon or raised at that time. Dr Craig stated in his evidence of 19th December 2019:

> Maybe moving to the Programmed Treatment Unit ("PTU"), we're almost out of sight, out of mind, again, we were assuming that two per week were being done in PTU, but, when you look at the figures, there clearly have to have been more than two per week getting done. We weren't directly managing that space. I wasn't getting any – whereas, if that had been in the ward, I suspect, Vanessa and all the other players who were managing that space would have been saying, "This is now, you know – we told you it was four a week, and, yes, that did apply some weeks. Now it's actually four every week." So, I think, you know, that moving things to the PTU, the visibility, in terms of what was happening, was maybe less, but I don't recall anything through 2016.

6.120 An analysis of index events regarding the extraordinary increase in blood patch procedures reveals several opportunities to have recognised what ultimately became a serious problem. These matters are amplified in the Blood Patching chapter, but the Inquiry Panel would highlight:

- On 9th March 2015 the then Assistant Service Manager Claire Lundy emailed the Service Manager Mr Atkinson, the Co-Director Mr Young and the Clinical Director Dr Craig requesting a meeting about the *"significant increase"* in activity in the Clinical Room in Ward 4E and the fact that many were blood patch patients.
- At the same time a complaint response to INI 284 highlighted the fact that Dr Seamus Kearney was of the view that in relation to 2 blood patches administered by Dr Watt there were no objective abnormal neurological findings and no evidence of intracranial hypotension. It was noted that Dr Watt had performed two blood patches without effect.
- The extent to which blood patch procedures were being carried out was continually highlighted in emails during this period by the Assistant Services Manager and senior nursing staff.
- Dr McDonnell and Dr McKinley had queried in personal correspondence in October 2015 why the numbers seemed *"incredibly excessive"* and wondered where they had all come from. Dr McDonnell in an email to consultant colleagues had asked why neurology needed 90 slots a year for outpatient blood patches. A neurology consultant's meeting in November 2015 had discussed the impact of elective blood patch procedure and after a very approximate sense check seem to have falsely reassured themselves that the numbers were not problematic.

6.121 The growing evidence of a problem with blood patch procedure evolved over several years from 2014-2016 and should, if properly evaluated, have led to a much deeper investigation of the practice. The dramatic increase of such procedures and the demand for hospital space should have cause more questions to be asked at an earlier stage and ultimately the matter should have been escalated to the Medical Director. Unfortunately, the seriousness of the problem that had developed was not fully grasped until December 2016. The Inquiry Panel can only express its surprise that there was a general lack of curiosity among the neurology consultant body at the dramatic increase in the diagnosis of such a rare condition by one consultant.

(iii) Other Complaints/Concerns

6.122 At or around this period, a number of significant complaints were received by the Trust in relation to Dr Watt. Some of these complaints flagged clinical issues of concern which were not addressed, see for example INI 284, INI 436 and INI 441. Others either flagged, or in the handling of the same, demonstrated issues with the administration of Dr Watt's practice, similar to those seen with regards to appraisal or the matters discussed at the August 2016 meeting, see for example INI 450, INI 434, INI 435, INI 437, INI 438, INI 451, INI 452 and INI 371. It is considered by the Inquiry Panel that these complaints contained potentially significant issues which should have been addressed and raised with the Medical Director or Director for Acute Services either individually or as a group. A substantive consideration of how these complaints were handled is set out in the Complaint's Chapter.

Further Concerns Outside of BHSCT:

6.123 On 13th May 2015, INI 453 raised a complaint with the South Eastern Health & Social Care Trust. This complaint related to an admission on 16th December 2013 where, after an MRI, CT scan and lumbar puncture, INI 453 was discharged with a diagnosis of migraine. INI 453 was subsequently referred by her GP to Dr Watt who, in April 2014, informed her she had suffered a stroke in December 2013.

6.124 The complaint was investigated by the SEHSCT who responded on 15th October 2015 as follows:

> In your email you stated that during this attendance Dr Watt advised you that you had suffered a stroke during your admission to the Ulster Hospital in December 2013. Dr John McConville, Consultant Neurologist, has reviewed your Ulster Hospital notes relating to this admission. In addition, Dr McConville has reviewed the MRI scans carried out in the Ulster Hospital on 17 December

> 2013 with Dr Corry, Consultant Radiologist. Dr McConville does not feel there is any clinical or radiological evidence to support the diagnosis of a stroke in December 2013.

6.125 Dr McConville did not treat INI 453 as a patient and, according to the South Eastern Trust, was asked to assist the South Eastern Trust in an advisory capacity with a response to the complaint from INI 453. In his evidence to the Inquiry Panel on 8th October 2018, Dr McConville took the view that the difference in diagnosis between himself and Dr Watt was *"a sort of cognitive error that a competent person can make"*.

6.126 The South Eastern Trust, in written evidence to the Inquiry dated 1st April 2022, suggested that there was no basis for escalation to Dr Watt's Responsible Officer where there was a difference of opinion between Dr McConville and Dr Watt on the diagnosis of INI 453. The point is made that not every divergence of view in medicine merits escalation. The Inquiry Panel strongly disagrees in the present context and believes that where a complaint has been made about misdiagnosis, and the investigation of that complaint highlights a difference of opinion (including the express comment that there is no clinical or radiological evidence to support the relevant diagnosis), then this may be a trigger for further enquiry.

6.127 The decision and responsibility around the extent of that further enquiry is for the Responsible Officer of the relevant doctor to determine. They are the appropriate authority to decide whether the treatment and care provided by the relevant consultant gives rise to a concern. There is no possibility of pattern recognition or assessing whether there is a broader concern, if a care provider (whether that is another Trust or the independent sector) simply determines that a difference of view is routine and not worthy of passing on to the person whose responsibility it is to evaluate.

6.128 At the heart of the concerns raised by the doctors in the Northern Trust in the INI 286 complaint was the view that Dr Watt was misdiagnosing a patient. Dr Esmonde believed he had uncovered further evidence of this trend when he emailed Dr Ken Lowry, the Medical Director of the Northern Trust, on 5th May 2016 about a further private patient of Dr Watt's that he had encountered in the NHS. This information was not passed at that time by Dr Lowry to Dr Jack, the then Medical Director of the Belfast Trust. INI 453 raised similar questions, but the information was not shared with the Medical Director of the Belfast Trust (i.e. Dr Watt's Responsible Officer) by the South-Eastern Trust.

6.129 This was a further example of where significant information which, if brought together and given to the right person at the right time would potentially have

raised concerns about a pattern of aberrant practice. The fact is that, for a variety of reasons, including the Trust's structures, information relevant to patient safety was retained in an isolated format to the extent that it was of negligible value in recognising whether there was a broader problem. This is an issue, which must be considered by all NHS and independent sector care providers if patient safety is the paramount concern in the governance of health in Northern Ireland.

6.130 On 3rd February 2016, at around the same time the BHSCT received the INI 286 concern, INI 77 raised a complaint with the Ulster Independent Clinic. INI 77 referenced an appointment in 2013 at which Dr Watt *"asked a few questions & then told me I did not have MS"*. The substance of INI 77's complaint is as follows:

> I would now like you to inform Dr Watt that he was wrong & that after further scans & a lumbar puncture that I do actually have RRMS. I find it appalling that a doctor like him asked so few questions & made his assumptions based on the very little information he asked & 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 fell that Dr Watt should refund the fee which was paid to him at the time for his appalling diagnosis.

6.131 INI 77 did receive a refund as a *"without prejudice gesture of goodwill"*. However, the substance of her concerns was not investigated nor was it shared with Dr Jack, Dr Watt's Responsible Officer.

Conclusions and Findings:

6.132 In considering the various strands, which make up what the Inquiry Panel believes was a missed opportunity in 2016, it is instructive to set out where the relevant information was retained prior to Dr Fitzpatrick's raising of the index cases in November 2016.

6.133 In his evidence to the Inquiry Panel on 19th December 2019, Dr Craig referred to a *"real head of steam building"* in 2016 prior to Dr Fitzpatrick raising his index cases. Dr Craig further reflected in his evidence:

> When you look back at it, in the round, there were – joining the dots or triangulation, or whatever way you want to put it in, is fair, in that there was clearly information that I was probably privy to that the Medical Director was not privy to. And there was certainly information that I wasn't privy to that they were privy to. And it's hard to triangulate effectively if there's that disconnect between those two layers.

6.134 What Dr Craig refers to as the *"triangulation of data"*, was a conspicuous problem. In reality, there was a wealth of information about Dr Watt, which should have given rise to concern. In practice, that information was so diffusively spread in various places that the Trust was not able to present an accurate assessment of Dr Watt's history when required to do so. This was a serious failing of governance.

6.135 First, one looks at what was held within the knowledge of the Medical Director's Office. In November 2016 this would have included:

(i) Details of the Northern Trust concern raised on 1st February 2016, the subsequent report from Professor Wills and the preparation for the meeting that took place with Dr Craig and Mr Young on 13th September 2016, but, significantly, excluding the second concern raised by Dr Tom Esmonde with Dr Lowry in May 2016.

(ii) The fact that Dr Watt had not been appraised since 2014, despite his contractual obligation with the Belfast Trust.

(iii) An anonymous complaint, which was looked into by Dr Craig, and which ultimately proved not to be a matter of concern.

(iv) The fact that Dr Watt had been admitted to DDCRM in the early part of 2016 following the INI 286 concern. There was an update at the DDCRM on 3rd May 2016, but there is no recorded discussion of Dr Watt at DDCRM between May 2016 and November 2016.

(v) The fact that Dr Watt had failed over many months to provide a report for the Coroner's Service, despite numerous reminders and eventually the intervention of the Medical Director's Office.

6.136 The second category is information within the knowledge of the Directorate Management of the Neurosciences Division. This essentially relates to Mr Young, the Co-Director and Dr Craig, the Clinical Director and, to a lesser extent, the Neurology Services Manager, Mr Atkinson and the information discussed at a meeting with Dr Watt on 30th August 2016, which highlighted:

(i) Queries regarding Dr Watt's use of and requests for HIG.

(ii) Complaints from INI 284, INI 130 and INI 440.

(iii) The meeting with the INI 286.

(iv) Issues around non-participation in appraisal over several years.

6.137 The next category relates to information within the Neurosciences Division/ Directorate. This would have included:

(i) Difficulties with the prescription of Alemtuzumab, both to NHS and private patients; the fact that Dr Watt was a significant outlier in terms of that prescription and the frustration, in particular, of Dr McDonnell, the Clinical Lead in terms of the process of individual funding request approvals (IFRs).

(ii) The dramatic increase in the incidence of epidural blood patching.

(iii) Recent complaints including INI 284, INI 436, INI 441, INI 450, INI 434, INI 435, INI 437, INI 438, INI 451, INI 452 and INI 371.

6.138 Importantly, the fourth category is information, which is not within the Belfast Trust. This includes:

(i) Dr Esmonde's further concern raised with Dr Lowry in May 2016.

(ii) The INI 77 complaint in 2016 to the Ulster Independent Clinic regarding the misdiagnosis of multiple sclerosis.

(iii) The INI 453 complaint in October 2015, which emanated from the South-Eastern Trust.

6.139 The Inquiry Panel queried why a formal meeting, which had been directed by the Director of Acute Services, Mrs Owens, to discuss specific issues, was not brought to the attention of the Medical Director. Dr Jack, in her evidence, was clear that she was not aware that such a meeting had taken place. She does not seem to have been informed about it either by Mrs Owens, Mr Young or Dr Craig. While the issues that arose may not have been decisive, the Inquiry Panel believes that the summary of concerns might have initiated a more in-depth investigation regarding the matters raised.

6.140 While it was difficult to collate all of the relevant potential clinical matters because of the manner in which information was stored and retained, the same cannot be said about Dr Watt's administrative failings. He had, as far back as 2007, received a 5-year warning from the GMC regarding his failure to provide a medical report. That same issue had emerged on numerous occasions and his record in relation to appraisal was risible. Administrative problems were known about, but the culture in the organisation is such that doctors were not routinely troubled to any significant degree by failures in their paperwork. Mrs Owens, the Director of Acute Services, in her evidence of 3rd February 2020 was quite candid:

> We all knew there were certain things happening here in terms of his admin, his delayed reports and all the rest of it[5], and we have tolerated it and have not chosen to deal with it properly and I can see that … I personally think there here we have, because I remember having a conversation with John Craig at a point in time about the admin and his delays in getting the admin, and obviously the issue for him was he was very busy. He had a very busy clinic and whatever, so that, you know, admin was obviously the last thing he got to and whatever. So what I am saying is in terms of because of the view held by a lot of people he was a good doctor. He was a busy doctor that we had to give some tolerance or some level of bye-ball to the situation.

6.141 In 2016, information was stored in various locations, and was not appropriately triangulated. There was still sufficient information, which should have caused a more in-depth review to be carried out as to Dr Watt's clinical and administrative history and failings. Communication between various tiers of management was poor. The Inquiry cannot regard this as anything other than inadequate governance for which senior managers are ultimately accountable. While it is not clear whether further action in 2016 would have ultimately made a substantial difference to the timing of events, it would certainly have informed the Medical Director's Office that there was a significant underlying problem.

6.142 At the heart of concern in relation to this time period is, however, the actions taken by the Belfast Trust following the obtaining of Professor Wills' report. The Inquiry Panel has accepted that, given that Dr Magorrian had agreed with Dr Watt, it was not difficult to conclude that although Dr Watt may have been wrong in his diagnosis in relation to patient INI 286 he was not, at that point, a risk to patient safety. One could reasonably conclude that the diagnosis in this case was complex, as acknowledged by Professor Wills. The Inquiry Panel is critical of the fact that the following actions were not taken:

(i) The immediate disclosure of Professor Wills' report to Dr Lowry in the Northern Trust.

(ii) The failure to ensure that INI 286 was fully aware that there would be changes to his medication and that, even though he was continuing to be treated by Dr Watt, that he would be treated in line with the recommendations of Professor Wills.

5 In written evidence to the Inquiry of 19th May 2022. Mrs Owens pointed out that in referring to "all the rest of it" she was referring exclusively to administrative issues with Dr Watt. The Inquiry having heard her evidence on 3rd February 2020 accepts that this was what she was alluding to in her oral evidence.

(iii) The failure to ensure that Dr Watt was carrying out the recommendations of Professor Wills and the fact that this situation continued after Dr Watt effectively ceased practice in July 2017.

6.143 The Inquiry Panel believes that, had the report from Professor Wills been disclosed to the Northern Trust, it is likely that Dr Lowry would then have further informed Dr Jack regarding the additional concerns raised in May 2016 by Dr Tom Esmonde. In his evidence, Dr Lowry accepted that the additional concerns raised by Dr Esmonde were strikingly similar to the concerns raised by Dr Esmonde and two other physicians about the end of January 2016. Had Dr Jack received those concerns, the Inquiry Panel is entirely satisfied that she would have acted, and this new information may also have provoked further contact with Professor Wills.

6.144 The Inquiry Panel was interested in the actions to be taken in respect of a meeting with INI 286 and his family in relation to the Northern Trust concern and the report from Professor Wills. The follow up actions clearly stated that recommendations were to be tracked to ensure that they were completed following the meeting with the family. Subsequent evidence revealed that, despite the recommendation of Professor Wills, INI 286 continued with the same medication as initially prescribed by Dr Watt. The failure to ensure that the recommendations of Professor Wills were implemented highlighted gaps in both communication and governance.

6.145 One of the besetting problems is that barriers had developed in relation to the sharing of information between Trusts. This is, in part, fuelled by a concern about patient confidentiality. Consent is rightly seen as essential, absent a court order or some other extraordinary reason. In this case, as confirmed by INI 286 and his family, they were always of the view that their concern or complaint related to the Antrim Area Hospital as part of the Northern Trust. There was, in fact, no good reason why the report from Professor Wills was not immediately shared with the Northern Trust. Given the consent originally obtained to instruct Professor Wills. The decision to withhold it had a significant impact on subsequent events and Trusts must recognise that if patient safety is to be paramount, it will eclipse patient confidentiality in appropriate circumstances.

6.146 The Inquiry Panel recognises that this is a delicate issue. It obtained an expert opinion from David Scoffield QC (now Mr Justice Scoffield) and Alistair Fletcher BL. Their opinion is focused on the retention and storing of sensitive personal data and, in particular, medical information by the Medical Director's Office for reasons of patient safety.

6.147 The opinion highlighted the monitoring role of the Responsible Officer as follows:

> Put simply, in the course of his or her monitoring role, the responsible office [sic] can and must keep up to date with general information held by their designated body in order to seek to identify issues relating to particular medical practitioners and ensure that, if there are any such issues, they are addressed. There should not be a narrow focus on the practitioner's own information; but it should be considered, and compared with, wider information relevant to patient safety which is held by the body.

6.148 The opinion further highlights the ambit of Regulation 14(3) of the Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010:

> This provision fleshes out the obligations of a responsible officer where there are "concerns" in relation to a medical practitioner's conduct or performance. Addressing "concerns" is a feature of the regulations, as with much other policy and guidance in this area. A variety of processes are available in this regard, depending on the nature and severity of the concern and the initial fact-finding in relation to it. The responsibilities set out in regulation 14, however, point again to statutory aims of ensuring that concerns are identified and addressed whatever their source; that there is "joined up thinking" when a concern is being investigated, appropriately linking it to "other relevant matters" within the designated body, which might include other concerns or systems issues; and that a practitioner's conduct and performance is monitored on an ongoing basis where appropriate.

6.149 The Inquiry Panel is in no doubt that the sharing and retention of sensitive information is for many involved at a senior level in healthcare, a perceived minefield. There is rightly a concern at every level that patient consent must be treated with the greatest care. The increase of statutory intervention through the General Data Protection Regulations (GDPR), and other Data Protection regulations, highlights the complexity of this area. It is, therefore, unsurprising that there is a degree of circumspection at every level. It was, for this reason, that the Inquiry sought its own legal advice and the opinion obtained strongly reinforces the Inquiry's own view that patient safety is paramount and that those charged with overseeing the practices of medical practitioners have an enhanced ability to investigate a broad range of concerns and retain information on file during the practice of the doctor concerned.

6.150 The INI 286 concern highlighted the real and genuine difficulties that existed between Trusts. For reasons of patient consent, information was not shared, and opportunities were clearly missed. It is essential that if the current Trust arrangements

are to continue in place, that guidelines need to be established for Medical Directors, which highlight the discretion that they are afforded under the relevant legislation.

6.151 While the Belfast Trust should have disclosed the report to Dr Lowry, the failure by Dr Lowry to pass on Dr Esmonde's further concerns was, in the view of the Inquiry Panel, much more significant. Dr Lowry explained that he was somewhat cautious about raising further concerns, given previous pushback and was also, to the best of his recollection, awaiting further detail from Dr Esmonde. Neither of those explanations is satisfactory. While he can be rightly upset that the report from Professor Wills was not disclosed to him at the time, he could have taken steps to insist on same or formally raise the issue. He failed to do so and, more importantly, failed to pass on what can now be viewed as critical information. As a Medical Director, he would have been fully aware of the importance of his duty.

6.152 Although not part of the National Health Service, the Ulster Independent Clinic ("UIC") must also take a degree of responsibility because they failed to pass on to the Medical Director's Office, relevant information in relation to INI 77. Full details of that complaint, passed on in a timeous manner, would have been given to the Medical Director at a critical time. Unfortunately, at that point, there was a flawed understanding of the role of the UIC and their responsibility to pass on and disclose information to Dr Watt's Responsible Officer. In the view of the Inquiry Panel, this was a significant omission and was compounded subsequently by a written response from the UIC to a specific question regarding previous complaints, which was inaccurate.

6.153 The Terms of Reference of the Inquiry create a distinction between Part A, November 2016 to May 2018, and Part B, the period before November 2016. It is important however to not lose sight of the fact that the concerns raised by Dr Fitzpatrick occurred only a matter of weeks after concerns regarding Dr Watt were considered by the those within the Neurosciences Directorate.

6.154 A feature is that when concerns were raised by Dr Fitzpatrick in November 2016, little or no reference was made to the concerns which were actively considered in the period February to September 2016.

6.155 A paradigm example of this failure to look back on previous concerns is the fact that the Inquiry Panel has seen only three references to the INI 286 concern from November 2016, when concerns were raised, to May 2018, when the recall was announced. These references can be outlined as follows:

(i) At a meeting on 1st December 2016, discussing the concerns raised by Dr Fitzpatrick, a handwritten note prepared by Peter Watson states, inter alia, *"previous issue with NHSCT patient – INI 286"*.

(ii) At a meeting on 1st August 2017 attended by Dr Jack, Dr Craig, Mr Watson, Mr Young and Ms Claire Cairns, Risk and Governance Manager, which recorded *"last year, Northern Trust Colleagues concerns re care. I Expert -> unsubstantiated"*.

(iii) On 1st May 2021, Mr Watson prepared a timeline of events addressing the period from when considers were first raised to the calling of the recall. The first entry on which began *"16 September 2016 – Concerns regarding patient INI 286 closed further to receipt of independent expert report from Prof Adrian Wills and meeting with complainant on 13th September"*.

6.156 Regardless of the perceived outcome of Professor Wills' report re INI 286 and whether he was deemed to have raised or assuaged concerns regarding Dr Watt, the Inquiry Panel is concerned that this matter was not substantively looked at again by the Trust. While using INI 286 as an example, it is also the case that the Trust, also failed to refer to concerns regarding HIG, Alemtuzumab, complaints and appraisal, all of which had been considered at least within the neurosciences division at one point or another during the period February to September 2016. This may have enabled patterns to be identified and, potentially, showed that there were broader issues with Dr Watt's practice. While it is important that an organisation handles concerns as they arise; important information could have been gleaned by looking back at matters previously considered or shared from any of the repositories of information once Dr Watt's practice was known to be under investigation. The fact that an earlier issue has been investigated and determined as not requiring further action does not mean that it can be safely ignored in any review.

CHAPTER 7 – INDEPENDENT SECTOR

Introduction

7.1 There are four key aspects of the Inquiry's Terms of Reference, which require it to consider the involvement of the independent healthcare sector.

7.2 First, the Inquiry is required to review the Belfast Trust's handling of relevant complaints or concerns identified or received prior to November 2016. One of the complaints (INI 45, which is detailed below at paragraph 86 onwards), which came to the Trust's attention prior to that date, and identified by the Inquiry as significant, originated in the independent sector. To properly assess the Trust's handling of the INI 45 complaint, which is detailed in chapter entitled 2012-13 Missed Opportunities, the Inquiry must consider the manner in which relevant information came to the Trust.

7.3 Second, the Inquiry is asked to determine whether there were any related concerns or circumstances, which should have alerted the Belfast Trust to instigate an earlier and more thorough investigation over and above the extant arrangements for raising concerns and the existing complaints procedure. Dr Watt had an extensive practice in the independent sector and the Inquiry heard evidence in relation to complaints made about that practice. The Inquiry has considered the extent to which, if any, the Trust was aware of those complaints; if so, whether this should have led to further investigation; and if not, whether it should have been made aware of the relevant complaints or concerns.

7.4 Third, the Inquiry is required to review the Trust's participation in processes to maintain standards of professional practice, including appraisals. An appraisal is required to be one of 'whole practice', and the Trust had a responsibility to ensure Dr Watt's independent sector practice was taken into account in the same way as his NHS practice in that process. Further, for the relevant periods being looked at by the Inquiry, the Trust Medical Director was Dr Watt's Responsible Officer and, therefore, required to make a recommendation to the General Medical Council ("GMC") as to whether he should be revalidated. To make a positive recommendation, the Responsible Officer must be satisfied that there are no outstanding concerns. To reach that conclusion safely, they must first know about any concerns raised, regardless of the sector in which they have arisen. They must have access to all the relevant facts, such as whether this is a one off or if there is a pattern. If information is retained in silos, including in the independent sector, then the opportunity for proper analysis is limited.

7.5 This chapter, therefore, considers the governance structures and the attitudes of management in the independent sector providers ("ISP") in which Dr Watt practiced, to assess whether they were fit for purpose to facilitate the full and safe assessment of concerns by both the ISP and the Responsible Officer, and the completion of a 'whole practice' appraisal. In this regard, it also considers the extent and effectiveness of regulation of the independent sector by the Regulation and Quality Improvement Authority ("RQIA").

7.6 Fourth, the Inquiry is required to evaluate the corporate governance procedures in the Belfast Trust in areas directly bearing on patient care and public safety, with reference to the period from November 2016 until May 2018. As set out in the chapter on Part A of the Inquiry's Terms of Reference, by mid-December 2016 concerns about a number of index cases had been raised with the Trust by a General Practitioner. There was an onus on the Trust thereafter to investigate those concerns as safely and efficiently as possible. All 6 index cases had been seen by Dr Watt in the independent sector at some stage. There was, therefore, key material in patient notes and records, which was required for an assessment of the clinical appropriateness of Dr Watt's care and treatment outside the control and easy access of the Trust. The delay in accessing notes in those specific cases is dealt with in detail in the November 2016 - May 2018 chapter, but, in this chapter, the patient safety concern arising from limited access to full notes and records for treating clinicians in either the NHS or independent sector - and those responsible for their oversight - is considered in general terms.

Dr Watt's Private Practice:

7.7 Dr Watt practiced at the Ulster Independent Clinic ("UIC"), Hillsborough Private Clinic ("HPC") and Orthoderm Private Medical Clinic ("Orthoderm"). Representatives from these organisations gave evidence to the Inquiry Panel as well as individuals from Kingsbridge Private Hospital, North-West Independent Hospital, the Independent Healthcare Providers Network and RQIA.

Regulatory Framework:

7.8 The Health and Personal Social Services (Quality, Improvement and Regulation (Northern Ireland) Order 2003 ("the 2003 Order") defines an independent hospital as a hospital that is not vested in the Department of Health or managed by an HSS trust. There are currently six independent hospitals in Northern Ireland. These are: Kingsbridge

Private Hospital; North-West Independent Hospital; The Ulster Independent Clinic; Fitzwilliam Clinic; Hillsborough Private Clinic and Orthoderm Clinic.

7.9 In July 2014, the Department of Health published a document entitled, *"Minimum Care Standards for Independent Healthcare Establishments"*[1] in accordance with their power under Article 38 of the 2003 Order. This document set out minimum standards for independent health care in Northern Ireland.

7.10 The RQIA is the independent body that regulates and inspects the quality and availability of Northern Ireland's health and social care ("HSC") services. RQIA have a responsibility to regulate those independent care facilities which carry out medical procedures, including all the independent clinics where Dr Watt practiced.

7.11 In her evidence to the Inquiry Panel on 14th January 2020, Dr Lourda Geoghegan, Medical Director and Responsible Officer within the RQIA explained:

> Whether you are a [independent] hospital, or a clinic depends on what you do. And then there are a whole range of prescribed techniques that it depends on what you're doing. It depends if you have an overnight bed or not. Or even an operating theatre use of anaesthesia, well it's not the theatre; it's the use of anaesthesia, essentially services that need anaesthesia. And then there's an issue about a private doctor. Okay, so, if you are running a service, which is run exclusively or provided exclusively by a private doctor, then you must register with us, and it's the clinic that's registered. The private doctor and the clinic are registered. But if you have a facility, which has either somebody on the GP performers list or working in the NHS, then you may not be required to register with us. So, there are facilities that are not required to register with us because they don't come in under any of these categories.

7.12 RQIA was established in 2005 under Article 3 of the 2003 Order to drive improvements for everyone using health and social care services. Whilst accountable to the Department of Health, it is an independent health and social care regulatory body.[2]

7.13 The RQIA must consider the extent to which the minimum standards have been met in determining whether a service maintains registration or has its registration cancelled, or whether to take action for a breach of the regulations.[3] It can provide assurance about the quality of care; challenge poor practice; promote improvement; safeguard the rights of service users and inform the public through the publication of reports.

1 https://www.rqia.org.uk/RQIA/media/RQIA/Resources/Standards/IndependentHealthcareMinimumStandards.pdf

2 DHSSPS Framework Document 2011, section 2.21.

3 Minimum Care Standards for Independent Healthcare Establishments, p6.

7.14 Dr Geoghegan explain the interactions between all the various pieces of legislation and standards through which RQIA conducts its business:

> So, the independent healthcare program, the independent sector comes under our 2003 order … so they have to register with us. And there's a minimum frequency of inspection every year, there are certain prescribed things they have to do. There are the regulations and the standards there are minimum standards set of regulations. And then they have to achieve those, we have to inspect them, it's annually. And then they're arranged powers with the 2003 order that we can take. If they're not achieving … you go to serious concerns; you'd have a failure to comply notice. We can apply with a magistrate for an emergency procedure to get their licence taken, or they have their facility closed. So that's the independent sector.

7.15 Prior to the events of the recall process, which commenced in May 2018, the evidence from UIC and HPC representatives was that RQIA personnel would have carried out annual inspections and occasional audits and, in addition to reviewing operating facilities and procedures, also checked complaints policies and procedures and doctors' files.

7.16 RQIA's regulatory responsibility extended in some part to the complaints systems that were in existence. The focus, according to UIC and HPC representatives, was on ensuring that a complaints system was in existence, not in assessing what action was taken as a result of a complaint. This was not the view of Dr David Stewart, a former Medical Director of the RQIA, who told the Inquiry Panel on 7th January 2020:

> [RQIA Inspectors] would have looked at the record of complaints. But in some cases all complaints. [They would have looked] at complaints; and at what the response had been given to the complaint; what the process was. Whilst I can't say whether, if the complaint related to a clinical issue, that they would have looked for - I think there was an issue that was felt to have been needed to be sent through to the professional regulator, which probably, given this number of people involved would have been more often to the nursing regulator.

7.17 Written evidence, as provided to the Inquiry by RQIA, included inspection reports for the 6 independent hospitals in Northern Ireland. References within inspection reports recorded that complaints files and the complaints register were reviewed and looked at to ascertain how they were recorded, and what the outcomes of those were and how complaints were managed within the establishment by speaking with staff and management and reviewing patient questionnaires.

7.18 The extent to which clinical complaints were followed through remained a question for the Inquiry Panel. The view was taken by RQIA, as confirmed by Dr Stewart, that this was a matter for the relevant professional regulator.

7.19 RQIA was tasked to regulate only those independent hospitals, which provided operating facilities. Traditionally, many consultants would have seen patients in their own homes and the advent of private clinics and hospitals has been a comparatively recent phenomenon. Consequently, clinical governance and management has been influenced by a light touch approach, given that regulation is the responsibility of an independent professional Regulator (the GMC) and in many cases in Northern Ireland, consultants are also employed, trained and managed within the NHS.

7.20 The Inquiry noted with interest that a report by the RQIA was published in June 2021, which reviewed governance arrangements within the independent sector. In a letter to the Inquiry Chairman on 29th June 2021, Ms Christine Collins, Interim Chair of the RQIA, stated:

> The Report provides a strategic and system-wide assessment of the governance arrangements in place, presents detailed evidence to support its findings, and makes 20 recommendations (see list at Annex 2) to bring about system wide improvements to governance arrangements across independent sector hospitals and hospices.
>
> Full implementation of these recommendations will significantly improve the quality and safety of care provided by independent hospitals and hospices in Northern Ireland. RQIA will continue, through its annual inspection programme and regulatory framework, to support and where necessary enforce improvement in governance systems. In addition, RQIA is reviewing its approach to registration of establishments in the independent sector.
>
> The independent sector is increasingly important in delivering health and social care for the population of Northern Ireland; it is also becoming increasingly diverse. Robust registration and governance arrangements must be in place, to safeguard patients and services users; RQIA will continue to encourage all independent sector organisations to learn continuously and implement best practice guidance, with a focus on the sound governance essential for safe, effective and high-quality health provision.

7.21 The RQIA review involved a more focused analysis of the existing governance structures within the independent sector than had previously been attempted. The recommendations made resonate strongly with the observations of the Inquiry Panel in relation to the overall sector and there appears to be an overlap in terms of the extension of the Electronic Care Record to the independent sector and the need

for much greater clarity about communication with a doctor's Responsible Officer. The Inquiry welcomes the fact that there has already been an internal review by UIC and adds its voice to the increasing necessity for the independent sector to take on a more significant role and robust approach to clinical governance so that patient safety can be enhanced.

EVIDENCE:

Ulster Independent Clinic ("UIC"):

7.22 Miss Diane Graham, Matron and Chief Executive at UIC gave evidence to the Inquiry Panel on 30th October 2018. She explained how consultants who are approved initially by UIC to practice have to go through a process of providing certain forms and certification. Miss Graham described this as a *"further induction process"*:

> **Miss Graham:** So they have to produce their documentation with regards to their GMC, their hepatitis reference from their Clinical Director. I am trying think what else. Their MDU or MPS certificate.
>
> **Professor Mascie-Taylor:** Do you have recent appraisal in it?
>
> **Miss Graham:** Yes. It is the sign off form 6, we don't get the whole document And a CV as well.
>
> **Professor Mascie-Taylor:** Right. Is that kept up-to-date?
>
> **Miss Graham:** They are requested to update us on an annual basis whenever their appraisal is done.
>
> **Professor Mascie-Taylor:** And what if they don't?
>
> **Miss Graham:** We send repeated reminders to them.

7.23 When asked about the approach of RQIA to checking up on the processes, Miss Graham explained:

> **Professor Mascie-Taylor:** Just as a matter of interest, what does your regulator do to make sure you are doing that?
>
> **Miss Graham:** They will do spot checks. The names of people with admitting privileges and they will spot check them.
>
> **Professor Mascie-Taylor:** Right. My suspicion is therefore that some of those they spot check won't be up-to-date.
>
> **Miss Graham:** There have been issues in the past.

> **Professor Mascie-Taylor:** What happened, what does the regulator then do? Miss Graham: Then we have to assure them that we are following up and have put additional measures in place.

7.24 Although it was the case, according to Miss Graham, that on limited occasions, consultants who were not up to date with their paperwork had been stopped from practising, this was a rare occurrence and did not have any relevance to Dr Watt even though he had failed to produce appraisals for 3 years.

7.25 The UIC complaints policy[4] was managed by the *"Hospital's Registered Manager, ie Matron/Chief Executive"*. A key principle of the Complaints Policy was that *"Hospital management takes responsibility for and co-ordinated the resolution of all complaints including those against clinicians"*. Investigation comprised 3 stages: local resolution; internal appeal and Independent External Adjudication.[5] What is conspicuously absent in the complaints policy is the issue of when the Clinic will report a clinical complaint to the consultant's Responsible Officer.

7.26 The evidence below sets out several index examples of where complaints are handled internally, but were not disclosed to the Responsible Officer. It is correct to say that the consultants themselves do have an obligation to disclose any complaints in their appraisal form and, further, that being appraised is a requirement of having practising privileges with UIC. However, if a consultant, such as Dr Watt, is not appraised, as was the case between 2013-2016, or fails to disclose a complaint(s) for various reasons, then there will not be a whole of practice appraisal and the opportunity for the complaints to be disclosed via this process would be negated. It is also worth noting that reliance on the appraisal process for timely sharing of complaints would be misplaced in any event. Even if undertaken in a timely fashion by the doctor, the appraisal process may take place a considerable time after the complaint. In Dr Watt's case, appraisals did not take place at all for several years. Further, as is discussed in the Appraisal and Revalidation Chapter, appraisal is a reflective process, not a vehicle for communication with a doctor's employer or Responsible Officer.

7.27 Miss Graham indicated that it was her understanding that the doctor brought complaints to the Responsible Officer by way of the annual appraisal process. Miss Graham further explained to the Inquiry Panel:

> **Professor Mascie-Taylor:** So the information you have is you have all that information every quarter about the doctor's practice to your credit.

4 The 2012 policy was revised in September 2017.

5 In accordance with the Independent Healthcare Advisory Services document "Making a compliant in the independent sector' October 2007, the Code of Practice for members of the Independent Sector Complaints Adjudication Services May 2013 and Complaints in Health and Social Care Standards and Guidelines for Resolution and Learning DHPPS April 2009.

> **Miss Graham:** Mm-hmm. Professor Mascie-Taylor: Yes. Miss Graham: Mm-hmm.
>
> **Professor Mascie-Taylor:** You have individual letters of complaint.
>
> **Miss Graham:** Mm-hmm.
>
> **Professor Mascie-Taylor:** I am not quite sure how you investigate them other than bringing it to the attention of the doctor.
>
> **Miss Graham:** Mm-hmm.
>
> **Professor Mascie-Taylor:** So there is quite a lot of information there but none of it gets to the RO.
>
> **Miss Graham:** No.

7.28 Miss Graham, in her evidence to the Inquiry Panel on 30th October 2018, also referred to the Clinical Governance and Medical Audit Sub-Committee of Directors in UIC. She indicated, as Chief Executive, that she would take to the committee at that point, on a quarterly basis, any complaints or any clinical matters of concern for review. If there was something that she had an immediate concern about then Miss Graham indicated to the Inquiry Panel that she would telephone the Chairman of the sub-committee or the Chairman of the Directors for advice.

7.29 Miss Graham also explained that when she got a clinical complaint, she would initially work with the clinician who was the subject of complaint and then the matter would go through to the relevant sub-committee. At that time, however, the matter was not automatically reported to the Responsible Officer.

7.30 The current Chairman of the Board of Management, Mr Ian Brown, gave evidence on 29th September 2020, and advised the Inquiry Panel that the UIC has now introduced a requirement that the Responsible Officer must be contacted with complaints in relation to a doctor at any time. Responding to the Inquiry Chairman's specific question, Mr Brown stated:

> **Mr Lockhart QC:** … Because of the whole of system approach, our view is that a patient, whether they go to the Ulster Independent Clinic or the Royal Victoria Hospital, should have the same expectation. What we are concerned about is that the flow of information is easy and is immediate between UIC and the Responsible Officer. The slight concern I picked up at the time was in the past I think the obligation has been on that of the doctor.
>
> **Mr Brown:** Of the doctor.
>
> **Mr Lockhart QC:** Yes.

> **Mr Brown:** That perhaps includes agreement with the doctor. The UIC has now changed that. We have to directly contact the Responsible Officer with any complaints at any time.

7.31 It is also the case that letters of good standing are required by the Belfast Trust, as part of the appraisal process, to be obtained by the consultant from the independent provider every year. If those letters of good standing are standard documents, which give a bald and generic statement without further detail, they are of limited value if the aim is for the Responsible Officer to be sighted on all aspects of a consultant's practice.

7.32 In September 2020, UIC furnished an external report, which had been provided to the Clinical Governance & Medical Audit Committee of the UIC by Mr Keith Hawley, Independent Risk & Governance Consultant. The Inquiry Panel notes paragraph 3, which states that the Terms of Reference are to:

> Make recommendations to enable a functioning system, which effectively monitors quality, identifies all relevant issues thereby ensuring triangulation of information and intelligence thus providing the Board with assurance of a high standard of patient care.

7.33 In the complaints that the Inquiry received from UIC, it was noted that complainants were informed that *'each consultant using the facilities of the Ulster Independent Clinic does so in the capacity of a self-employed practitioner'*. Whilst this may be correct as a statement of employment law, the wording could legitimately be understood by a complainant to suggest that they should sort the complaint out directly with the relevant consultant. At the same time, this conveys to the consultant that a key strand of clinical governance is primarily a matter for the consultant rather than the provider.

Significant Complaints:

7.34 On 9th January 2012, the mother of patient INI 325 wrote to Miss Graham following an appointment with Dr Watt on 23rd February 2011. The patient had been referred by her GP, having had continuous headaches since 2010. The following symptoms, according to the patient's mother, were relayed to Dr Watt:

(i) Headaches throughout the day which were worse in the morning, and which woke the patient at night.

(ii) Head pain and heaviness around the front of her head and forehead and bottom of her head above her neck.

(iii) Feeling nauseous.

(iv) Dizziness especially when climbing stairs.

(v) Fatigue.

(vi) Sore eyes.

7.35 The letter of 9th January 2012 complained that Dr Watt did not carry out a clinical examination, including eye assessment, or perform any neurological tests. The patient's mother alleged that Dr Watt diagnosed migraine and suggested that the patient should take up swimming to assist stress. He also prescribed propranolol. The patient's symptoms continued, and she was subsequently examined by an optician, who recommended she be seen by an ophthalmologist. Mr Sharkey carried out an examination and referred the patient for an MRI scan, which was carried out at UIC on 5th July 2011. The scan revealed, according to the statement made by the patient's mother, a tumour on the patient's brain stem and hydrocephalus.

7.36 The patient's mother further stated:

> I would like the opportunity to ask the following questions:
>
> (i) Why was a full clinical examination not undertaken at the consultation?
>
> (ii) Why was an MRI scan not considered, especially as we were covered through our private health insurance?
>
> (iii) What are the current guidelines for the management of headaches in a fourteen year-old?

7.37 The letter concluded:

> I look forward to receiving an acknowledgement of this letter. I would like a thorough investigation into my concerns. I would like a response in accordance with your complaints procedure within 20 days.

7.38 The correspondence of 9th January 2012 was acknowledged on 17th January 2012 and Miss Graham promised to pass the letter to Dr Watt for a response.

7.39 Dr Watt prepared a note on 31st January 2012, enclosing a copy of his letter to the patient's GP. The letter set out details of the complaint and noted that *"examination was unremarkable"*. Dr Watt's letter concluded:

> I feel that the headaches are migraine and largely stress related. I have suggested trying propranolol 10mg twice daily, increased as needed and tolerated as migraine prophylaxis. She could eventually increase to 80mg or 160 mg M/R daily. I have also encouraged her to take regular exercise in an attempt to reduce her stress levels. I have not arranged to review her for the moment.

7.40 In contrast, in his note, Dr Watt explained that he *"did not perform a full clinical examination because there was nothing on history to suggest that it would influence my decisions regarding diagnosis and management"*. He continued:

> I always consider performing an MRI scan but did not because there was nothing on the history to suggest I should. At the time I felt the history was typical of a 14 year-old girl presenting with migrainous headaches. MRI in these circumstances is much more likely to reveal an incident abnormality which adds to everyone's worries.
>
> However, I do as a rule scan patients if they return because of headaches are not setting with treatment.
>
> There are various guidelines to be found on the internet for the management of headaches in teenagers.

7.41 On 7th February 2012, Miss Graham wrote to the patient's mother enclosing Dr Watt's report and his initial letter to the GP. Miss Graham followed up by saying:

> Should you wish to discuss the matter further with Dr Watt I can facilitate such a meeting at the Ulster Clinic.
>
> For information each consultant using the facilities of the Ulster Independent Clinic does so in the capacity of a self-employed practitioner.

7.42 No further correspondence was received from the patient or her mother, nor was the matter further investigated by UIC. In response to written questions posed by the Inquiry, the solicitor for UIC confirmed in a letter dated 6th February 2019 that the above complaint had not been shared with Dr Watt's Responsible Officer.

7.43 The Inquiry also notes that in the appraisal documentation submitted by Dr Watt for the period January to December 2012, Dr Watt has signed the Declaration of Absence of Complaints and declared that: *"to the best of my knowledge I have received no complaints relating to my professional practice since my last NHS Appraisal on 23rd March 2012"*. Further, under the heading 'Maintaining Trust' the appraiser, Dr Stanley Hawkins, has written: *"Issues in previous years discussed. No issues in year 2012"*.

7.44 At the same time as Miss Graham was dealing with the complaint from INI 325, correspondence was received from the GMC regarding the complaint that had been made by INI 45 following an attendance with Dr Watt at HPC (see below at paragraphs 86 onwards for more details on the INI 45 complaint). In correspondence of 20th January 2012, Miss Graham was asked about any concerns relating to Dr Watt's practice and, in particular:

- details of any other concerns or previous complaints (if any) about Dr Watt.
- any audit findings (or other quality assurance measures) which might indicate problems with Dr Watt's practice.
- any data (e.g. in relation to prescribing patterns) which might indicate poor practice.
- any other information which you think might be relevant to our inquiries.
- confirmation of the capacity in which Dr Watt is employed by you.

7.45 The letter was not responded to within the timescale provided (2nd February 2012) and on 3rd February 2012 a GMC investigation officer again wrote to Miss Graham and asked if a substantive response could be provided by 9th February 2012.

7.46 On 9th February 2012, Miss Graham responded apologising for the delay, which had been due to her inability to speak with the Chairman of Medical Staff until 7th February 2012. In relation to the queries raised, Miss Graham stated:

> Dr Watt joined the medical staff of the Ulster Independent Clinic in March 1997; his speciality being neurology. The internal audit system of the Ulster Clinic does not highlight any concerns regarding Dr Watt. Dr Watt uses the outpatient facilities of the Ulster Clinic on a regular basis and does so in a self-employed capacity. He is not an employee of the Ulster Clinic.
>
> I have no further information regarding the complaint, which you have highlighted.
>
> I am currently dealing with a complaint by a mother regarding her daughter's consultation with Dr Watt.

7.47 Subsequently, the same Investigation Officer wrote again to Miss Graham at the UIC on 15th February 2012 and enquired if the complaint raised any fitness to practise concerns. No response was received to this inquiry and the matter was not followed up further by the GMC.

7.48 On 29th September 2020, this complaint was explored in oral evidence with UIC witnesses. Miss Graham indicated that as the matter was 8 years ago, one could only look to the minutes of the Clinical Governance Committee. It was accepted that these minutes were generic and the specific case relevant to the GMC enquiry could not be identified. Miss Graham also explained the normal process when an enquiry was made by the GMC:

> It would go through clinical governance, and it would be discussed, and a formal response made.

7.49 The Inquiry Panel regards the minutes as being inadequate in failing to highlight a material fact; namely, that Dr Watt was being investigated by the GMC and that UIC had been asked about other complaints. Given that there was another material complaint, the failure to identify this properly or ensure that it was recorded in the minutes of the meeting of the Clinical Governance Committee meant that the significance of the matter was never appreciated either by the GMC or subsequently by the Belfast Trust.

7.50 The Inquiry Panel also notes that there were similarities between INI 45 and INI 325 in several respects:

(i) Both involved headache/migraine type complaints where there was ultimately an underlying sinister condition.

(ii) It was alleged in each case that Dr Watt had not performed an examination.

(iii) In both cases, follow-up tests were not carried out.

7.51 The fact that the complaint by INI 325 was not disclosed to the Responsible Officer, or the GMC, ensured that those similarities were not noted or analysed. This was a missed opportunity to recognise a potentially aberrant pattern with Dr Watt.

7.52 In response to the concern that the same inadequate and limited disclosure to the GMC could happen again, the following exchange took place at the hearing before the Inquiry Panel on 21st September 2020:

> **Mr Lockhart QC:** How do we reassure ourselves this kind of inquiry will lead to the GMC getting the information?
>
> **Miss Graham:** Recent experience of the GMC is if you don't respond they will continue to communicate with you until they get a response, plus we have also got the employment liaison.
>
> **Mr Lockhart QC:** Joanne Donnelly.
>
> **Miss Graham:** Yes, as well.

7.53 Mr Ian Brown, a consultant orthopaedic surgeon, (who at the time of giving evidence had assumed the role of Chairman of UIC) pointed to *"a higher index of suspicion"* in more recent times. In particular, the Clinical Governance Committee had changed the approach to reporting matters to the Responsible Officer:

> Mr Brown: As soon as Matron gets a complaint that we are concerned about, that she is concerned about, then it has to be escalated up. I am stating that loud and clear. We may consider, we may say, and we discussed at the Governance Committee and further information requested but the [Responsible Officer] will be informed.

7.54 Mr Brown also stressed that the following changes have been implemented:

- Increased focus on detailed minutes of meetings of the Clinical Governance Committee.
- Liaison with the GMC or the Responsible Officer is not done in conjunction with the consultant who is the subject of the complaint.
- Collation of records on a database, which assists searching through relevant files.
- Amendments to the Practice and Privileges Application form, which underlines the independence of UIC and its right to liaise directly with the Responsible Officer.

7.55 A further issue in relation to liaison with the Responsible Officer was considered by the Inquiry. On 8th August 2017, a letter from Dr Cathy Jack, then Medical Director of the Belfast Trust and Dr Watt's Responsible Officer within the NHS, was emailed to Miss Graham for the attention of Mr Peter Ramsey-Baggs, the Responsible Officer for UIC, in relation to those consultants not working within the NHS. Dr Jack summarised the concerns in relation to Dr Watt, outlined the steps that had been taken regarding clinical restriction and indicated that the RCP had been asked to conduct a case review. In the penultimate paragraph, Dr Jack made the following request:

> Finally, I should be grateful if you would advise me as Dr Watt's Responsible Officer of any concerns or complaints which have arisen in your institution regarding Dr Watt in the last 3 years.

7.56 As Dr Watt's Responsible Officer at this time, Dr Jack was required to make a revalidation recommendation, which took account of the entirety of Dr Watt's practice, in both the NHS and independent sector.

7.57 On 25th August 2017, Miss Graham emailed Mr Peter Watson from the Medical Director's Office at the Belfast Trust and indicated that Mr Ramsey- Baggs had requested that the email from Dr Jack be shared with Dr Colin Russell, Chairman of the Clinical Governance Committee at UIC.

7.58 Dr Russell wrote to Dr Jack on 21st August 2017 to confirm that Dr Watt had not carried out any clinical duties at the clinic and also confirmed:

> I am also pleased to confirm that we have no record of any concern relating to Dr Watt's clinical practice at the Ulster Independent Clinic having been raised in the course of the last 3 years.

7.59 The correspondence from Dr Russell was misleading, in that a complaint from INI 77 had been made in 2016. The rationale appears to have been that because it related to earlier treatment by Dr Watt outside the 3-year period, that it was not relevant.

7.60 On 25th June 2018, Dr Seamus O'Reilly, Medical Director in the Northern Trust, wrote to Dr Kieran Fitzpatrick, Chairman of UIC. Dr O'Reilly had been appointed as Responsible Officer for Dr Watt in place of Dr Jack. The correspondence requested Dr Fitzpatrick to assist Dr O'Reilly as follows:

> The other purpose in my writing to you is to seek your cooperation in the identification of any additional cases, which give rise to concern in relation to Dr Watt's diagnostic processes, his diagnoses or his treatment of individual patients, or indeed any other concerns about his practice. I am conscious that the recall exercise may result in a number of appointments for individual patients, such that you will not be able as yet to provide details of all concerns to me. Please do however highlight the names of relevant patients and the nature of the concerns identified in due course. I will then consider how I as Responsible Officer should review these concerns within the MHPS[6] framework and indeed also ensure that the GMC are kept updated.

7.61 The documentary evidence initially provided to the Inquiry by UIC did not contain any complaints about Dr Watt. Upon further request by the Inquiry, UIC provided a schedule of complaints relating to Dr Watt on 16th January 2019. This listed 7 verbal and 3 written complaints. Most involved questions of delay in onward referral, or the results of a scan. None of these were provided to Dr O'Reilly.

7.62 The schedule reveals that Dr Watt responded quickly to some complaints. It is noted that on the one occasion a patient complained about a delay of a week for Dr Watt to provide a letter to an insurance company, Dr Watt responded within 24 hours.

7.63 The schedule does not, however, easily permit an understanding of any clinical dimension to the complaints. The complaint by INI 77 is recorded as follows under written complaints:

> 1 received 3 years after an initial consultation requesting return of consultation fees as patient had been given another diagnosis (Feb 2016).

7.64 The documentation provided to the Inquiry included an email from INI 77 on 3rd February 2016 to UIC, which stated:

> 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

6 Maintaining High Professional Standards.

> Watt who asked a few questions & then told me I did not have MS. I would now like to inform Dr Watt that he was wrong & that after further scans & lumbar puncture that I do actually have RRMS. I find it appalling that a doctor like him asked so few questions & made his assumptions based on the very little information he asked & a quick review of my own MRI scan. If had at least asked me to have further tests & come 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.

7.65 Miss Graham, responding to the above mail on 5th February 2016, stated:

> Good evening [INI 77]
>
> I acknowledge receipt of your email dated 3/2/16 and accordingly have now forwarded it to Dr Watt for comment. By way of explanation each consultant undertaking work in the Ulster Clinic does so in a self- employed capacity so I will await his response.

7.66 The Inquiry also had sight of a letter written to INI 77's GP by Dr Watt at the time of the patient's first consultation in May 2013. The conclusion section stated:

> I feel the recurrent episodes of visual disturbance are migrainous. She has already attended Gawn McIlwaine about them. He arranged an MRI scan of the brain that was reported by Mark McClure as showing appearances suggestive of demyelination.
>
> I have told her that these changes can be related to migraine and are sometimes seen in patients with inflammatory bowel disease. There is certainly nothing on her history or examination to point to a diagnosis of MS at the moment.
>
> She finds the episodes of visual disturbance quite troublesome and I have suggested trying Lamotrigine for them, beginning at 25mgs daily and increasing gradually to 100 mgs daily.
>
> I will review her as needed.

7.67 As a result of the complaint, the fee paid to Dr Watt by INI 77 was refunded by Dr Watt. On 3rd March 2016, Miss Graham wrote to INI 77 as follows:

> Dear [INI 77]
>
> 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 on 22/05/13.
>
> As requested and as a "without prejudice" gesture of goodwill, he has asked that the enclosed cheque be forwarded to you.

> I trust this now addresses the matter for you.
>
> Yours sincerely
>
> D Graham (Miss)
> MATRON/CHIEF EXECUTIVE

7.68 This complaint was lodged in February 2016, shortly prior to the Medical Director of the Northern Trust raising a concern about Dr Watt's practice with his Responsible Officer on behalf of three consultants concerned about misdiagnosis. The INI 77 complaint was not shared with Dr Watt's Responsible Officer at that time, and this is considered in further detail in the 2016 Missed Opportunities chapter.

7.69 No further action was taken by UIC, and Dr Watt's Responsible Officer remained unaware of this complaint until after the Inquiry commenced. Dr Watt's appraisal in November 2017, which covered multiple preceding years, also makes no reference to this complaint.

7.70 In a separate matter, on 22nd March 2017, in response to a request from the Coroner's Office, Dr Watt forwarded a covering letter on UIC headed notepaper enclosing an earlier report to a GP dated 25th November 2015. The letter was typed by a member of staff in the medical secretaries' office, according to the explanation provided by UIC. That member of staff had received calls from the Coroner's Office requesting the report sent to the deceased's GP by Dr Watt. Without consulting with, or advising her line manager, the staff member typed the covering letter as 'a one off' to assist Dr Watt, who did not have a secretary at UIC. No copy of the letter was retained on the UIC IT system and UIC only became aware of the existence of the letter when it was forwarded to them by the Inquiry in November 2020.

7.71 Responding to a question from the Inquiry about the systems that were in place at UIC in March 2017, Miss Graham stated in correspondence dated 18th December 2020:

> Staff have been reminded that all correspondence on Ulster Independent Clinic headed notepaper must be held on the Clinic's IT system and that they must advise their manage of any additional correspondence requested by Consultants Correspondence received address to named consultants is placed unopened into each Consultant's correspondence folder located in the Medical Secretaries' office.
>
> In March 2017 and to date any correspondence addressed to the Ulster clinic from the Coroner's Office is responded to by the Ulster Clinic.

> If the consultant is in direct communication with the Coroner's Office regarding a patient the Ulster Clinic is unaware, unless informed by the individual Consultant.

The Hillsborough Private Clinic ("HPC"):

7.72 Sister Dianne Shanks gave evidence to the Inquiry Panel on 21st September 2018. She was the Nurse Manager at HPC and had overall responsibility for the administration of the Clinic whilst retaining some clinical duties. Sister Shanks explained that the Clinic had 12 staff, made up of the Manager, Deputy Manager, permanent nurses, auxiliaries, and administrative staff. In addition, bank nurses were also employed. The two Medical Directors of the Clinic were Mr James Sharkey, Consultant Ophthalmologist, and Mr Gary McKee, ENT Consultant. The Clinic was a limited company regulated by the RQIA.

7.73 Sister Shanks explained to the Inquiry Panel the role of the RQIA as follows:

> RQIA carry out an annual inspection of all documents, including complaints, policies and procedures, and patient files. They also pick another specific area to consider that particular year. Inspections are usually announced with 48 hours' notice or more. In addition, they do occasional audits as required, such as on infection control.
>
> The clinic is registered with RQIA because of its theatre; otherwise, we wouldn't need any regulation whatsoever. The RQIA inspects all doctors' files, even those who only do outpatient work. That file includes documents relating to their GMC registration, medical indemnity insurance, their annual appraisal and the practising privileges agreement. In respect of the appraisal, some doctors will just give us the back page which shows it has been done; others provide the full document.
>
> Any incidents at the clinic must be referred to RQIA, and they are very helpful in assisting us to deal with issues as they arise.

7.74 Around 50 consultants worked at the Clinic, but Dr Watt was the only neurologist who practised there, and he had one 3-hour clinic each month.

7.75 One of the directors of HPC, Mr Jim Sharkey, spoke of the Clinic's relationship with RQIA in his evidence of 11th November 2019:

> **Professor Mascie-Taylor:** So, going on a bit, you talk briefly about the RQIA. How would you describe your relationship with them? And, perhaps even more importantly, how could the RQIA, in your view, go about their job more effectively?

> **Mr Sharkey:** Well, the first thing I think is that we have tried to have a very constructive and good relationship with them, which I think we do. We don't see them as, in any way — anything other than treating them as a constructive organisation that will be helpful. If you complain about quality improvement, you have a problem. So we see them as being a good thing and not a bad thing. But the second part of your question, of course, is absolutely the case: are they experienced enough? Do they have the right skill mix? Who should they have on there?
>
> **Professor Mascie-Taylor:** To do their job.
>
> **Mr Sharkey:** And I would say to you, and it's not a criticism again, that they are nurse-heavy and doctor-light in terms of assessing organisations. That's what I would say. Because very often they will come in and we will meet with them, and they'll say, "What does this mean?" you know, and you've to take them through what the significance – "Why have you recorded this? Why do you think that this is significant?"

7.76 Mr Sharkey also confirmed that all complaints were reported directly to the RQIA.

7.77 Sister Shanks was asked about the appraisal forms for all doctors who worked in HPC. She told the Inquiry Panel:

> We have to chase almost every doctor for their appraisal. My secretary does this and we keep a document on file recording each reminder and when it was sent. We had a similar issue with ICO registrations which I took to the Medical Directors. If no appraisal is received, we ask for a reason why, and if the doctor is still working in an NHS practice, we accept that is satisfactory. Our policy is that at the expiry of 4 weeks after documentation expires the Medical Directors take a decision on suspending practising privileges. We have never had to consider that because all our doctors still work in the NHS. There are several reasons for appraisal running later, and it is not often the doctor's fault.

7.78 When asked by the Chairman as to what happened when there were appraisals missing from a doctor's file during an RQIA inspection, Sister Shanks stated that RQIA seemed happy that the appraisals were being chased up and were aware that all appraisals ran behind. When further asked about Dr Watt's particular file, she stated:

> His last appraisal was in 2014. On 18th July 2016 I was informed that he did not have a more up to date appraisal, and on 23rd May 2017 I was further advised that he would be doing it shortly. On looking back that length of time was perhaps unusual, but there were many other consultants behind too. At a rough estimate, over 80% would be over a year behind.

7.79 Dr Lourda Geoghegan, in her evidence to the Inquiry Panel on 14th January 2020, did not agree that the RQIA approach to ensuring appraisal had been completed by those seeking practising privileges, was as described by Sister Shanks:

> There are a couple of things because that's part of the bundle that you shared with me. And when we've had a chance to talk through with the inspection team, both in the previous regime and in the current regime, I would argue that that's not accurate either in the previous regime, and it's certainly not accurate in the current regime. In the previous regime, it would have been a small number of inspectors probably too, they would have looked at paperwork in relation to practicing privileges, and they would have looked at paperwork in relation to appraisal, but they absolutely would have looked to see are the appraisals done for a sample of staff and that sample will always have included medical stuff, and we have examples of where, when appraisals weren't done, that it was escalated. A recommendation or a requirement was made as part of the improvement plan to the provider. And we have, I've an example of internal escalation of a repeated recommendation around appraisal for a particular clinician in a particular clinic, even under the previous regime. So I would say that that's not accurate even under the previous regime, under the current regime, in my team is relating it now, it would not be sufficient to either rely on NHS for your assurance, and it certainly would not be sufficient to have an extended time without all they require.

7.80 There was little or no material difference in the methods utilised by UIC in relation to the failure to provide appraisals. Sister Shanks was asked to explain how complaints were dealt with at HPC. She explained that she would have investigated complaints against staff, but a complaint against a consultant would go to the Medical Directors, Mr Sharkey and Mr McKee, and a response would also be provided by the relevant consultant. Sister Shanks explained to the Inquiry Panel:

> If a complaint is made to a member of staff, they let me know straight away. I complete a form, filling in patient details and all information relevant to the complaint. I then contact the doctor with that information and ask for a formal response. If it is something I can deal with, I will investigate it with the team; but if it is a complaint against a consultant, their response is provided to the patient and then the complaint goes to the Directors.
>
> We don't get a lot of complaints; recently there have been a few about communication. We have never had one about clinical practice, where a patient has been unhappy with any element of their diagnosis or treatment and have never had to report anything to the GMC. All of our consultants have substantive posts in the NHS. We have before had a behavioural complaint, which was notified to the doctor's Responsible Officer and they reported it to the GMC. If we had a

clinical complaint, the same procedure would be followed: look back at all patients with similar problems at the clinic and carry out a risk assessment to identify any commonalities. There were none identified. This issue was taken to the Medical Directors and RQIA. The assessment covered the clinic, not just that doctor, but only considered that doctor's practice insofar as it was carried out in the clinic.

7.81 On 21st August 2018, the Inquiry wrote to HPC seeking:

> … any documentation held by your organisation relating to concerns in respect of patient care and or patient safety within neurology services including Dr Michael Watt, Consultant Neurologist.

7.82 In a reply of 5th September 2018, Sister Shanks stated:

> Dr Watt consulted at the clinic from 2002 until he voluntarily suspended clinics in June 2017. There have been no concerns or incidents relating to patient care or safety during Dr Watt's practice.

7.83 In addition, policies and procedures were forwarded, which included:

- Complaints
- Fitness to Practise
- Reporting Poor Professional Practice
- Practising Privileges Policy
- Monitoring the Quality of Clinical Care and Treatment

7.84 Under the definition section of the complaints policy, HPC adopted the DHSSPS definition of a complaint being *"an expression of dissatisfaction that requires a response"*. The procedure for dealing with the complaint is set out as follows:

> Local resolution should always be attempted.
>
> The manager must be notified of all complaints as soon as possible.
>
> The nurse in charge should document the complaint in the complaints file. A record should be maintained of each complaint including:
>
> - The name of the complainant
> - Details of the complaint
> - Details of the investigation
> - The outcome of the investigation and action taken for service improvement; and
> - The satisfaction of the complainant

> All complaints will be discussed with the medical directors at the Directors meetings.
>
> An audit of the complaints will be carried out by the nurse manager and included in the Clinic's Quality Improvement Report.

7.85 HPC also have a policy on reporting poor professional practice, which was issued in January 2018 and revised in January 2020, subsequent to Sister Shanks giving evidence to the Inquiry Panel. The Inquiry notes the following salient extract:

> The Nurse Manager and Directors should meet to discuss the allegations. If the complaints are serious the General Medical Council or NMC should be notified. All efforts will be made by the clinic to liaise with the Professional Bodies and assist them with their investigations. The Doctor's Responsible Officer should also be made aware of poor practice.

INI 45:

7.86 On 17th October 2011, INI 45 attended HPC to consult with Dr Watt. He brought with him MRI scans that he had obtained. The consultation did not go well and on 18th October 2011, the patient wrote directly to Dr Watt expressing his deep dissatisfaction regarding the lack of examination, the inability of Dr Watt to access the MRI results and the lack of any follow up or investigation. Dr Watt responded on 6th December 2011 and, following the patient's detailed response, the matter was referred directly by the patient to the GMC on 15th December 2011.

7.87 Details of the complaint and the manner in which it was handled are set out in detail in the GMC chapter, but, in summary, the patient complained that Dr Watt had not performed an examination and had not arranged any investigation or tests as well as the fact that he was not in a position to consider MRI scans as he had no computer. After investigation, the complaint from INI 45 was characterised as one relating to poor communication and the attitude of Dr Watt. The case examiner decided that no further action was required. This case was subsequently reviewed by the Assistant Registrar in April 2018. It was recognised that a more specialist opinion should have been obtained and that the thrust of the complaint had not been addressed.

7.88 On 20th January 2012, an Investigation Officer with the Fitness to Practise Directorate of the GMC, wrote to Sister Shanks. The substance of the letter asked for further information about the complaint or any other concerns about Dr Watt's practice. On 21st January 2012, Sister Shanks responded as follows:

> In response to your letter I would like to confirm that Dr Michael Watt has Practising Privileges to consult at the clinic on a private basis. This agreement

> has been in place since 2002. During this time we have received no complaints or concerns from patients under the care of Dr Watt and have had no indication of poor practice.
>
> With regard to this particular complaint, [INI 45] has not contacted me or written to me at the clinic with regard to this complaint. It will, however, now be recorded in our files …

7.89 The issue of a response to the complaint and the initial decision was raised with Mr Gary McKee, a Director of HPC, during his evidence to the Inquiry Panel on 9th January 2019. In response to a question from the Chairman as to whether he felt HPC should follow up on the observations made in the GMC correspondence of 13th April 2012, Mr McKee stated:

> **Mr McKee:** Not really, because his practice is regulated by the GMC. We facilitate his occupation but, ultimately, we can't say, "You're suspended", unless he does something in breach of his privileges.
>
> **Mr Lockhart QC:** I'm not asking you to suspend him. All I'm simply saying is, even at the lowest level, to say, "Look, the GMC have written to us, and we want to ensure that we have just talked this through with you". Even your own complaints policy actually talks about trying to learn from issues etc …
>
> **Mr McKee:** Yes. Usually, in a situation like that, the GMC will be writing directly to Dr Watt with their adjudication.
>
> **Mr Lockhart QC:** But they've written to you; that's the point.
>
> **Mr McKee:** Yes, but he will get a letter. Most consultants that I know of would take that as the learning opportunity. I mean, if you've been chastised by the GMC, you would certainly change your practice, unless you're very strange. Most people would take a warning from the GMC with the utmost seriousness. And if his problem is miscommunication —. I've a feeling that that was a major element in it and he didn't respond to a result or something: is that what the allegation was about? He didn't notify the patient about a result or something, and I think that was the gist of it.
>
> **Mr Lockhart QC:** Well, more than that, it was also the manner of the initial consultation. He said you should exercise and take cold showers and the guy ultimately ended up having an MRI scan reveal significant problems, lesions, etc
>
> … it was an angry complaint, there was no doubt about that — but it was quite a complex complaint … What I'm trying to tease out a little is the responsibility that you do or do not feel. And I'm saying that they come to you and say, "We have certain concerns here. It may not reach the threshold but you'd maybe want to have a conversation at the very least with them".

> Mr McKee: We didn't at the time. Neurology is a very difficult field, and if you're a medical professor, Dr Mascie-Taylor, you understand that.

7.90 This specific complaint, which was forwarded to the GMC, was considered by the Directors. In his evidence, Mr McKee stated:

> We received correspondence from the GMC stating that [INI 45] had complained that he attended Dr Watt, he hadn't received a full examination, and that Dr Watt was quite dismissive of him. The Medical Directors saw this correspondence. They didn't contact the Responsible Officer and that was the end of the matter. The original correspondence from the GMC was quite a full report with a lot of documentation attached. The GMC then updated us to say that the incident did not warrant a warning, but they had advised Dr Watt to refer to the Good Practice Guidelines.
>
> This was not included in the appraisal letter,[7] as it was not a complaint from a patient to us – it was made directly to the GMC and they were already investigating, so it didn't go into our complaints file. We would assume they would not be in the part of the file they look at.

7.91 On 13th April 2012, the GMC wrote to Sister Shanks at HPC. While deciding not to issue a warning, the GMC Investigation Officer stated in her correspondence:

> The case examiners have considered the evidence carefully. Dr Watt's consultation was less than desirable. Even if his preliminary working diagnosis was reasonable, which we accept that it probably was initially, he should have examined the patient, considered the possibility of other causes for the patient's symptoms, discussed management options with, and considered review or referral to a colleague if the symptoms continued or worsened.
>
> We note Dr Watt's reflections and his attendance at the "small vessel disease session at the UK Stroke Forum meeting" and feel that this is a constructive response to feedback.
>
> Whilst the Realistic Prospect Test is not met evidentially and we feel that, on this occasion, a warning would be disproportionate.
>
> Dr Watt is strongly reminded to familiarise himself with the terms of paragraphs 2, 20 and 21 of Good Medical Practice which states:
>
> 2. Good clinical care must include:
>
> a. adequately assessing the patient's conditions, taking account of the history (including the symptoms, and psychological and social factors), the patient's views, and where necessary examining the patient;

7 In completing appraisal, a consultant is required to obtain a letter of good standing from the independent provider. In practice, as discussed above, this tends to be a generic document with little or no detail regarding complaints although it is an opportunity for the independent provider to highlight the fact that a complaint has been received. The consistent position of HPC was that they had not received any complaint and, therefore, did not feel the need to raise the matter directly or through the letter of good standing.

b. providing or arranging advice, investigations or treatment where necessary

c. referring a patient to another practitioner, when this is in the patient's best interests

20. Relationships based on openness, trust and good communication will enable you to work in partnership with your patients to address their individual needs.

21. To fulfil your role in the doctor patient partnership you must:

a Be polite considerate and honest.

b Treat patients with dignity.

c Treat each patient as an individual.

d Respect patient's privacy and right to confidentiality.

e Support patients in caring for themselves to improve and maintain their health.

f Encourage patients who have knowledge about their condition to use this when they are making decisions about their care.

7.92 In relation to the INI 45 complaint, Mr McKee set out the response of HPC:

Mr McKee: Yes well, I mean in this case there was one incident, I think, where, I'm not sure what the foundation of it was – the patient complained directly to the GMC. That was about 2012. I think.

Mr Lockhart QC: That's right.

Mr McKee: So, we then got a note from the GMC to say "we have received an allegation", but they didn't complain to us directly, so that in a case like that, we would actually have any action. All we can do is to be passive and respond to what the GMC have authorised us or insisted that we do."

Mr Lockhart QC: But in that letter, I don't know if you remember it Gary, they asked you or they certainly requested you, you know that Dr Watt be made aware of certain issues of concern. They said "This does not reach the threshold for warning. It's disproportionate. Nevertheless we have concerns about ..." _ Do you not think that there some kind of obligation on the private healthcare clinic to say "Well we've received a direct communication for the GMC about this doctor's practice.

Mr McKee: The thing is we had no complaints about him at all for the entire time he worked in Hillsborough. None. That's the problem.

7.93 The Inquiry also noted the earlier reassurance to the Inquiry by Sister Shanks in her email of 5th September 2018, that there were no concerns or incidents relating to patient care or safety in Dr Watt's practice at the HPC. This reassurance was given despite INI 45 having been brought to HPC's attention by the GMC in January 2012. It is further noted that Dr Watt did not bring to the attention of HPC the complaint received from INI 45. This was despite the obligation in the HPC policy on monitoring quality of clinical treatment and care, to report any incident, complaint or concern.

7.94 Sister Shanks explained that because this was not a complaint directly to the Clinic, it was sufficient for the Clinic to reassure itself that there were no concerns or incidents relating to patient care or safety regarding Dr Watt. In her oral evidence on 21st September 2018, Sister Shanks clarified that in her initial response to the Inquiry, she meant that no patient had raised a concern *directly* with the clinic and that, with hindsight, it should have gone into the complaints file.

7.95 Mr McKee also set out for the Inquiry Panel, his observations on the need for the independent sector in Northern Ireland. He described the pressures on the NHS:

> It's very, very difficult. I mean, the regulation of healthcare involves growing and growing costs and, as you know, the NHS is completely disintegrating as we speak. Certainly, in Northern Ireland it's virtually ceased to function as a health service. So, people are probably being forced into going down the private route now, because there just isn't any access in the NHS for neurology, for instance.

7.96 In contrast, the independent sector, in his view, had offered a model, which had worked. As he put it:

> But what we've done is we have created a good, safe environment hopefully with people who have been approved on the NHS, regulated by the GMC. It's a nice environment to work in. We have a very low complaint profile, which is what we want. We want patients who are happy, patients who are well treated, patients with good outcomes. So far that's what we have been able to achieve.

7.97 The Inquiry Panel fully accepts that HPC has received few complaints and further acknowledge that both the GMC and the Belfast Trust were aware of the INI 45 case. Nevertheless, as Sister Shanks accepted, the GMC enquiry should have been logged as a complaint and a discussion had with Dr Watt following the GMC initial decision on 13th April 2012. Dr Watt had been advised that he should familiarise himself with paragraphs 2, 20 and 21 of Good Medical Practice and the Case Examiner had recorded that his consultation with INI 45 was less than desirable. This was a matter which should have been reflected upon by HPC with Dr Watt. It should also have

been of concern to HPC that Dr Watt did not comply with its policy to report to the Clinic any complaints received directly by a consultant.

7.98 In his evidence, Mr McKee highlighted what one might term a market approach to private medicine. He explained:

> **Mr McKee:** Well, if your quality is bad generally, the population hear about it. So word of mouth is an extremely potent thing, unless you are in an area where there's an extreme shortage of specialists, in which case people go to anybody. But, by and large, if somebody does something badly, very quickly in the private sector they become quiet.
>
> **Professor Mascie-Taylor:** So the market decides, in a sense.
>
> **Mr McKee:** It is. More so than in the NHS, where you have got no choice.

7.99 Mr McKee felt that appraisal was of limited value, but that revalidation introduced a higher threshold, in particular, because of the 360 Feedback exercise that accompanied the process, where colleagues and patients would be asked to comment on a doctor's practice:

> **Mr McKee:** We've had very few complaints, which is a crude but accurate measure probably of your performance. If we start becoming very invasive in terms of say regulation, if somebody is qualified to work in the NHS and has gone through the appraisal process and its very time consuming, hassle-y process. Revalidation is a reasonably stiff threshold to meet. The annual appraisals to be frank are not. They are just paperwork.
>
> **Professor Mascie-Taylor:** ... So your view of appraisal would be that in terms of guaranteeing patient safety, it doesn't happen.
>
> **Mr McKee:** Just paperwork. It's not going to stop anything happening.

7.100 On 11th November 2019, the Inquiry Panel also heard oral evidence from the other Director of HPC, Mr Jim Sharkey. Mr Sharkey highlighted concerns that recommendations made by the Inquiry would be too sweeping and could cause smaller clinics to suffer an undue burden, thus threatening their viability. He told the Inquiry Panel:

> You can make great — and I'm sure you'll make some very good recommendations, but it's like Kant used to say:
>
> *"There's no instrument so fine enough to grasp all the detail."*
>
> The danger with making sweeping statements and broad changes in regulation is that the unintended consequence comes along and then you regulate people

> out of existence because they're not a big enough organisation to take on that regulation and to have the extra layers of management, administration and so on and, indeed, insurance. One of the other things that will come out of this: it's hard enough to get insurance to have a clinic insured, and one of the big problems may come that companies will just cease insuring clinics because of the regulatory burden that comes on it and the potential for unexpected consequences, you know?

7.101 Mr Sharkey went on to point out how increasingly important the independent sector had become to the provision of healthcare in Northern Ireland:

> **Mr Sharkey:** — But it's also probably become apparent to you as well, how important the private sector is in healthcare.
>
> **Mr Lockhart QC:** Well certainly in neurology it was critical.
>
> **Mr Sharkey:** It was critical and it's critical in every department. Increasingly, every year we're asked to do big blocks of NHS work and all the rest of it. It is now I would guess put in as a capacity valve, you know. And without it the health system, I think would find it difficult to reach targets that it needs to reach. So it's important that obviously commissioners have confidence in what we're providing, as well.

7.102 The Inquiry Panel explored with Mr McKee the extent to which the independent sector could properly address a catastrophic incident if a light touch regulatory approach, which may have certain advantages, was utilised. Mr McKee strongly preferred that kind of model. In an exchange with the Inquiry Chairman, he stated:

> **Mr Lockhart QC:** …. I suppose, in summary, you've got two ends of the spectrum. On the one end, you know, "We simply rent out rooms" –
>
> **Mr McKee:** And that's all we do.
>
> **Mr Lockhart QC:** "What do the public perceive you to be doing?" …
>
> **Mr McKee:** It's difficult, because it is basically a relationship between the patient and the consultant, and, really, I mean, it's the same in the NHS. From a complaints point of view, we communicate all the complaints on an annual basis to the RQIA. So, there is some feedback there if we get complaints, but, if we don't get complaints, then we can't really – it's difficult for us to take the consultant's notes and copy the consultant's notes and ensure that they're on the system. It's difficult. I can't see an easy solution to that, because, I mean, ultimately, the consultant prepares the notes. He uses either his own secretary or our secretary, which is how we had access to some of the notes, because it was on our system, which facilitated our sort of follow-up, but that would be a major change – for the consultants, private consultants, to circulate the notes on

> the NHS system – and it would involve pretty large costs, because they'd then have to upload all those on to the existing systems.

7.103 The Inquiry Panel was struck by Mr McKee's candour and the clarity of his analysis. Frustrated by his experience of the NHS, he clearly favoured governance and regulatory systems, which did not become over-bureaucratic or impede the primary aim of doctors seeing patients, many of whom had been waiting within the NHS system for a long time. The Inquiry Panel can, to some extent, understand that analysis, but is of the view that light touch governance or regulatory systems caused problems whenever more serious incidents occurred or where there was a pattern of aberrant practice. Further, the public have a reasonable expectation that clinical governance standards will be the same whether they are in the NHS or the independent sector. This is a view shared by the then Medical Director of RQIA, Dr Geoghgan, who stated in her evidence to the Inquiry Panel on the 14th January 2020:

> And we were clear that a hospital is a hospital, whether it's independent sector, or whether it's NHS, and we should not be inspecting them differently or treating them differently. And so, the Chief Executive and I were clear from pretty early on, that we needed to be inspecting our independent sector hospitals and clinics as thoroughly and as comprehensively as we were doing HSE work at that stage.

7.104 The Inquiry Panel also notes the recent conclusions on 4th February 2020, of the *Independent Inquiry into the Issues raised by Paterson* chaired by the Right Reverend Graham James, Bishop of Norwich, which was published by the House of Commons. In his opening statement, Bishop James stated that the report was *"the story of a healthcare system which proved itself dysfunctional at almost every level when it came to keeping patients safe"*. He went on to say:

> [Patients] were initially let down by a consultant surgeon who performed inappropriate or unnecessary procedures and operations. They were then let down both by an NHS Trust and an independent healthcare provider, who failed to supervise him appropriately and did not respond correctly to well-evidenced complaints about his practice.

7.105 The report explored the differences between the hospital services run by the NHS and by the independent sector. It has much to say about the governance of both sectors, but it has relevance to the independent sector in Northern Ireland and medical culture, which is considered in a separate chapter of this report.

7.106 The report further stated:

> We heard from witnesses that, while the independent sector shares a regulatory system with the NHS, it has a different governance model. Therefore, it is not possible for the Government to require the independent sector to implement all the recommendations it accepts. Where good practice is implemented in the NHS, it is often voluntary in the independent sector. Where the independent sector does adopt best practice, it is often slow and decisions to adopt such practice focus on innovation and flexibility, rather than keeping patients safe.[8]

7.107 There are obvious dangers in conflating the findings and recommendations of separate inquiries where the issues and the Terms of Reference are different. Nevertheless, the Inquiry Panel believes it significant that the Paterson Inquiry reported during the currency of this present Inquiry as the Paterson report has given increased prominence to the importance of clinical governance within the independent sector.

Orthoderm:

7.108 The Inquiry Panel also received evidence from Mr Michael Eames, a Director of Orthoderm, a private clinic in Hillsborough, and Mrs Andrea Pollock, Manager, on 21st December 2018. Orthoderm, which was founded by Mr Eames, an orthopaedic surgeon, and his wife, a dermatologist, engaged Dr Watt to carry out work for the Northern, Western and South-Eastern Trusts through waiting list initiatives. Mr Eames and Mrs Pollock indicated that there were no issues with Dr Watt's practice and the Inquiry did not receive evidence of any complaints being raised. Mr Eames described the governance model of Orthoderm in similar terms to Mr McKee:

> … It's a model like the Ulster Independent Clinic: we hire the rooms out to consultants to be independent practitioners, again, in a private model. So, we don't hold their notes necessarily unless they pay us – unless we're doing their admin for them etc.

7.109 When asked if he considered private patients coming to Orthoderm to expect Orthoderm to be in some way underwriting the quality of the work done, he explained that patients distinguished between the consultant and clinic:

> I think the patients are — I think they understand that they are coming to a private facility that they will judge on the level of cleanliness, how easy to car-park, the ease of finding it, the reception staff, but then, in my experience — and now I'm talking with Michael Eames's hat on – is that they will then judge the consultant as a separate entity.

8 p222

7.110 He contrasted the approach to work done on behalf of trusts via waiting list initiatives, and the purely private work conducted at Orthoderm:

> The big difference is if it's an NHS waiting list patient, then yes, we are — when I say "we" now, it's Orthoderm — booking the patient in, we will ensure that the consultant that we have told, "There's a clinic running for you" is going to turn up and that we will be chasing the results. We'll be making sure there's a review on the system — there's lots of different red flags can appear if they need to in terms of our system and our governance. So, we have a degree of responsibility for those patients; we feel it. If it's a private patient, well then, you could be renting room 4 in Hillsborough from us and I, we as an organisation, would not know — you don't need to tell us what patients are coming to that.

7.111 However, he went on to point out that the business had an interest in patients having a good experience of Orthoderm, and they were, therefore, 'very sharp' on any medical issues arising.

Orthoderm had a similar policy to the UIC and HPC in respect of requiring appraisal to be completed. Mr Eames explained the approach to any consultants who did not have appraisal completed as follows:

> **Mr Eames:** The way we look at it, OK, is we're very strict about getting into the door, OK? So, in other words, if you want to come and practise with us and you don't have your form 6 or form 7, no; but, once you've had that that and you're in the system, then we will, if you're not coming up with your form 6 one year later again… we will look you up on the GMC website, and, so long as there's no restrictions to your practice, OK, and we have not heard of anything and we're not aware of anything then we will tick over for another 6 months or so, because we are aware of delays.
>
> **Mrs Pollock:** Yes, and we have done that with Michael watt back in the day. We checked the GMC register. We checked again down the line when he worked with us.

7.112 Orthoderm had a different system for complaints in relation to waiting list initiatives and purely private practice. In relation to the latter, Mrs Pollock described a system similar to those in place in UIC and HPC: any complaint addressed to the Clinic would go to Mrs Pollock first, who would seek the doctor's input, bring it to the Directors' Committee Meeting and feed back to the patient. Mr Eames advised that if a complaint raised a clinical issue, the doctor's Responsible Officer would be informed. In the history of the Clinic, this had never been required.

NI LLP:

7.113 The Inquiry Panel observed that at times of increased pressure on waiting lists, there is evidence of groups of practitioners banding together and offering their paid services for specific waiting list initiatives. This is, in fact, what happened with Neurology NI LLP, which was established by a group of Northern Ireland neurologists, including Dr Watt in 2011. The initiative was not universally welcomed by all neurologists.

7.114 Dr Gavin McDonnell emailed his colleagues when the issue was raised and stated:

> I don't suppose there is any hope of getting some common sense into the Trusts / DoH on this and avoiding this sort of short□termism? The costs involved in clearing just this will be more than the take home pay for 3 consultant neurologists for a year. That does not take into account the additional nursing and secretarial support. Then there will be reviews generated who will add to a
>
> W/L for review and of course that will require additional remuneration for "backlog clinics". How about a radical suggestion? We agree to do these for the going hourly NHS rate (effectively just getting appropriate additional PAs) on the proviso that x additional consultant posts are created by say August 2015?

7.115 The merits or demerits of such an initiative are beyond the remit of this Inquiry, but the Inquiry Panel does note that such an ad hoc group would need to ensure that clinical governance standards were incorporated into its actions and that patients would not be disadvantaged, by receiving care from a separate entity outside the NHS.

Electronic Care Record:

7.116 The Northern Ireland Electronic Care Record ("ECR") is a computer system that health and social care staff can use to get information about patients' medical history. It is rightly regarded as one of the outstanding achievements of the Northern Ireland healthcare system and has greatly assisted speed of access for medical professionals to critical medical information.

7.117 As helpful as this development has been, the current system is presently handicapped by the fact that the ECR is accessible only to the NHS in Northern Ireland. Therefore, only letters and results of tests generated in the NHS are uploaded; equally, only treating clinicians acting in an NHS capacity can view those records. This has significant and detrimental consequences for patient safety.

7.118 First, a treating clinician in the NHS may not have access to the outcome of certain investigations undertaken in the independent sector, or relevant information contained in correspondence.

7.119 Second, the same applies to a treating clinician in the independent sector, both in relation to treatment and investigations by others in the independent sector prior to their involvement, and on the NHS. In both scenarios, the treating clinician is dependent on a history from the patient and any documentation they may produce. At best, this leads to unnecessary delay in diagnosis and treatment for the patient. It is also an inefficient use of resources, particularly where the NHS is required, to repeat tests which have already been carried out and which would not have been repeated by the clinician had the results been available.

7.120 The Inquiry was presented with examples of patients who had been seen by Dr Watt in the independent sector and were then assessed by another neurologist who reached a different diagnosis. These original diagnoses spanned a broad range, including multiple sclerosis, motor neurone disease, intracranial hypotension and epilepsy. The Inquiry Panel heard evidence from neurologists that such a change in diagnosis was not uncommon and did not necessarily reflect poor practice in the initial diagnosis.

7.121 Dr McDonnell had reviewed in November 2016 in the NHS, a patient who was one of the index cases and, concluded that there was *"no supportive evidence for a diagnosis of MS"*, despite the patient having been diagnosed with MS by Dr Watt. Upon a subsequent review by another neurologist MS was considered *"a not unreasonable working diagnosis"* but ultimately not correct. The patient's GP believed Dr Watt to have formed a conclusive diagnosis. Dr McDonnell's view, when he first saw the patient, was that MS was a plausible diagnosis, but it could not be definite without further investigations. As he pointed out in his evidence on 29th April 2021, in respect of Dr Watt's diagnosis:

> But we don't know what the certainty was of the diagnosis for the patient, I don't know that. The other information I don't have, and wouldn't have had, would have been his private letters or handwritten notes at the time. Those would not have been available in Coleraine Hospital.

7.122 He continued:

> We don't have the history that was made available to Dr Watt on which he based that diagnosis either, that's missing in all of this …

7.123 Having access to the original clinician's record of history, diagnostic reasoning and planned investigations in the letter to the referrer, alongside the results of any diagnostic tests, can either provide reassurance to the subsequent clinician or raise question marks over the appropriateness of the earlier diagnosis and treatment. Whilst there may be some information contained in private notes that would not in any event be available on ECR, access to those documents would be of significant assistance in addressing this problem.

7.124 Third, and relatedly, anyone tasked with reviewing a case, or number of cases, has limited rapid access to relevant information. Whilst the ECR will not contain a full set of notes, it provides crucial information, which allows a case to be assessed quickly with a relatively fulsome picture. The potential blind spots created by the absence of relevant independent sector records is a significant risk to patient safety in circumstances where concerns about a doctor's practice have been raised.

7.125 This is exacerbated by the problems the Inquiry has been made aware of, particularly by patient witnesses, in relation to access to records generated in the independent sector. The delay for the Trust in accessing independent sector notes between December 2016 and April 2017 to investigate Dr Watt's practice is rehearsed in the November 2016 - May 2018 chapter. This, in turn, caused significant delay in implementing proper restrictions to protect patient safety.

7.126 This problem was highlighted in the evidence of some patients who contacted UIC at the time of the patient recall and who had great difficulty trying to access their own notes. INI 124, who wrote to UIC seeking her notes shortly after the patient recall was announced, stated in her evidence of 21st January 2019:

> **INI 124:** Well, they phoned me not that long ago, a few weeks back. They didn't actually answer that letter.
>
> **Mr Lockhart QC:** And what did they say in the phone call? ….
>
> **INI 124:** She said that Dr Watt has held on to his own notes, we have asked him for them but he hasn't released them.

7.127 INI 46 stated when she gave evidence on 13th November 2018:

> **Professor Mascie-Taylor:** On this occasion you went to a private hospital where you'd previously been a patient, and you could argue you were still a patient or you weren't depending on how you interpret that particular nuance.
>
> **INI 46:** Yes.

Professor Mascie-Taylor: But your expectation was that as a current or ex-patient with that organisation they would sort it out?

INI 46: Yes …

Mr Lockhart QC: … In total how many conversations did you have with them? INI 46: There was probably at least three or four phone calls. I think initially the first couple of phone calls are about "can I get reviewed?" Then there was an issue about your notes, so that led into more phone calls and more delaying and "no, Dr Watt holds these notes".

7.128 The Inquiry Panel also became aware that there had been problems with the storage of records in relation to patients who were being seen in the independent sector. Ordinarily, these records were retained by the consultant and the arrangements made were too often informal and ad hoc. The Inquiry Panel, in exploring the ambit of audit, had the following exchange with Miss Graham:

Professor Mascie-Taylor: Diane, you were talking about the audits you are doing. I just wondered whether any of those involved a review of the patients' notes in any way? For example, the quality of out-patient letters? I want to get a flavour of what the audits are that you are conducting. Certainly you can conduct some audits without them, but most of them you need the patient notes, don't you, to make them readable?

Miss Graham: Yes, we do audit the patient records, but as regards out-patient the only information we hold with regards to them are the letters to their GP referrer.

Mr Lockhart QC: At the moment, you would not have all the Records … The records are still kept by the consultant; is that right?

Miss Graham: Mm-hmm.

Mr Lockhart QC: Again, from an audit perspective going forward, we think the consultant holding the notes is going to be an impediment to audit, because unless you have the access to the records --

Miss Graham: Access to that --

Mr Lockhart QC: If you only get a letter to the GP and not the rest of the records.

Miss Graham: Access to the record is part of the conditions.

Mr Lockhart QC: I saw that. I did see that, but I feel again it is timing. It is the ability to say, 'we are going to do audit here and we now have access to the record'.

7.129 The Inquiry Panel had the opportunity to hear oral evidence from Dr Adrian Mairs, then Director of Public Health and formerly an Assistant Director of Public Health. From 1st March 2018, Dr Mairs was the Chair of the Northern Ireland Electronic Care Record Programme Board. When it was put to Dr Mairs that the independent sector had requested access to the record on many occasions, Dr Mairs stated:

> You're right. I'm aware that the independent sector has been seeking to have this access for some time. And I think there have been a number of reasons why it hasn't happened. It really hasn't happened because of the work plan of NIECR. It simply hasn't -. It wasn't one of the original goals of NIECR, and NIECR had been concentrating on addressing the issues that it was set up to address in the first instance. Because NIECR has been so well thought of and so successful …
>
> the jewel in the crown, it has, along the way, been asked to do a myriad of other things by a whole range of people. And one of them is independent sector access. If you want to know my view, I think it just didn't come up the priority list high enough …

7.130 Dr Mairs explained that following his initial attendance at the Inquiry, the issue was given enhanced priority and a paper has now been discussed with various independent sector organisations.

7.131 While it is encouraging to note that the focus on extending the ECR by the Inquiry has given a heightened degree of importance to the discussions, it remains the case that at the drafting of this report, the ECR has not been extended in full to the independent sector nor has the independent sector devised a means by which the records of consultants seeing patients in that sector can be accessed by an NHS doctor. The Inquiry Panel believes that the independent sector should proportionately share the cost of the ECR. The focus must be on ensuring that patients are better protected, which they undoubtedly will be, if access is extended.

7.132 The Inquiry Panel noted the response of the Permanent Secretary in the Department of Health, Mr Richard Pengelly, to the provision of the ECR in the independent sector. In his oral evidence to the Inquiry on 19th January 2021, Mr Pengelly was asked by the Chairman about the importance of access to the record and the following exchange took place:

> **Mr Lockhart:** Our concern is that all sorts of appointments, tests, etc. are missed because you cannot necessarily access the record from the private sector and, therefore, there's a potential duplication, additional cost, the left hand not knowing what the right hand is doing. Adrian indicated to us at the beginning, probably about a year and a half ago now, that there was potential data protection issues. We said data protection issues should be subordinate to patient safety

> issues. Have you any thoughts on that, or is there anything the Department feels about that, because again obviously your imprimatur would be of assistance?
>
> **Mr Pengelly:** … My own view is there is no question whatsoever that there should be full access to this [ECR] without question … This is a fantastic resource, and when we are in the business of improving the quality of care we provide, it is just beyond my comprehension that that should be denied, that any regulated professional should be denied access to that when they have someone's care in their hands.

7.133 Those consultants operating within the independent sector are unable to access the ECR unless they are dealing with NHS patients who have been referred because of a waiting list initiative. This has left a real and obvious gap in patient care and, in the view of the Inquiry Panel, undermines patient safety. Evidence obtained from the independent sector, as well as those who are responsible within the public health authority for the development and maintenance of the current system, unanimously agreed that extending the ECR to the independent sector makes complete sense and can only strengthen patient safety.

7.134 The Inquiry adds its voice to the increasing clamour for the ECR to be fully available to both the independent sector and the NHS. Ideological objections to such a development based on, for instance, a dislike of private medicine must be subordinate to patient safety concerns and there is no logical reason for this to be delayed any longer. It may well be that there is an additional cost and that it would be both equitable and necessary for the independent sector to contribute to that cost. This can, if necessary, be a matter for regulation, but any such steps should not inhibit the immediate introduction of the integrated digital ECR across both the NHS and the independent sector.

7.135 It was suggested at an early stage in the Inquiry evidence that extending the patient record to the independent sector raised data protection concerns. It will still be possible for a patient who attends a doctor privately to expressly withhold their consent to being a part of the public record. This remains a right a patient has under current arrangements. The evidence from Dr Adrian Mairs, however, reveals that only a small fraction of people, exercise such a right and the great majority of patients, as well as medical practitioners, will see such an extension as an inherently useful and appropriate step. The fact that many private institutions are developing much more comprehensive clinical governance systems should also enable the independent sector to address any data protection question about the storing of records even before the introduction of the ECR. None of these suggested impediments should undermine the paramountcy of patient safety.

7.136 The Inquiry Panel agreed with the observations of Mr Mark Regan, Chief Executive of the Kingsbridge Hospital, who, in his evidence of 13th March 2019, queried how the independent sector could be commissioned to carry out a substantial body of NHS work and yet be second-guessed on its approach to data protection when an organisation is sharing a data encrypted email. The issues raised under data protection concerns must be subordinate to the demands of patient safety.

Conclusions and Findings:

7.137 Having heard evidence from numerous independent healthcare providers, the Inquiry Panel noted what one might term as the 'hotel' model of services, and offering facilities, remains a feature of the healthcare system in Northern Ireland. That model is, however, no longer fit for purpose and the Inquiry Panel was encouraged to see some evidence of RQIA challenging this viewpoint. A patient who goes to an independent healthcare provider is entitled to the same degree of care and responsibility as anyone accessing NHS services.

7.138 In some of the early hearings, there was a noticeable reluctance among some independent providers to recognise the new reality that the growth in private provision carried with it a commensurate responsibility for clinical governance and patient safety.

7.139 The system that has evolved appears to be primarily focused on the consultant and ensuring that the provider can assist and facilitate the medical service he or she provides. Consequently, the consultant is the true customer and unwittingly the patient is subordinate to the requirements of the relevant consultant. When, however, the focus shifts to the point where patient safety is the paramount concern, this has a corresponding impact on governance and risk assessment.

7.140 Having explored the governance arrangements across various independent healthcare providers in Northern Ireland, and fully accepting this has been through a limited lens, the Inquiry Panel believes that there is a significant cultural shift required within the independent sector and is in no doubt that such a paradigm change is both necessary and urgent. An independent healthcare provider, which offers inpatient and outpatient services must expect to be regulated as a hospital, not a hotel. As such, equivalent standards of clinical governance and patient safety are required.

7.141 The Inquiry Panel does recognise that "sweeping recommendations" may lead to unintended consequences. They also agree with Mr Sharkey that the independent

sector is in many sub-specialties operating as a 'safety valve' for waiting lists in the NHS that have become, at times, unmanageable. Many patients who have been on an NHS waiting list for years feel that they have no alternative but to pay directly for a consultation. This is a significant cost for patients who can ill afford to pay for their healthcare. That said, the recommendations made in this chapter are seeking to specifically focus on concrete and targeted steps, which, it is believed, will improve communication and standards generally.

7.142 The Inquiry noted that the consistent method by which independent sector providers permit doctors to practice was via a practising privileges process, whereby facilities were granted to doctors to practice at an independent clinic on the basis that they had fulfilled the criteria required. At the heart of this process was a requirement that all doctors be up to date with their appraisal. The extent to which doctors were up to date with their appraisal was, however, an ongoing issue and no specific evidence was found of a consultant's failure to be appraised, acting as an impediment to continuing with private practice. The fact is, as pointed out in the Appraisal and Revalidation chapter, ongoing appraisal does not provide an adequate basis of ensuring patient safety.

7.143 It was also recognised that in granting practising privileges, a consultant was required to give evidence of having completed appraisal. The evidence from both HPC and UIC was that there was often a delay in obtaining the annual appraisal. To circumvent the requirement of completing an annual appraisal, the ISP would often contact the Trust to reassure itself that the consultant was still employed by the Trust. This was viewed as sufficient evidence to enable the relevant consultant to continue practising at the ISP. This approach raised an issue for RQIA but the problem of delay was not resolved.

7.144 In Dr Watt's case, appraisals were often outstanding for several years. He was, however, able to continue private practice throughout the period until being restricted from all clinical duties by the Trust on 22nd July 2017. This would suggest that the requirement to complete annual appraisal for consultants practising in the independent sector was not taken sufficiently seriously and sometimes effectively ignored by the independent healthcare providers where Dr Watt practiced. In real terms, it appears that they more often relied upon the consultant's good standing in the NHS.

7.145 In completing an annual appraisal, a consultant is obliged to disclose to his appraiser, details of any complaints or other relevant matters that had arisen in private practice. Appraisal covers the whole of a consultant's practice. The obligation is on

the consultants, but, nevertheless, the independent providers also had the option of disclosing to the Responsible Officer details of any complaints received. From the evidence that the Inquiry has seen, it appears that this was routinely not done and was a glaring gap in governance. The focus of the independent provider was, in too many instances, on satisfying a complainant. This was illustrated by the INI 77 complaint to UIC that resulted in a refund being offered and no further steps being taken.

7.146 The present system of granting practising privileges is not fit for purpose. It is nonsensical for independent institutions to rely on the validation of a Responsible Officer, when that same institution has, for whatever reason, omitted to send to the Responsible Officer details of the clinical complaints, which are relevant to the practice of the consultant concerned. At the very least, the opportunities for recognising a pattern of practise were reduced, while in some cases the omission led to a missed opportunity to identify a specific problem. This is outlined in detail in the Missed Opportunities chapters concerning 2012-13 and 2016. The aim from a patient safety perspective is that the Responsible Officer is fully sighted on all aspects of a consultant's practice, including their private practice.

7.147 Whatever view one takes about the governance methods within the independent sector in Northern Ireland, in almost all instances a consultant's Responsible Officer will remain the Medical Director of the Trust where the consultant is employed. In granting practising privileges, the independent clinic will rely on the fact that a consultant has been revalidated every 5 years and has carried out their annual appraisal within the Trust.

7.148 It is noteworthy that during the course of this Inquiry, the RQIA took enforcement action against UIC around the issue of ensuring that practising privileges were properly in place. The Inquiry Panel recognises that since the commencement of the Inquiry, there has been, in UIC, a more focused concern about clinical governance and the handling of complaints and the sharing of information with Responsible Officers. The Inquiry Panel welcomes the fact that UIC initiated its own external review of clinical governance and re-joined the national body now known as The Independent Healthcare provider network. HPC was also proactive in seeking to improve overall communication with the Responsible Officer and reviewed its own policies. It is disappointing, that in response to a formal notice from the Inquiry, the Directors of HPC, having checked with what they refer to as *"their regulatory body (the RQIA)"*, decided not to join the national body as it was (a) not mandatory and (b) they had in place a complaints policy and *"associated governance structure"* to manage complaints.

7.149 The importance of communicating with both the GMC and the Responsible Officer was highlighted graphically in the INI 325 case. There were striking similarities in the INI 45 and INI 325 complaints. If that had been grasped by a case examiner at the relevant time, then it is likely that further investigation would have occurred. This was, in the view of the Inquiry Panel, a significant missed opportunity at a critical time.

7.150 When the Inquiry commenced, none of the independent providers in Northern Ireland were members of the national body. Although UIC had been a member, this had not been renewed and, generally, the view was that the issues in the UK were different and of less relevance in Northern Ireland. The Inquiry Panel notes that some providers have now joined or re-joined the organisation, the Association of Independent Healthcare Organisations ("AIHO"), which represents over 250 hospitals that provide services to insured, self-paying and NHS-funded patients. AIHO members vary from large hospital groups to smaller, specialist providers of specific surgeries and treatments. Ms Carmichael, the Registered Manager of the then North-West Independent Hospital, referred to a meeting that had taken place with many of the Northern Ireland providers of private healthcare. The benefits of such a body are obvious including the adoption of similar governance standards and the pooling of relevant information which may enhance patient safety.

7.151 In the view of the Inquiry Panel, membership of a national body increases the opportunity for best practice and moves away from the idea that Northern Ireland is somehow a place apart with its own priorities, which differs significantly from other jurisdictions. As independent providers increasingly take on governance responsibilities, the prospect of each provider adhering to its own view of governance will ensure that statutory regulation becomes essential.

7.152 This Inquiry is not the forum to discuss the merits and de-merits of independent provision within the healthcare system. Having considered the evidence, however, the case for reform of present arrangements is overwhelming. In particular, the complaints system needs to be radically overhauled. It should be a requirement for all independent providers to provide details of any complaint with a clinical component to the Responsible Officer as soon as the complaint is received. The obligation to investigate a complaint should remain with the private clinic, but the outcome and details of the investigation should be provided to the Responsible Officer at the conclusion of any investigation and the fact that an investigation has commenced, should immediately be brought to the attention of the Responsible Officer.

7.153 Further, clinical governance needs to be viewed by independent providers through the prism of its role as a hospital with commensurate responsibilities for patient safety and the welfare of patients. The practice of deflecting complaints or concerns only to the consultant concerned needs to immediately cease. Clinical governance will need to be developed and a clear system of escalation of concerns put in place. If an ISP requires a consultant to have completed annual appraisal, then the failure to do so should result in a withdrawal of practicing privileges until the matter is rectified forthwith.

7.154 The Inquiry Panel understands that there are significant advantages to the independent sector being able to keep overhead costs to a minimum and that this may also be a factor in facilitating access for a greater number of people. The point has been reached, however, where investment is needed at management level to ensure that the highest clinical governance standards are met to match those experienced by patients within the NHS.

7.155 While it is noted above that there are obvious dangers in conflating two separate reports, there are consistent themes, which emerge, not just in the Paterson report, but in the RQIA review into governance within the independent sector in Northern Ireland and the independent governance review carried out by Keith Hawley at the instigation of UIC. The Inquiry Panel noted the following issues consistently identified across the three reports of relevance to its own Terms of Reference:

(i) There is often a conflict of interest between the maintenance and development of the independent healthcare business model and the safety of patients. Almost inevitably, patient safety, particularly if one was perceived to be dealing with low level concerns, suffered when pitted against the reputation of the organisation.

(ii) The culture that prevailed discouraged escalation to Responsible Officers and there was an over-reliance on the fact that a consultant was practising within the NHS. The rationale was adopted that if the GMC or the Responsible Officer was not getting in touch, then there no reason for concern.

(iii) The system of being admitted to practising privileges was too heavily reliant on the appraisal system and on the actions of the consultant disclosing to the ISP matters which had arisen elsewhere.

(iv) There was an over-reliance by the independent provider on the NHS governance and regulation. A light touch approach, which had been adopted during the early evolution of private healthcare in Northern Ireland was viewed as a positive and there was a reluctance to over-

> complicate medical governance. Consequently, important information did not get passed on and opportunities for the identification of aberrant practice were missed.

7.156 The initial responsibility of RQIA could reasonably be described as discrete and limited. The recent report into governance within the independent hospital and hospice sector in Northern Ireland is a measure of how the importance of governance has now been recognised and assessed in greater depth. Nevertheless, the evolutionary expansion needs to be properly codified. There is every reason to expand the role of RQIA, not just too formally include clinical governance, but also to analyse and check the handling of complaints and communication with a consultant's Responsible Officer.

7.157 Ultimately, responsibility for all healthcare in Northern Ireland rests with the Department of Health. The increased development of waiting list initiatives ensures that the sector will have a growing importance. The impact of the global pandemic only underlines this reality.

7.158 Ultimately, the Department does need to review whether greater regulation of the independent sector is required to ensure that standards of governance are fit for purpose across the health sector. At the heart of the Inquiry Panel's concern is the fact that, at times, critical information about a consultant's practice was not passed on to the Responsible Officer so that a proper view could be taken of the entirety of the practice. The gaps that can, and do, appear, undermine patient safety and allow discrepancies to emerge.

CHAPTER 8 - GENERAL MEDICAL COUNCIL

8.1 The General Medical Council ("GMC") is the regulator of individual doctors. The GMC explains its role on the GMC website as protecting patients and improving medical education. As such, it is the GMC who decides which doctors are qualified to work in the UK, who oversees medical education and training, sets the standards doctors need to follow and where necessary takes action to prevent a doctor from putting the safety of patients or public confidence in the medical profession at risk.

8.2 This specific responsibility for doctors' contrasts with the role of the National Health Service and the individual Trusts, who have a direct responsibility for the welfare and safety of their patients. A Trust will appoint a Medical Director, who will have within the ambit of his or her responsibilities, an overall concern for patient safety and the management of doctors. The roles of the Medical Director, as an employee of the NHS Trust, and as a doctor, who will liaise directly with the GMC, come together in the post of Responsible Officer, pursuant to the Medical Profession (Responsible Officers) Regulations 2010 and in Northern Ireland, the Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010. It is usually the case that the Medical Director is also the Responsible Officer for doctors within their Trust for the purposes of the Regulations. The Responsible Officer is required to recommend to the GMC the revalidation of an individual doctor and to escalate to the GMC any problem (relating to a doctor's conduct, competence or health), which could affect a doctor's registration. The responsibilities of the Responsible Officer are discussed in greater depth in the chapter on Appraisal and Revalidation.

8.3 The Terms of Reference require the Inquiry to determine whether there were any related concerns or circumstances, which should have alerted the Belfast Trust to instigate an earlier and more thorough investigation over and above the extant arrangements for raising concerns and the existing complaints procedure. At times, it appears that the Belfast Trust relied on the GMC's investigations in respect of issues raised and the Trust's internal processes and investigations may have been influenced by the GMC's determination. The Inquiry Panel is clear that the role of the GMC is an important one which needs to be carefully addressed, given both the input of the GMC in respect of earlier complaints and, more widely, in terms of its responsibility for Dr Watt's ongoing registration as a doctor.

8.4 In October 2021, the Medical Practitioners Tribunal convened to consider the case made by the GMC in relation to Dr Watt and acceded to an application by Dr Watt's lawyers for voluntary erasure based on Dr Watt's fragile mental health. The GMC

expressed its "extreme disappointment" at the decision, but after taking legal advice, concluded that there was no prospect of successfully judicially reviewing the case and pointed out that there was no right of appeal against the finding.

8.5 This matter was taken up by the Northern Ireland Assembly Health Committee, who invited the GMC to explain the position. The effect of the voluntary erasure decision was to prevent any public scrutiny of Dr Watt's practice and for many patients this raised the most serious concerns. Judicial Review proceedings were subsequently initiated in November 2021 by various patients of Dr Watt and, at the time of writing, the High Court in Northern Ireland is considering various applications, including an intervention by the Professional Standard's Authority, who has appealed the decision by the Medical Practitioners Tribunal allowing Dr Watt's application for voluntary erasure.

8.6 This Inquiry was set up on the basis that it was specifically not asked to investigate the clinical practice of Dr Watt, as this was the responsibility of the Belfast Trust as his employer and the GMC as the regulator. The decision of the Medical Practitioners Tribunal (which is independent of the GMC) to grant voluntary erasure to Dr Watt has, therefore, created a vacuum which has caused deep distress to patients and prevented proper public scrutiny of the clinical aspects that led to the patient recall and issues which arose regarding the allegations of aberrant practice. The Inquiry hopes that the review referred to by the Chief Executive of the GMC before the Northern Ireland Health Committee carefully considers the effects of voluntary erasure in cases where there is grave public disquiet.

8.7 The Inquiry Panel heard evidence from the GMC on two occasions. It also heard from Ms Joanne Donnelly, the GMC Employment Liaison Adviser in Northern Ireland. The approach taken in this chapter is to consider the actions of the GMC in relation to (1) Dr Watt, (2) the Belfast Trust and (3) the independent sector.

Dr Watt: The Issue of a GMC Warning

8.8 One of the questions that arose at an early stage of the Inquiry was the impact and meaning of the 5 year warning given to Dr Watt in 2007 in respect of delay in providing a medical report. In October 2005, the GMC wrote to Dr Michael McBride, the then Medical Director of the Royal Victoria Hospital Trust, regarding a complaint received from solicitors. Efforts had been made over a period of nearly 2 years to obtain a report from Dr Watt in respect of a claim for compensation. Dr Watt had not responded to any of the correspondence. Full details of this complaint are set out in the 2006-2007 chapter.

8.9 As far as Mr Anthony Omo, General Counsel to the GMC and its Director of Fitness to Practise, was concerned, practitioners were quite clear that a warning from the GMC could have implications for obtaining professional indemnity cover and this was also the view of the relevant medical defence organisations. The Chief Executive, Mr Charlie Massey, recognised, however, that there was a degree of inconsistency as to how warnings were approached within clinical governance structures. He told the Inquiry Panel, in his evidence of 15th January 2020:

> … There are a number of Responsible Officers I've spoken to elsewhere in the UK, who do see those warnings having real weight and importance in terms of them being a doctor who is on their radar.

8.10 Nevertheless, Mr Massey felt that a warning is basically *"something that goes on to your record"*. Mr Omo explained:

> Its regulatory action, the regulator has felt it necessary to warn you as to future practice and that is a black mark as you say, and it does have implications for the doctor.

8.11 The GMC's understanding was not shared by those within the Belfast Trust. Dr McBride, now Chief Medical Officer, and formerly the Medical Director of the Belfast Trust, stated to the Inquiry Panel that he had not heard of a written warning before he had read the 2007 letter. Dr Tony Stevens, his successor as Medical Director emphasised how unusual such a warning was, in his experience:

> **Mr Lockhart QC:** Was there any other doctor in the Belfast Trust who was under any GMC warning at this stage?
>
> **Dr Stevens:** I'm not aware of it. I mean, this was still the Royal Hospitals not the Belfast Trust, so I'm not aware of any others … and would not necessarily have been terribly well sighted on that. But Peter Walby seems to indicate that it's the first time he's come across it, so I'm pretty well sure he's right … I'm not sure what our response to a five-year warning is. There's no instructions, as I am aware, from the GMC as to what they would expect of us as an employer, and, in fact, as you point out, the [INI 346] case is their own case. And, indeed, [INI 45] came in inside the five-year warning period as well. So, they seem to place no particular weight on the warning. Now, that doesn't mean that we shouldn't have. I probably don't have a really good explanation for this other than to say to you that a lot of these issues were not Trust issues. They came to us because it was outside his normal work and we were finding ourselves picking it up … I'm not entirely clear what the Trust was required to do with a five-year warning. In reading the letter, I couldn't see any clear instruction or advice to the Trust. They [complaints] probably weren't being escalated to a level in the organisation where we might've been able to think that through. And I'm not

> sure what difference it would've made, given the [INI 346] case, anyway, and the fact that they didn't seem to weigh terribly heavily with the GMC.

8.12 INI 346 involved a request directly from the GMC to Dr Watt to complete a medical report for the GMC in respect of a matter that had been raised with them by INI 346. Dr Watt had failed to respond to the request for a medical report and the GMC had contacted the Medical Director of the Belfast Trust. It was not realised by the GMC, at that time, that the failure to provide a report was the same issue that had caused Dr Watt to be given a 5 year warning in 2007 by the GMC.

8.13 The Inquiry Panel noted that both the INI 45 complaint and the case involving INI 346 occurred within the 5-year timeframe. Ms Una Lane of the GMC felt that as Dr Watt would have been the treating physician, and the GMC was investigating concerns about another doctor, they would not have triangulated the information and would simply have followed up with the Belfast Trust, as Dr Watt had not provided a report in a timely fashion. Mr Massey indicated that historically the GMC would have kept behavioural and clinical concerns *"in different buckets"*.

8.14 Dr Watt's attitude to the GMC was commented upon by a number of witnesses. Mr Peter Walby, Associate Medical Director, stated on 8th January 2019:

> … it appears I went to him and said, "I'm going to have to say this to the GMC". And he was happy to let it go. Well, he didn't —. You know, when I say "happy", he wasn't concerned by that. And the other issue: that he didn't think his defence organisation even ought to be aware of a GMC complaint, which… was most unusual. I mean, I can't remember anything like that before, somebody being so arrogant about that aspect of their practice.

8.15 The former Clinical Director, Mr David Adams, told the Inquiry Panel on 8th January 2020, in relation to the warning that was given in 2007:

> As far as he was concerned, it [the warning] meant nothing.

INI 45

8.16 On 15th December 2011, INI 45 complained to the GMC directly regarding a consultation at the Hillsborough Private Clinic ("HPC") on 17th October 2011. A summary of the complaint is set out in the email as follows:

> … Dr Watt performed no examination of any kind and briskly diagnosed "exercise-induced migraine". He recommended that my condition be managed with "cold showers after exercise". He arranged no follow up. He arranged no further investigation or tests. He claimed that he could not opine on my MRI

> scans, as he had no computer. My wife was present throughout. His recent letter to me speaks for itself …

8.17 Following the initial consultation, patient INI 45 wrote to Dr Watt the following day, on 18th October 2011. In the detailed letter of complaint, the patient highlighted Dr Watt's advice to have "a cold shower after exercise" and the patient also referred to the following matters:

(i) The fact that Dr Watt did not have access to a computer to review scans, which the patient had brought with him.

(ii) The failure to carry out further investigations or provide a follow up appointment.

(iii) The ruling out of various conditions without recourse to reported symptoms or scan results.

8.18 Dr Watt responded to the letter of complaint from patient INI 45 on 6th December 2011, in the following manner:

> Thank you for your letter. I find your attitude hard to understand. Despite your arriving late I spent a considerable amount of time attempting to allay your fears which seems to have been wasted as you obviously have already reached your own diagnosis and just wanted someone to confirm it. If I had realised that I could have saved us both a significant amount of time and effort as I mistakenly thought you wanted my opinion.

8.19 Patient INI 45 responded in some detail on 14th December 2011, maintaining the criticisms and complaining that he was not late for the appointment, nor did he have a diagnosis of his own and pointing out that he had gone to some trouble to get Dr Watt's opinion. He stated:

> … I made fair and reasonable criticisms in my letter. You have responded with a kind of vacuous petulance that has no place in professional correspondence. If you have anything of substance to add in support of your diagnosis I will certainly consider it. Honestly, I am not quite sure what you propose to base your "opinion' upon …

8.20 Arising out of this correspondence, the patient then referred the matter directly to the GMC. This was immediately acknowledged and forwarded to the GMC Fitness to Practise Directorate.

8.21 On 28th December 2011, a GMC investigation officer, wrote to patient INI 45 seeking his consent to contact both the doctor concerned and the employer. In addition, the correspondence stated:

> … It will probably be necessary for the GMC to obtain an independent expert report from a Consultant Neurologist to inform our investigation. We will need copies of your relevant medical records (including copies of any x-rays and scans) from your general practitioner (GP), hospitals and any other private consultations you may have had. I need your consent to request these. Please therefore complete the enclosed medical records consent form and return to me by 6 January 2012 making sure to include the names and address of each party holding your relevant records …

8.22 The consent was duly provided on 5th January 2012. Patient INI 45 stated in his response to the GMC:

> … I am posting to you today the MR images on memory stick in DICOM format together with radiologists' reports from Dr A at [US hospital] and Dr B at [UK Hospital]. This is the entirety of the relevant medical data. Dr Watt did not ask for data and he claimed that he was unable to review the images.
>
> Dr X in X referred me to Dr Michael Watt for assessment as a result of the abnormalities on my MRI. You have my consent to contact Dr X if you wish. I have remitted the MR images to [the hospital] and obtained an appointment. They feel that a stroke evaluation is necessary. They propose a transcranial Doppler bubble study and detailed examination of my heart and extra-cranial vasculature.

8.23 The GMC had contacted Dr Watt on 5th January 2012 and sent a reminder on 13th January. Dr Watt responded on 17th January apologising for the delay and explaining that he was so annoyed when he opened the letter *"it was a week before I could face it again"*.

8.24 On 11th January 2012, the GMC investigation officer wrote an internal memo to the Case Examiner. The memorandum asked for advice on whether an expert report would be required. The GMC investigation officer also stated:

> … I would ask you to note that I have not yet requested the medical records as my reading of the complaint suggests to me that the issue may be one of communication and not necessarily wholly clinical in nature. I do not wish to go the expense of requesting records if it then transpires that they are not necessary …

8.25 The case summary prepared by the GMC investigation officer stated:

> On 15 December 2011 the GMC received a complaint (KD01) from [INI 45] about Dr Watt, a Consultant Neurologist. He complains that Dr Watt performed no examination of any kind and briskly diagnosed "exercise-induced migraine" which he recommended could be managed with "cold showers after exercise".

> [INI 45] further complains that Dr Watt arranged no follow up nor any further tests or investigations. In addition [INI 45] complains that Dr Watt said he could not view the patients MRI scans as he had no computer.
>
> [INI 45] finishes by stating that Dr Watt's latest letter speaks for itself … It appears that this letter is, possibly Dr Watt's reply to [INI 45's] letter of complaint to him dated 18 October 2011 (contained in email thread).

8.26 The GMC history was also included and, in particular, the case involving Dr Watt's failure to provide a report that had resulted in a patient being unable to progress a claim in respect of criminal injuries. That case resulted in the GMC issuing a 5-year warning referred to above on 22nd February 2007. Two other complaints in 1999 and 2006 had been closed without further action.

8.27 On 16th January, the GMC medical case examiner, responding to the GMC investigation officer internally, highlighted her advice:

> The medical records are definitely required. Whilst closure (+/- advise) seems the likely outcome we need to see how the doctor has recorded the consultation with respect to history and examination. An ER [expert report] is unlikely to be required.

8.28 Examination of the medical records revealed that on 17th October 2011, Dr Watt wrote to INI 45's General Practitioner. In the correspondence Dr Watt stated:

> On examination I did not detect any significant abnormalities. Overall I feel that these problems are probably migrainous. He has already had an MRI scan of brain, which showed white matters of indeterminate significance one cause of which could be migraine.

8.29 On 20th January 2012, the GMC investigation officer wrote to Sister Dianne Shanks, the Nurse Manager at the HPC. The substance of the letter asked for further information about the particular complaint or any other concerns about Dr Watt's practice. On 21st January, Sister Shanks responded to the GMC investigation officer as follows:

> In response to your letter I would like to confirm that Dr Michael Watt has Practising Privileges to consult at the clinic on a private basis. This agreement has been in place since 2002. During this time we have received no complaints or concerns from patients under the care of Dr Watt and have had no indication of poor practice.
>
> With regard to this particular complaint, [INI 45] has not contacted me or written to me at the clinic with regard to this complaint. It will, however, now be recorded in our files …

8.30 A similar letter was sent to the Chief Executive of the Ulster Independent Clinic ("UIC"), Miss Diane Graham on 20th January 2012. A reminder was sent on 3rd February and on 9th February Miss Graham responded and stated:

> … Dr Watt joined the medical staff of the Ulster Independent Clinic in March 1997; his speciality being Neurology. The internal audit system of the Ulster Clinic does not highlight any concerns regarding Dr Watt. Dr Watt uses the outpatient facilities of the Ulster Clinic on a regular basis and does so in a self-employed capacity. He is not an employee of the Ulster Clinic.
>
> I have no further information regarding the complaint, which you have highlighted.
>
> I am currently dealing with a complaint by a mother regarding her daughter's consultation with Dr Watt …

8.31 The case referred to by Miss Graham was that of INI 325. That complaint had been lodged by INI 325's mother on 9th January 2012. INI 325's mother indicated that her daughter had attended Dr Watt on 23rd February 2011 when aged 14 years old complaining of headaches and various other symptoms.

8.32 INI 325's mother complained that Dr Watt did not clinically examine her daughter or carry out any neurological tests. She went on to state:

> … Dr Watt spoke to [INI 325] about her headaches and he diagnosed [INI 325] as having classic migraine. He suggested that she should take up swimming because he found this helped his stress. [INI 325] was prescribed Propranolol …

8.33 INI 325's mother asked the following questions:

- Why was a full clinical examination not undertaken at the consultation?
- Why was an MRI scan not considered, especially as it was covered through Private Health Insurance?
- What are the current guidelines for the management of headaches in a fourteen year-old?

8.34 Dr Watt's letter to INI 325's GP following a consultation with INI 325 on 23rd February 2011 indicated that examination had been unremarkable and concluded that, in his view, the headaches were migraine and were largely stress related. Dr Watt had encouraged regular exercise to reduce stress levels and had not arranged to review.

8.35 Problems continued and INI 325 was eventually referred to an Ophthalmologist, Dr Jim Sharkey. The complaint to UIC alleged that the MRI carried out on 5th July 2011 had revealed that the patient had a brain stem tumour and hydrocephalus.

8.36 When the complaint was received at UIC from INI 325's mother, it was forwarded to Dr Watt for a response. Dr Watt responded on 31st January 2012 and indicated that he did not perform a full clinical examination *"because there was nothing on history to suggest that it would influence my decisions regarding diagnosis and management"*. Dr Watt went on to state:

> … I always consider performing an MRI scan but did not because there was nothing on the history to suggest I should. At the time I felt the history was typical of a 14 year-old girl presenting with migrainous headaches. MRI in these circumstances is very unlikely to reveal an incident abnormality, which adds to everyone's worries.
>
> However, I do, as a rule, scan patients if they return because the headaches are not settling with treatment …

8.37 When Miss Graham's response to the GMC was considered, the GMC investigation officer brought it to the attention of the Investigation Manager, Mr Stephen Farnworth. The GMC investigation officer asked him on 9th February 2012:

> This is an employer response in relation to Dr Michael Watt. Our current case concerns Dr Watt's attitude and poor performance during a consultation. Please see this employers response – should we be treating their current complaint as adverse information and as such be asking for further information?

8.38 Mr Farnworth responded as follows:

> Thanks for asking me to consider the Ulster Clinic response. I am content that we ask them to simply inform us if the complaint raises any FTP concerns, we can proceed otherwise.

8.39 Subsequently, the GMC investigation officer wrote again to Miss Graham at the Ulster Independent Clinic on 15th February 2012 and enquired if the complaint raised any fitness to practise concerns. No response was made to this inquiry by the GMC and the matter was not followed up further. As a result, the detail set out at paragraphs 31 to 36 relating to the INI 325 UIC complaint did not come to be in the possession of the GMC despite its obvious potential relevance to the GMC's handling of the INI 45 complaint.

8.40 At the same time as enquiries were made with UIC and HPC, the GMC also sought further information from the Belfast Trust. A response from the Belfast Trust was provided by Dr Stevens, then Medical Director, on 27th February 2012 as follows:

> … With regard to any other concerns I can advise that I am aware of a previous warning that Dr Watt received from the GMC, which was based on Dr Watt's record on 22 February 2007. This related to delays in preparing a report.

> With regard to previous complaints, I can advise you of five complaints. This included one complaint respectively from 2004, 2003, 2007, 2008 and 2010. The underlying theme appears to be concern about Dr Watt's attitude and relationship/communication with patients. You are also aware of correspondence between the Trust and GMC regarding Dr Watt in reference to [INI 346] your ref ND/2002/0950/01/CR.
>
> From a clinical perspective the Trust does not have any concerns at that this time [sic]. There are no audit or other quality assurance measures that would raise concern or evidence of poor practice. I can confirm that Dr Watt is employed as a full-time consultant neurologist by the Belfast Trust.
>
> Given that this is the third time that the GMC have been in contact with the Trust about Dr Watt we now intend to review the situation with respect to his performance and will be in touch.

8.41 This response omitted several clinical complaints, which, in the view of the Inquiry Panel, were relevant. Dr Stevens in his evidence commented upon this:

> … when [INI 45] came along and the GMC asked me for the complaints information, our system let us down. And I recognise — and, I presume, you've reached this conclusion as well — the GMC didn't reference it in their review, but, if they had had a long list of complaints, would that have affected the investigation? You cannot know.
>
> Having said that, we did give them —. If they'd asked us for the details of the five we had listed, they were reasonably meaty, so — well, some of them were; [INI 5][1] was in there. And so, I, you know —Yes, complaints are important; I think our processes now are stronger. The Datix system has developed; it's more reliable.

8.42 The Inquiry notes that there were, in fact, numerous complaints, including INI 87 and INI 222, both of which had serious concerns regarding diagnosis, examination and treatment. Further, the Inquiry Panel notes that the system also seems to have been deficient when the Medical Director was asked to comment on whether there had been any previous indication of a problem by the BBC in May 2018. The problem identified by Dr Stevens remained.

8.43 Following receipt of the response from the Belfast Trust, the GMC investigation officer emailed Mr Farnworth, the Investigation Manager, on 2nd March 2012, and stated:

> … Our index complaint is essentially one of communication; the complainant [INI 45] was not happy with Dr Watt's attitude during a consultation. Given

1 INI 5 was a complaint, which is set out in detail in the Complaints chapter and in the 2012-13 Missed Opportunities chapter.

> that, should we be asking the trust to provide us with the full details of the previous five complaints and treating this as adverse information.
>
> I have previously asked for your advice in regard a similar matter in relation to the reply from the Ulster Clinic – see Case Advice.

8.44 Mr Farnworth responded on 6th March as follows:

> Thanks for asking me to consider the employer response received from Belfast City Hospital. I note the index complaint relates to the doctor's attitude during a consultation and the trust has confirmed that they have had five complaints in the past about his communication with patients. I note that the five complaints are spread over a number of years, 2003-2010 and a complaint concerning his communication style of less than one a year does not in my view signify any significant Fitness To Practise concern …

8.45 Dr Watt's substantive response to the GMC was provided on 31st January 2012 and stated:

> Firstly, I wish to apologise to [INI 45] for the manner of my reply. I have never written such a letter before and certainly will never again. He is right when he says he was not late. I confused him with another patient whose appointment preceded his. With the benefit of hindsight I should have replied offering to see him again to discuss the points raised in his letter to me. At the time I felt that I had addressed the issues during the consultation, which had been quite prolonged and demanding.
>
> I do feel my analysis and the information given was reasonable. I attended a session on small vessel disease at the UK Stroke Forum in Glasgow in December with [INI 45's] criticism still ringing in my ears and heard nothing to suggest what I told him was incorrect.
>
> I did not perform a neurological or fundoscopic examination because I did not feel they would influence my management. [INI 45] had already attended another neurologist and had had extensive investigations. I thought he was consulting me about the MRI findings and their relevance to his symptoms.
>
> Finally, while it might have been nice to see the images, I am not a neuroradiologist and was happy to accept the report of one …

8.46 The GMC subsequently, on receipt of Dr Watt's substantive response, wrote by way of a letter from the GMC investigation officer to INI 45 on 3rd February asking for any further comment. It was stated that a medical and non-medical case examiner would consider the complaint and further indicated that *"case examiners are senior GMC staff appointed to make decisions on cases once the GMC have completed their preliminary enquiries"*.

8.47 Patient INI 45 responded on 3rd February and highlighted the lack of any examination by Dr Watt. INI 45 also followed up with further information at the end of February regarding percutaneous cardiac surgery, which was scheduled in the United States. This letter sought to appraise the GMC of recent developments.

8.48 The Case Examiner's decision was communicated to INI 45 on 13th April 2012. The conclusion had been reached that no further action was required. The reasons were given in Annex A to the correspondence. The conclusion section is set out in extenso:

> Whilst Dr Watt's conclusions about the MRI findings in the context of the history he obtained seemed reasonable on the basis of possible and probable diagnosis it appears that Dr Watt did not examine the patient or consider alternative options. In his response to the GMC he stated that he *"did not perform neurologic or fundoscopic examination because I did not feel they would influence my management."* Perhaps this is true, but Dr Watt did not meet the patient's expectations in not doing so. When a diagnosis is subsequently amended or refuted it is usually better to have recorded a physical examination in line with *Good Medical Practice* guidance (paragraph 2). It appears that the underlying cause of [INI 45] symptoms was cardiac rather than neurological. It would not be unreasonable, however, for a specialist ordinarily to consider a number of options, a so-called "differential diagnosis", and make further recommendations regarding investigation, referral and management on that basis.
>
> Dr Watt apologised to the patient because he also made the mistake of thinking that [INI 45] was late for his appointment.
>
> The case examiners have considered the evidence carefully. Dr Watt's consultation was less than desirable. Even if his preliminary working diagnosis was reasonable, which we accept that it probably was initially, he should have examined the patient, considered the possibility of other causes for the patient's symptoms, discussed management options with [INI 45] and considered review or referral to a colleague if the symptoms continued or worsened.
>
> We note Dr Watt's reflections and his attendance at the "small vessel disease session at the UK Stroke Forum meeting" and feel that this is a constructive response to [INI 45's] feedback.
>
> Whiles the realist Prospect Test is not met evidentially, and we feel that, on this occasion, a warning would be disproportionate.

8.49 Dr Watt was advised that he should familiarise himself with paragraphs 2, 20 and 21 of Good Medical Practice.

8.50 INI 45 responded to the GMC decision on 16th April 2012 indicating that his concern was that Dr Watt would eventually cause serious injury or worse to one of

his patients. He went on to state:

> There is an air of "make believe" about the reasons given by the General Medical Council. I find the rationale to be strained, illogical and expedient. I have done my duty in bringing this matter to your attention. You are responsible for ensuring that harm does not come to patients through incompetence, disinterest or mendacity amongst your doctors …

8.51 This was a powerful critique of the GMC decision. It would have been better if the input had been seriously considered by the GMC when the comment was made, rather than the review, which subsequently took place in 2019 after the neurology patient recall had commenced. On 16th April 2018, the GMC received a referral regarding Dr Watt from the Belfast Trust. This referral enclosed a report of a clinical record review carried out by the Royal College of Physicians ("the RCP report"). The GMC noted that the RCP report had found that there were significant concerns that Dr Watt lacked the basics of careful diagnosis and openness to the opinion of others. In light of this, the GMC opened an investigation in April 2018, which led to Dr Watt being referred to the Medical Practitioner's Tribunal. It was decided that because of the material that had been brought to the attention of the GMC in 2018, there should be a review of the information currently on record regarding Dr Watt's practice, including the 2011/2012 investigation into the complaint by INI 45.

8.52 Rule 12 of the General Medical Council (Fitness to Practise) Rules 2004 outlines two alternative grounds for reviewing any decision previously made by the GMC. First, if the GMC has reason to believe that the decision may be materially flawed and, secondly, if there is reason to believe that there is new information, which may have led to a different decision. Even if either of the grounds are met, the reviewer must also be satisfied that a review is necessary in the public interest.

8.53 The Assistant Registrar prefaced the 2019 decision with the following comment:

> I would like to note that this case was closed more than six years ago and if it had been open today, I consider it extremely likely that we would have obtained an expert report, which would have addressed some of the gaps left by Dr Watt's comments on his treatment of [INI 45]. In 2012, it was more common for us to leave questions of the quality of medical assessments to our Case Examiners, one of whom would always be a qualified doctor. In the past few years, there has been a recognition by the GMC that often a more specialised approach is needed, which is why in clinical cases we would now ask a qualified consultant in the same specific field of medicine to provide an opinion in addition to relying on the judgment of medical Case Examiners.

8.54 The Assistant Registrar went through the reasoning on the details in the decision to close the complaint. The following points from the review are highlighted below:

- Despite the criticisms of the patient, Dr Watt did not address at any time why he made the diagnosis of exercise-induced migraine over other potential diagnoses.
- It was surprising that Dr Watt had not addressed how he formulated the diagnosis and why an examination was not required in order to come to a conclusion.
- Dr Watt's reflection on the consultation that it was entirely reasonable to act as he had done was not constructive as had been found by the Case Examiners because he had failed to address the thrust of the complaint and shown no insight into any aspect of the complaint other than post-consultation communication.
- Reference to attending a Stroke Forum was of limited relevance. Such attendance is a usual part of a consultant's obligation and there was no correlation between what had been focused on at the course and how this was relevant to a very specific medical case.

8.55 The Assistant Registrar concluded that the observations made by the Case Examiner pertaining to remediation were potentially flawed in that they may not have adequately[2]considered remediation when finding that the realistic prospect test was not met.

8.56 The Assistant Registrar further noted that the Case Examiners did not fully consider that Dr Watt gave no reason for his diagnosis and, therefore, they could not have been satisfied that the deficiencies in care had been resolved.

8.57 The Assistant Registrar further stated:

> If Case Examiners had in fact concluded that Dr Watt's response was not constructive, they may have taken a different view as to his fitness to practise and therefore their assessment of insight and remediation has the potential to be a material flaw. It is a possibility that having considered the above factors which they omitted to fully address they could have come to a different conclusion as to how to dispose of the case. Even in the event that they came to the conclusion that this one single clinical incident was not deplorable and, as an isolated failing, did not meet the threshold for impairment, they still would have had open to them the option of issuing Dr Watt with a warning.

2 At the end of every investigation the Case Examiners have to decide whether there is a realistic prospect of proving, on a balance of probabilities, that the doctor's fitness to practise is currently impaired. In other words, if the doctor remained on the medical register with no restrictions, there would be a current and future risk to patient safety and/or confidence in the profession.

8.58 The Assistant Registrar, having concluded that the closure decision may be materially flawed, went on to consider whether a review is necessary for the protection of the public or otherwise necessary in the public interest. It was concluded that, but for the recent RCP report from the Belfast Trust, there remained a patient safety concern, which had been left unaddressed because of flaws in the original investigation and, in such circumstances, a review should have taken place to satisfy not only patient protection, but the public interest. Nevertheless, as a result of the RCP report, the GMC had opened an investigation, which was much wider in scope than the original single allegation made by INI 45. As a broader investigation into Dr Watt's performance was now taking place, which would consider his general proficiency in neurology, this would provide a much more reliable picture of Dr Watt's current alleged impairment. For those reasons, the Assistant Registrar decided that a review was not necessary under Rule 12(3).

8.59 The Inquiry Panel discussed with the GMC at some length the INI 45 complaint received in 2011. Mr Massey, the Chief Executive of the GMC, indicated that, in 2011, it was not the common practice of the GMC to commission an expert report on the basis that one of the Case Examiners would have always been medically qualified. The Rule 12 Review by the Assistant Registrar had found that if the case had arisen today, an expert report would have been commissioned. Mr Anthony Omo, General Counsel & Director of the Fitness to Practise Directorate at the GMC commented, in relation to the initial inquiry in his evidence on 15th January 2020:

> I think, without any doubt they were over generous to the doctor, or -- I can't say with any certainty but -- they certainly seem to, without the benefit of an expert, reached views in his favour and even took what he claimed to be reflection and insight to new levels, and I think all that comes out when you go forward with the review we did undertake of our own volition which says … and that's why we did change the system, that's why they do get expert reports. We also changed how they structure decision making so that it is a lot clearer about what they are doing, what they are not doing and where they are going with it …

8.60 In his evidence to the Inquiry Panel, Mr Massey felt, on re-reading the INI 45 papers, that the decision to only require disclosure of the medical records and not obtain an expert report, was probably driven by Dr Watt's letter to the GMC and the perception, at that stage, that this was a concern about communication and attitude to the patient, rather than a clinical issue. He felt that this may have got in the way of other questions that might have been considered. Mr Massey also noted that Dr Watt's history with the GMC may have *"reinforced that presumption rather than raised a wider issue"*.

8.61 Mr Omo took a similar view and highlighted the responses from the Belfast Trust and independent providers:

> … all of his employers through that complaint we are looking at, positively assured us there was nothing with his performance. Now I'm not sure what systems they had in place to make those judgements given that in the same letter the Chief Exec of the Ulster [Independent Clinic] is saying the internal audit system does not highlight any concerns regarding him but I'm dealing with a complaint, and I'm not sure how they are classifying concerns and complaints. Belfast Trust is similar when you get to the letter from Tony Stevens, he sets out, 'actually I am aware of the history with the GMC we know of five complaints, we've got no clinical concerns, our data is not showing us, but we will have a review,' and of course we didn't follow that up. I don't know -- and your evidence may have taken you there -- there is something for me about local governance systems.

8.62 Mr Massey was also concerned about the reinforcement of a perception that any issues in the INI 45 complaint related solely to communication or attitude. In his evidence to the Inquiry Panel on 15th January 2020, he stated:

> … What comes through very clearly in my mind, whether it be in terms of what the Trust said or Ulster Independent Clinic, is that actually – these are my words not theirs – there is almost a deference to the clinical judgement being appropriate, and to an acknowledgement that there are long standing issues around communication and attitude; and because of that almost historical context there's almost a presumption when something came up that this was a communication or attitudinal issue. And therefore the system as a whole, including ourselves, failed to pick up the fact that there were a deeper suite of issues going on … you look at some of the pieces in here like [INI 325] or [INI 5], which were clearly quite significant complaints handled respectively by the Ulster Clinic and by the Belfast Trust, but even with those having gone through all of the tiers within those providers in terms of complaints there is still a backing for the clinical judgement …

This was a welcome and candid assessment by Mr Massey and highlights a matter, which in the view of the Inquiry Panel, needs to be addressed by the GMC.

8.63 Mr Omo, when he gave evidence to the Inquiry Panel on 15th January 2020, indicated that the present system of investigation often involves, in any case where clinical issues are raised, the option of getting a *"quick clinical opinion"* from an expert. This would not be a full-blown expert report, but what the GMC referred to as *"provisional enquiries"*. If the matter is escalated to a full investigation, then a full expert report is obtained in almost every case. Mr Omo concluded on the INI 45 matter:

> … So now when you put the whole thing together, this was clearly like a broken window syndrome. There's enough there to: say there's a problem, whether you class it as performance/clinical; and to do something about it, which I think Tony Stevens hinted at in his review, although he didn't cover what that review was, and we don't know what happened, because again we didn't follow-up …

8.64 The Inquiry Panel also heard evidence from key individuals within the Belfast Trust, who had some knowledge of the INI 45 complaint. Dr Tony Stevens was the Medical Director during the relevant period. As noted above, he had indicated to the GMC that, given that this was the third time that the GMC had been in contact regarding Dr Watt, the Trust intended to review the situation. Reflecting back on the INI 45 complaint, Dr Stevens stated:

> If his complaint had been to us, although it was a private practice complaint, that would've forced us to think about it, but our approach to this would be, "Well, this is the GMC looking for information. It's their problem. Let them solve it, and we'll look and see what they come up with". They actually came up with, effectively, nothing, and we let it go. And as I've said, in retrospect, should we have been — well, that's not true to say we let it go, because we had put him into doctors and dentists [case review meeting] and an informal investigation, but, you know, could we have put more weight on that case ourselves? We were probably influenced by the outcome of the GMC.
>
> I suppose the wind had been taken out of us a little bit by the GMC …

8.65 It is noted that the outcome of the GMC investigation was a significant influence on the Belfast Trust and highlights the importance of GMC inquiries having the requisite degree of specialist input.

8.66 Dr Stevens' view was shared by Dr Hannon, who, at that time was an Associate Medical Director in the Belfast Trust. He had been requested by the DDCRM[3] to conduct a Finding of the Facts exercise as the first stage of Maintaining High Professional Standards ("MHPS").[4] The approach to the exercise altered when the GMC decision regarding INI 45 was communicated to the Belfast Trust. Dr Hannon stated to the Inquiry Panel in his evidence of 3rd February 2020:

> Then at some point the GMC say 'right, we're not going to do anything more'. All of a sudden it appeared, from my point of view, to diffuse in as much as the impetus to get anything done, these were all old things and the GMC thing was the new thing and then they said they're not going to do anything more. So the heat, as it were, went out of it a bit.

3 Doctors & Dentists Case Review Meeting.

4 This is a mechanism agreed between the Trust and the British Medical Association for the investigation of a doctor in relation to clinical or behavioural issues.

> I probably read it and said I'm not a neurologist. It doesn't look great. Then they said they are not going to do anything with it. I am not a lawyer, but this has been up to the GMC, if they say they're not doing anything, who am I to get involved, sort of thing.

8.67 Dr Hannon's view was reinforced by Dr Ken Fullerton, who was also an Associate Medical Director in the Belfast Trust, who was also asked to review Dr Watt's situation. In his evidence of 5th November 2019, Dr Fullerton stated:

> There wasn't anything being looked at by the GMC at the time of his revalidation [in 2013]. Now I appreciate there was early correspondence… I was, at the time, aware of one case where a letter had gone from the GMC to Dr Watt, which, although it did contain some criticisms, was short of a warning, or wording, very like that was used in the letter.
>
> I mean, I think the question about the [INI 45] case is, should I have taken further action? Should I have sought a more detailed review and so on? ... There are, clearly, some difficulties, which, I suspect, from correspondence, arose at the consultation. So, [INI 45] and Dr Watt were, clearly, not on the friendliest of terms, and that, I think, is reflected in some of his wording. He has had a question; he has had some symptoms. He has expectations of the consultation, which are not met and he's reported episodes of weakness and episodic disruption of movement and speech … The bit that I might have been concerned about is where he says: "You performed no neurological examination". Yes? And he was referred because of an abnormal MRI and Dr Watt claimed that he didn't have access to look at the MRI. Now, this is the private sector and had I been that patient, I would have been very disappointed in that. And, indeed, Dr Watt's response to the questions that are asked seems less than complete. But from my perspective, this case, including the clinical aspects, had been reviewed by the GMC … I have now seen the GMC's rethinking in retrospect of the case. I mean, my expectation at the time was that if a case, which had clinical aspects, was sent to the GMC, then the GMC would have applied appropriate expertise to reach a conclusion on the clinical case. And the GMC, I think, used the words "reasonable", although they were critical of some aspects. They didn't issue a warning — so that's the first thing. Perhaps I shouldn't have been so willing to take the word of the GMC, but, at that point, I'd no reason to believe that their examination had been in any way deficient.

8.68 Dr Fullerton highlighted again the influence of the GMC. Their action was not neutral and did influence the approach of medical managers.

8.69 Professor Mascie-Taylor asked Dr Fullerton specifically about reliance upon the GMC:

> **Dr Fullerton:** If the GMC were investigating a case that had a clinical perspective and commented on the clinical aspects, then what they said was reliable.
>
> **Professor Mascie-Taylor:** And sufficient for you to be reassured.
>
> **Dr Fullerton:** Yes. Yes.

8.70 The Inquiry Panel also received evidence from Dr Cathy Jack, who was Medical Director of the Belfast Trust between 2014 and 2019. She had reviewed the INI 45 complaint and pointed out a discrepancy between Dr Watt telling the GP that he had performed an examination and admitting in his correspondence to the GMC that he had not performed an examination because he did not need to do so. In her evidence of 11th December 2019, she stated to the Inquiry Panel:

> Michael Watt writes in the letter that he performed an examination. He says it in the letter. "There's no abnormality on examination." On examination, there's no abnormality. He then admits [to the GMC] that he didn't do it. Nobody seems to have picked up that that's a probity issue … They never mention that, actually, what he wrote in the letter wasn't true. Surely that goes to the core of 'good medical practice'.

8.71 The Inquiry Panel was also focused on the fact that UIC did not respond to the specific question raised by the GMC on the INI 325 complaint that was referred to, in generic terms, as *"a mother complaining on behalf of her daughter"*. Mr Massey, the Chief Executive of the GMC, reflected that the GMC had to get better at triangulating information. His view was that even without doctors raising concerns, there was enough information being raised to warrant investigation. Commenting specifically on the INI 325 case, Mr Massey stated:

> I mean, I think, that complaint looks like it could well have raised fitness to practise concerns had it come to us. You will have seen … that we asked [UIC] to let us know if it raised any fitness to practise concerns, I think obviously the Clinic never came back to us on the back of that and nor did we chase them.
>
> I think one of the lessons … one of the things we have been talking about -- and it's not just in terms of this [INI 325] issue, it's also the question earlier in the pack about Mr Walby and the point that the doctor wasn't complying in the appraisal process -- is that, you know, the GMC then was less good at proactively following up when those issues were raised than obviously, with hindsight, one would have wanted us to have been and that I would expect us to be now.

GMC Interaction and Liaison with Responsible Officers:

8.72 A further issue that was the subject of scrutiny and reflection in the evidence obtained from the GMC was the question of information sharing and liaison with Responsible Officers. The GMC retains some historical information on file in relation to individual doctors, including relating to complaints received by it directly and previous referrals from employers. This information will include complaints or referrals, which did not meet the GMC threshold for investigation at the time they were considered by the GMC. In the view of the Inquiry Panel, information of this nature may still be relevant to a Responsible Officer or Trust when investigating a doctor, particularly in identifying patterns of behaviour. Dr Jack highlighted to the Inquiry Panel the difficulty she had faced in circumstances relating to an earlier public inquiry in obtaining information held by the GMC she considered relevant to her investigation. Dr Jack gave evidence to the Inquiry Panel on 29th October 2018 in relation to this issue:

> I am trying to manage the recommendations of the O'Hara Report and some of the concerns that were raised about members of staff in that. That then means I put individual doctors who appear to have been criticised into the same MHPS framework because that is the only framework I can use. I have actually approached the GMC asking if they have anything on file. So, they will tell me if they have anything that reaches the threshold. But when I asked them using the Medical Act 1983 I think it is, if there is anything that they have triaged out at a certain level, then they will not disclose that to me. Now I am sitting here as Responsible Officer with significant concerns that Sir Justice O'Hara raised and yet I am only being told about issues which reach a certain level from the GMC.
>
> [The GMC] do not provide the information if they screen out at triage any complaint or low level concern. So, they will tell me if they have given sanctions or warnings or they are proceeding to investigate, but they will not tell me of anything they have screened out.

8.73 Responding to this concern, the GMC in its evidence, made a distinction between issues, which could not possibly impact on a doctor's fitness to practise, such as parking in the wrong space, and a lower level behavioural or a clinical issue, which would not meet the threshold for investigation. Mr Massey explained:

> The reason we don't say we'll automatically do it for all of them is that (a) they're quite often trivial but (b) the process of disclosure itself is not a neutral action in the system in terms of then feeding the culture of fear…
>
> … it's always a question of that judgement of proportionality. So we get about eight or nine thousand complaints against doctors each year. I think if we just

> sort of did, I'd argue the 'lazy thing' of saying to Responsible Officers, here are those eight or nine thousand complaints, what we are doing is saying in order to identify this needle in a haystack we are just going to give you another haystack to go through …

8.74 Mr Massey felt there was still some room for judgement about relevance, even though the increasing tendency was for complaints with a clinical component to be reported to the Responsible Officer, even though the complaint may not have reached the threshold for investigation. The Inquiry Panel agrees that there may be complaints which are so obviously unrelated to a doctor's clinical practice that they can be screened out of possible disclosure, but generally the current closed procedure needs to have a lower threshold for disclosure to a Responsible Officer.

8.75 The Inquiry Panel considered more recent examples of complaints made directly to the GMC, which did not meet the threshold for notification to the Responsible Officer of the Belfast Trust. This was despite Mr Massey's reassurance that there was an increased tendency for complaints with a clinical component to be referred by the GMC to the Responsible Officer.

8.76 On 21st April 2016, INI 454 who had consulted with Dr Watt on 15th February 2016 at HPC, complained to the GMC that he was suffering from headaches. Following examination, Dr Watt explained that INI 454 should get an MRI scan. The patient explained that he had private health insurance with work, which would enable him to get an MRI scan within 10 weeks. He was anxious that this be done quickly as he intended to leave the company in the near future. According to INI 454 Dr Watt agreed that he would get the referral sorted that evening. This was not done and after 20+ phone calls to both HPC and Dr Watt's 'private clinic', the referral was eventually sent one month later. INI 454 stated:

> Whether it was intentional or just negligence Dr Watt decided against both phoning back and issuing the bill. As of yet I am still waiting on this call back. I did however receive the bill today 21/04/16. I find this absolutely disgraceful. Not only was I unable to get the MRI as Dr Watt didn't both sending my referral off for an entire month after our consultation, and only after 20+ messages left for him, he then held off for 10 weeks on sending my bill, this is outrageous. £180 for a consultation in which he didn't act as he said he would and which my health needed, luckily for him I haven't had any major episodes of late or I would be seeking substantial damages due to him not referring me for my MRI.

8.77 In the GMC's response of 13th May 2016, a Complaints & Correspondence Officer acknowledged the dissatisfaction with the service provided by Dr Watt, but noted

that: *"the GMC can only take action where we consider we may need to restrict or remove a doctor's registration with the GMC"*. She went on to note:

> We do appreciate your concerns; however, having considered all of the available information we do not feel that these issues raised meet the GMC threshold for investigation into Dr Watt's fitness to practise medicine.

8.78 The reasons given in the correspondence were that:

(i) The GMC cannot intervene in issues relating to the payment of fees. This does not raise a concern about a doctor's fitness to practise as a doctor.

(ii) There was no evidence in the information provided to suggest that the delays were deliberate or solely the responsibility of Dr Watt.

(iii) The GMC have no powers to investigate why the doctor did not phone back. This may have been *"due to a miscommunication or administrative error"*.

8.79 A further complaint was received by the GMC from INI 456 on 1st May 2018. This related to a consultation on 27th May 2017 at UIC. The patient saw Dr Watt at UIC, having been referred by her GP because of ongoing neurological symptoms. Dr Watt diagnosed multiple sclerosis. He indicated he would refer the patient for an MRI of the spine and the head and that he would see the patient in the next few months under the auspices of the Belfast Trust. Dr Watt, according to the patient, was to arrange the treatments and he advised the patient to take 5000mg of Vitamin D daily. The patient also referred to the fact that her husband had questioned Dr Watt directly as to whether he was certain about her having MS. At that point, Dr Watt had highlighted the symptoms that he had noticed on examination, including optic neuritis, lower neuropathy, tingling pins and needles, bladder control, pain, left eye weakness and sleep issues.

8.80 In September 2017, the patient rang to find out where she was on the Belfast Trust waiting list, only to discover that she was not on any waiting list. She was informed by UIC that Dr Watt was unwell and had not been able to action the MRI. A subsequent MRI, according to the patient, revealed that she did not have multiple sclerosis.

8.81 On 21st May 2018, an Investigation Assistant in the Fitness to Practise Directorate of the GMC, wanted to check whether Dr Watt had actually prescribed 5000mg of Vitamin D daily. Responding to this, the patient stated:

> You are quite correct. The daily dose of Vitamin D is 5000 IU. Dr Watt wrote this on a slip of paper and told me that I could buy it on 'Amazon'.

8.82 Internally, the GMC wondered whether this complaint needed to be looked at as a new inquiry as there were a number of allegations in another case that was being considered.

8.83 On 1st June 2018, a Complaints & Correspondence Officer on behalf of the Assistant Registrar, wrote to the patient and stated:

> … We have however carefully considered the issues you've raised about your own care, and sought advice from a medically trained member of staff. However, we have not identified issues, which would on their own merit meet our threshold for opening an individual investigation in Mr Watt's fitness to practise. We're sorry if this isn't the outcome you were hoping for …

8.84 The letter went on to outline the role of the GMC as follows:

> Our role is directly related to the registration of doctors. Our responsibilities are all connected to keeping the Medical Register. We oversee medical education; we give entry to the Register for those suitably qualified; we advise on good medical practice while registered; and we remove or restrict registration in response to fitness to practise concerns where there may be a risk to patient safety.
>
> An investigation can only be opened if the concerns raised are so serious that the doctor's fitness to practise medicine is called into question to such an extent that action may be required to stop or restrict the way in which they can work to protect future patient safety.
>
> The purpose of an investigation is to determine if or to what extent we need to restrict the doctor from working. We are not a general complaints body and we have no legal powers to intervene in or resolve matters for patients.

8.85 The decision, that this case did not merit the threshold for investigation, was taken by an Assistant Registrar of the GMC with advice from a medically qualified GMC case examiner. The only question which appears to have been considered relevant in reaching that decision was whether it was appropriate for Dr Watt to diagnose multiple sclerosis without waiting for the results of an MRI scan. The Medical Advisor believed that the symptoms reported were broadly consistent with multiple sclerosis. While MRI is often used to confirm a diagnosis, it is by no means the only method and the condition is sometimes diagnosed by assessing the patient and the patient's history.

8.86 Further, the medical case examiner did not have any concerns about taking a Vitamin D supplement, as there was some scientific opinion, in the view of the medical case examiner that low Vitamin D levels may have an influence on the disease. The letter

stated: *"While we appreciate the diagnosis was incorrect, there isn't information to suggest that it was so flawed that it would raise questions about Dr Watt's fitness to practise"*. In terms of the issue of a delay in ordering the MRI scan, it was noted that the Trust had informed the patient that this was because Dr Watt was off sick at the time. The GMC had also made enquiries and concluded:

> … On careful consideration we don't feel the delay in ordering the scan, given the period of sickness, and suggested failings by the trust in re-assigning work, would be sufficient to meet out criteria for further investigation.
>
> Please be assured that our decision isn't mean [sic] to undermine your concerns. We appreciate how the delay in the scan has impacted you and we are not excusing the trust's failure to pick up on Dr Watt's outstanding work …

8.87 Commenting on the ability of the GMC to investigate, the letter indicated that the GMC could only take action where the individual allegations can be shown to be primarily the fault of the doctor and where they are serious enough on their own to raise questions about the doctor's fitness to practise. It does not appear that there was any complaint made to UIC and this complaint was not brought to the attention of the Responsible Officer of the Belfast Trust.

8.88 When one views the INI 456 complaint in retrospect, it is clear that there are parallels with the initial examination of INI 45 in 2011. Although the GMC, in their evidence to the Inquiry Panel, were aware of the problem of medical case examiners commenting on areas outside their own sub-specialty, this issue has reoccurred in the INI 456 complaint. It was not a neurologist who was advising that the patient's symptoms were broadly consistent with multiple sclerosis and that an MRI was not necessary, nor was it a neurologist who was opining that Vitamin D was a perfectly appropriate treatment. This repeats the error of the initial INI 45 investigation and raises a continuing concern that medical case examiners are making clinical judgements and being tempted to overreach on questions which are outside their own specific expertise.

8.89 In the view of the Inquiry Panel, the GMC needs to ensure that Responsible Officers have access to the same clinical information as the GMC. Where a filtering process operates, the danger is that information which may help identify a pattern of aberrant practice is not forwarded to Responsible Officers, who are also being asked to exercise judgement and discretion.

8.90 Dr Jack had concerns regarding the disclosure of closed inquiries. In relation to one specific case, Dr Jack stated in an email of 25th September 2018:

> … As Responsible Officer at the Belfast Trust, I would seek full disclosure of all cases or enquiries in relation to REDACTED that have been closed with no GMC action, AND those where GMC action has been taken.
>
> As you suggested I have considered s35B(2) of the Medical Act and I would submit that there is a public interest in this full disclosure, for the following reasons:-
>
> 1. There has been unprecedented public scrutiny and concern regarding the management of the doctors involved in the Hyponatraemia Inquiry. This is such that the reputation of the profession and the regulator, and the confidence of the public in the profession, has been questioned. Similarly the confidence of the public in the Trust as employer has also been called into question.
> 2. I would wish to take all possible steps to ensure that my decision-making at this time is fully informed.
> 3. I would also wish to reassure the public (including the families of the deceased children) that I have taken all possible steps to ensure that my decision-making at this time is fully informed; furthermore to seek to restore public confidence in the profession and the Trust.
> 4. In order that I am fully informed, I would wish to obtain any and all information regarding any concerns raised regarding this doctor, and how these were managed.
> 5. I would also consider that, any revalidation recommendations made by me, should be fully informed, and as such any information provided to me will be used also in that context. You will be fully aware of the significance of my revalidation recommendation for the ongoing practice of this doctor, whose revalidation date is imminent.
>
> While I understand the rationale of the GMC in not ordinarily disclosing information about concerns closed with no GMC action, I believe for the reasons outline above, that full disclosure of information should be made at this time …

The Challenges of Overcoming Existing Medical Culture:

8.91 A full chapter of this report is dedicated to questions of medical culture. The Inquiry sought information from the GMC as to the extent to which the GMC has become involved where a doctor has failed to report a concern in line with good medical practice. This data was subsequently helpfully provided by the GMC. A total of 56 cases were identified between 2001-2018. None of the cases related to Northern

Ireland. In one case, a warning was issued at hearing and in one other case, the matter was concluded with an undertaking by the doctor. In the remainder of the 56 cases, they were closed at hearing, concluded following investigation, or concluded with advice following investigation. It is hard to resist the observation that doctors feel little pressure that they must come forward if they have a concern. It is noted that the duty of candour recommendation in *The Inquiry into Hyponatremia-Related Deaths* published in January 2018 is currently being considered by the Department of Health.

The Perception of the Role of the GMC:

8.92 The Clinical Director within Neurology, Dr John Craig, emphasised that doctors took extremely seriously the role and impact of correspondence from or reporting to the GMC. He told the Inquiry Panel: *"If I receive something from that, it will be an immediate response"*. A number of witnesses to the Inquiry Panel stressed just how significant a report to the GMC was for individual doctors. Dr John McConville described a report to the GMC as *"a nuclear option"* and stated that there was *"an intrinsic reluctance to report people to the GMC"*. Professor Ian Young, who was a Deputy Medical Director during the relevant period covered by the Inquiry, highlighted in his evidence of 9th April 2019, the problems of reporting colleagues as follows:

> I know that Cathy [Jack] and the Trust strive to do things properly and follow MHPS procedures properly and refer to the GMC, where appropriate. I also know that individuals find that extraordinarily stressful and oppressive. It really changes people's lives dramatically in lots of ways, and their colleagues see that. I think that colleagues need to do the right thing when they see a problem with their colleagues but, you know, I can kind of understand. You have somebody who's a friend: do you want to throw them into those sorts of processes? That's the cultural thing, I think, that needs to be fixed.

8.93 Peter Lees of the Faculty of Medicine Leadership and Management agreed about the GMC being a *"nuclear option"*. He referred to it as a threshold issue and that when the threshold reaches a certain point, and needs to be earmarked nationally as a problem with significant sanctions being applied, then the GMC should be the arbiter of that process. He did, however, submit to the Inquiry Panel that many of the cases referred to the GMC were remediable and could have been sorted out locally.

8.94 The evidence given by representatives of the GMC did not disagree with Mr Lees. The Chief Executive, Mr Massey told the Inquiry Panel on 15th January 2020:

> I think an ideal world is where things get best resolved locally. The regulator should be there as a backstop where things go wrong to essentially opine, but, essentially, we need to be putting our muscle – and we'd be the first to admit we need to continue to put more muscle – into how do we support doctors and clinical governance systems to be as good as they can be, and we're not there yet.

8.95 Dr Tony Stevens, Medical Director of the Belfast Trust between 2007 and 2013, told the Inquiry Panel on 3rd September 2019 that, in his view, doctors legalise what other employees deal with through their Trade Union. He emphasised just how legalistic referral to the GMC was and believed that the reticence of Dr Ray Hannon and Mr Steve Cooke to intensively investigate Dr Watt in 2012 was influenced by their previous experience. He told the Inquiry Panel:

> I think some of Steve Cooke's experience is reflected in the fact that the GMC didn't issue warnings or take any action and the Trust was left dealing with very difficult situations.

8.96 Dr Stevens agreed with Mr Cooke that one really needed a lot of information before going down the formal route.

8.97 Dr Cathy Jack, who succeeded Dr Stevens as Medical Director of the Belfast Trust, was concerned about the clarity of guidance from the GMC. In her evidence of 12th December 2019, she stated:

> I feel sometimes that the GMC and the Department say something and they don't make it absolutely clear, and our doctors then interpret it in the lightest way they possibly can. They talk about, you know, "This is the minimum requirement"… If I try to strengthen it, I get criticised. On the one hand, I have to bring the troops into order; on the other hand, they sit here like Pontius Pilate washing their hands, not telling me what I [need to hear].

Conclusions and Findings:

8.98 The Inquiry Panel first considered the actions of the GMC in relation to a 5-year warning given in 2007. There was a degree of confusion as to what a warning entailed. It was, according to the GMC, something on a doctor's record and did have implications. In stark contrast, however, neither Dr Michael McBride, who was Medical Director of the Belfast Trust in 2007, nor his successor, Dr Stevens, had any real understanding of the implications of what a warning was or what steps needed to be taken. This was particularly relevant in the INI 346 case, when the GMC contacted the Belfast Trust directly because of Dr Watt's failure to complete

a report. Given that this was precisely the reason for the warning in the first place, it was clear that different units of the GMC were unaware of what had happened previously. It may well be, as Mr Massey indicated, that *"behavioural and clinical concerns were kept in different buckets"*, but the Inquiry Panel finds it remarkable that the GMC complained to the Belfast Trust about Dr Watt within the currency of the 5-year warning period for a failure to provide a medical report, when it was the GMC who had imposed the warning for, in essence, the very same failure.

8.99 Further confusion arose because in 2016, INI 454 complained about the impact of a delay in Dr Watt ordering an MRI scan. This case was an additional example of where obligations taken on by Dr Watt had not been fulfilled. Not only did it appear that the GMC was unaware of its own earlier 5-year warning, but the explanation given to the complainant suggested that the issue of delay in providing or ordering a report or, in this case, an MRI scan, was not a fitness to practise issue, which would justify investigation. The contrast is stark and confusing, and the Inquiry Panel considers that the approach taken undermines the ability of the GMC to identify a clear pattern of behaviour, which had already been the subject of a formal warning.

8.100 This approach contrasts with the decision of the GMC in 2007 to issue a 5-year warning on the basis that Dr Watt had not provided a medico-legal report. From the written information provided to the Inquiry Panel on the INI 454 complaint, the investigator seems to have had no knowledge of the earlier warning and, more alarmingly, does not appear to have grasped the basic fact that delay in ordering an MRI scan, when an undertaking has been given to do so, is clearly a fitness to practise issue and one, which in previous instances has been taken seriously by the GMC. The INI 454 complaint gives rise to a concern that information sharing in relation to individual doctors is inadequate. It further raises questions of consistency and the apparent absence of a common understanding of what issues are legitimately considered under the rubric of fitness to practise.

8.101 It is, however, the INI 45 case, which has given the Inquiry Panel the greatest degree of concern. The Inquiry notes and acknowledges that a Rule 12 review was carried out and did conclude that, because of the larger investigation taking place, it was not in the public interest to re-open the original complaint. That said, the Assistant Registrar had come to the view that the original decision may have been materially flawed for the reasons, which are set out at paragraphs 53-58 above.

8.102 The Inquiry Panel is not in a position, nor is it required to properly assess the neurological issues, which arise in the INI 45 complaint. It notes, however, that the medical case examiner who advised on the complaint, who assessed the complaint,

was not a neurologist. The errors made by the GMC in its initial consideration of the complaint were, in the view of the Inquiry Panel, serious and obvious. A view seems to have been taken at an early stage of the complaint that the problem was one of communication and all subsequent events have been seen through that lens. Such an approach has missed, not just the matters identified by the Assistant Registrar in the Rule 12 review, but also other issues, which should have been noted and highlighted.

8.103 The Inquiry Panel agrees with Dr Jack that the inconsistency between what Dr Watt told the patient's GP and what he had said to the GMC, raised a potential probity issue. The medical records reveal that Dr Watt informed the GP that his findings were *"on examination"*. In his response to the GMC, however, Dr Watt stated that he did not perform a neurological or fundoscopic examination because he did not feel that they would influence his management (see paragraph 45 above).

8.104 At the heart of the complaint by INI 45 was the failure to conduct a neurological examination. In a situation where the medical records note the fact that Dr Watt had informed the patient's GP that he had performed such an examination, the discrepancy should have been investigated and an explanation sought for the inconsistency. This was not done.

8.105 In the view of the Inquiry Panel the significance of the INI 45 complaint was not just the inadequacy of the investigation carried out by the GMC, but the failure to follow up on a lead that was given by UIC. GMC correctly and appropriately contacted the various institutions at which Dr Watt practised to ascertain whether there were other relevant complaints or concerns. The Belfast Trust referred to administrative concerns and highlighted the fact that Dr Watt had already received a GMC warning for failing to complete a medical report in respect of a criminal injury claim.

8.106 In its response to the GMC's inquiry, the Belfast Trust did not accurately record the number of complaints nor did it make any reference to the INI 5 complaint, which had been received in 2010. While Dr Stevens had indicated that Dr Watt's name was appearing too frequently, he also provided a degree of reassurance by stating that there were no clinical concerns. Whatever view was taken on the advice given by Dr Watt to INI 45 the complaint was indisputably a clinical complaint and should have been referenced as such.

8.107 The reference to no clinical concerns reinforced, in the view of the Inquiry Panel, the perception that prevailed, not just within the GMC but within the Belfast Trust, that Dr Watt's problems were administrative and failures of communication. It is almost

as if subconscious filters were being applied on every occasion in which clinical queries were being raised.

8.108 The opportunity missed in the response of the Belfast Trust was applied more dramatically in the case of UIC. When the Chief Executive, Diane Graham, responded on behalf of the Clinic, there was, once again, a degree of reassurance. Miss Graham stated that: *"the internal audit system of the Ulster Clinic does not highlight any concerns regarding Dr Watt"*. Subsequently, in the correspondence, there is a somewhat Delphic reference to *"dealing with a complaint by a mother regarding her daughter's consultation with Dr Watt"*. While this reference was followed up by the GMC investigator, the subsequent request for information was done by way of a limited interrogation. Instead of straightforwardly asking for details of the complaint, the GMC sought reassurance that it did not raise fitness to practise concerns.

8.109 The letter of complaint itself should have been sufficient to alert the GMC to a potential clinical problem. By that stage, however, the perception, as demonstrated in the internal GMC correspondence was that this was a communication problem. Matters were compounded by the fact that UIC, for some reason, omitted to adequately respond to the question. The chapter on the independent sector comments more specifically on the internal clinical governance within the private sector, but it is sufficient to note, at this juncture, that no reasonable or adequate explanation was given to the Inquiry Panel for the obtuse response to the query by UIC, nor was any sufficient explanation provided by the GMC for failing to follow this up.

8.110 This omission, in the view of the Inquiry Panel, was of genuine significance. Aspects of both the INI 45 and the INI 325 complaints were strikingly similar. In each case Dr Watt in his GP letters had referred to the outcome of an examination. In his correspondence to the GMC in the INI 45 case and UIC in the INI 325 case, he advised that he had not in fact carried out an examination because he did not feel it was helpful or necessary in reaching a diagnosis. Given that a clinical examination is a key component of neurological practice, the discrepancy should, at the very least, have led to further inquiry.

8.111 Additionally, by way of comparison, these complaints focused on an alleged incorrect diagnosis, and both complained of no further proposed treatment or follow up, beyond advice which appeared to the patient to be inappropriate, or at the very least inadequate. In the case of INI 45, the advice was to take cold showers after exercise and, in the case of INI 325, Dr Watt suggested regular exercise as a means of combatting migraine headaches. It is obvious and apparent that the details included in the complaints were of a clinical nature and raised concerns, which needed to

be investigated. The approach taken by all of the institutions merely reinforced a strong perception that Dr Watt's ability as a clinician was not in doubt.

8.112 In addition, the timing of this complaint, coming as it did when a registrar had raised concerns about the practice of Dr Watt with her Clinical Director, and the extant investigation by two Associate Medical Directors under MHPS, could not have been more relevant. These matters are all set out in more detail in the 2012-13 Missed Opportunities chapter of the report.

8.113 The fact that none of the information was triangulated ensured that no action was taken and no concern escalated. The combined effect of a poor investigation by the GMC into the complaint by INI 45, the failure of the GMC to follow up on a generic complaint raised by UIC, the failure by UIC to respond properly to the GMC, and an incomplete and inadequate response from the Belfast Trust in respect of Dr Watt's complaint history, ensured that a significant opportunity to properly investigate concerns about Dr Watt's practice was missed.

8.114 A further issue, which was considered by the Inquiry Panel, was the extent to which cases that did not meet the threshold for investigation were not passed on to the Responsible Officer. Where there is evidence of poor or inadequate decision-making, the fact that information is not shared with the Responsible Officer inhibits pattern recognition. It also potentially reinforces the practice of putting one's own filter on information, which could be of use to the person charged with making a decision on the revalidation of a doctor's practice.

8.115 The Inquiry Panel notes that the GMC has sought to liberalise their approach to sharing information with the Responsible Officer, but, in the view of the Inquiry Panel, this new approach does not go far enough. It may well be the case that complaints about car parking or other matters concerning a doctor are so patently irrelevant to clinical practice, that they can be easily classified as not raising fitness to practise issues.

8.116 There are, however, many complaints, which do not reach the threshold of concern, which do have a distinct clinical component and, in the view of the Inquiry Panel, should automatically be shared with the Responsible Officer. The recent example of INI 456 above, which was not even investigated by the GMC, suggests to the Inquiry Panel that the issue of identifying clinical concerns and ensuring that medical case examiners have the relevant specialist expertise has still not been adequately addressed. This should be given a higher priority within the current framework for investigating complaints and concerns, which are made directly to the GMC. The

Inquiry Panel agrees with Dr Jack that the ability of a Medical Director, who is also the Responsible Officer to get a full picture of the doctor's practice, is undermined by current practice.

8.117 The difficulties that emerge as a result of the extant medical culture are commented upon in a separate chapter. A particular area of concern, however, which is relevant to the GMC as the regulator of doctors, is the extent to which doctors understand their duties and obligations to raise their concerns about a colleague when there is evidence of potentially dangerous or improper practice. At present, there is a marked reluctance among doctors to escalate and record concerns. This is evidenced in this Inquiry by all categories of medical practitioner in both primary and secondary care. It appears to the Inquiry Panel that doctors often believe that they need to prove to their own satisfaction that a concern they have, would pass their own threshold of proof. This can often be as high as the criminal standard, and yet such a standard of proof is not required in respect of the actions expected of doctors under Good Medical Practice when they have a concern. This is commented upon further in the chapter on Medical Culture.

8.118 The GMC Guidance on Good Medical Practice states at paragraph 25:

> 25. You must take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised.
>
> a. If a patient is not receiving basic care to meet their needs, you must immediately tell someone who is in a position to act straight away.
>
> b. If patients are at risk because of inadequate premises, equipment or other resources, policies or systems, you should put the matter right if that is possible. You must raise your concern in line with our guidance and your workplace policy. You should also make a record of the steps you have taken.
>
> c. 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.

8.119 The stark and compelling evidence of the difficulties doctors have in raising or escalating concerns is demonstrated clearly in the data provided to the Inquiry by the GMC and highlighted at paragraph 91 above, which reveals that no significant sanction has ever been taken in Northern Ireland or anywhere else in the UK in respect of a doctor, who has failed to report an obvious concern. The fact is that although patient safety is meant to be the paramount concern, there is a greater

concern that one does not escalate matters to the Regulator. This evidence is perhaps compounded in a jurisdiction where most of the medical practitioners all trained at the same medical school. In view of the Inquiry Panel and based on the totality of the evidence received, this attitude is deeply embedded within neurology and one can reasonably assume elsewhere and ensures that critical information regarding aberrant practice is often not picked up until harm has been caused.

Printed in the United Kingdom by Digital Print Services of the Northern Ireland Department of Finance

ISBN 978-1-912313-63-1